

FALL 2009 IDN SUMMIT
PEER-TO-PEER LEARNING EXCHANGE
RESEARCH REPORTS

Disaster Preparedness



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THE ROLE OF SUPPLY CHAIN IN PREPARING FOR DISASTERS

Disaster preparedness includes measures that individuals, households, organizations and communities can take to respond effectively and recover more quickly when disaster strikes. FEMA's Capability Assessment for Readiness (CAR) (<http://www1.va.gov/emshg/apps/kml/docs/CapabilityAssessmentforReadiness.pdf>) specifies 13 areas for targeted preparedness efforts, while the Department of Homeland Security (<http://www.dhs.gov/index.shtml>) has identified 37 targets. The following is a summary of preparedness dimensions and activities:

Hazard knowledge

- Conduct hazard, impact and vulnerability assessments
- Understand impacts on facilities, structures, infrastructure and populations
- Provide hazard information to customers and related stakeholders

Management, direction and coordination

- Assign responsibilities.
- Develop a division of labor.
- Identify response related roles and responsibilities.
- Adopt management procedures such as National Incident Management System
- Deliver training and educational programs

Formal and informal response plans and agreements

- Develop key documents
 - Disaster plans
 - Evacuation plans
 - Memoranda of understanding
 - Collaborative partnerships
 - Resource-sharing agreements
- Participate in community, regional, and industry preparedness initiatives and groups

Supportive response

- Acquire equipment and supplies to support response
- Ensure coping capacity
- Recruit staff
- Identify unrecognized resources
- Develop logistics

Life and safety protection

- Prepare employees to take action to prevent injury or harm
- Take actions to lessen the disaster's impact on health and safety

Property protection

- Act to prevent loss or damage of property
- Protect inventories
- Secure records
- Ensure critical functions can be maintained during the disaster
- Contain secondary threats

Emergency coping and restoration of key functions

- Develop the capacity to improvise and innovate
- Develop the ability to be self-sustaining

Recovery

- Prepare recovery plans
- Acquire adequate insurance
- Identify sources of aid

Writing in the August 2008 issue of *Materials Management in Healthcare*, Terri Rebmann, Ph.D., R.N., C.I.C., the associate director for curricular affairs, Institute of Biosecurity, and Assistant Professor, Division of Environmental and Occupational Health at Saint Louis University, School of Public Health, noted several unique features of infectious disease disaster planning and advised supply chain professionals to take the following actions:

- Plan for both victims and the safety of healthcare workers with supplies, protective gear and vaccines, as well as recommendations for quarantine policies.
- Prepare for implementation of infection prevention strategies such as isolation, quarantine and post-exposure prophylaxis, as well as a possible influx of infectious patients.
- Interface with infection control professionals and facility disaster planning committees.

- Be prepared to address broad infection control issues such as surveillance, isolation, personal protective equipment use, hand hygiene, quarantine, cleaning and disinfection of the environment, treatment, prophylaxis, vaccination, and post-mortem care of victims.
- Make needed supplies available. These include:
 - Protective equipment
 - Hand hygiene products: antimicrobial soap, water, and alcohol-based hand rubs
 - Medications (antibiotics, antivirals and vaccinations)
 - Ventilators
 - Linens
 - Isolation rooms
- Develop MOAs that outline how supplies and medical equipment will be provided before and during the disaster.
- Consider advising facilities to stockpile certain supplies and medical equipment based on their patient population and the capacity and proximity of other facilities.
- Plan for events involving a bacterial or viral agent.
- Plan in conjunction with local, state and regional public health resources.
- Avoid depending on local, state or federal resources for supplies and medical equipment during a disaster.
- Provide training programs that involve tasks such as hand hygiene, use of personal protective equipment, isolation, surveillance and re-use of equipment.

H1N1 Preparedness Precautions

Among the questions you may want to discuss with your colleagues are the following:

- What's the most perplexing and difficult issue concerning the H1N1 virus? For example, the American College of Emergency Physicians (<http://www.acep.org/WorkArea/DownloadAsset.aspx?id=45781>) has said: "Pharmacies may not be able to get additional supplies from distributors . . . supplies of personal protective equipment and other supplies may require stockpiling, and food services could encounter supply problems due to production and delivery. The workforce may be depleted due to infection."
- What are the lessons learned from previous attempts to grapple with the H1N1 virus, as well as SARs and natural and manmade disasters of the past?
- How will the H1N1 virus evolve in the future and how can supply chain executives prepare now for best and worst-case scenarios?

The Problem: How, When and Where?

One problem with the H1N1 virus is some experts aren't entirely convinced of the severity, scope and potential impact of the virus. The result: mixed messages, misunderstanding and confusion among members of the public, government officials, providers and vendors.

As recently as May 2009, the CDC claimed that the swine flu lacked the "virulence factors" seen in the 1918 Spanish flu or avian flu. Despite this admission, public health officials remained on high alert, which led to closed schools and flooding of emergency departments (EDs) by patients who thought they had the virus, even though they had no symptoms. As a result, waiting times at hospitals EDs increased, causing problems for those who genuinely needed emergency care. Especially affected were the EDs of children's hospitals such as Children's Memorial Hospital, in Chicago. In other locations, labs that went overtime in testing high numbers of H1N1 specimens.

The underlying problem is that the H1N1 virus is what some experts have called "fluid and evolving." Only recently have providers, vendors and public and government officials developed acceptable answers to core questions. In more than a few cases, the jury is still out. Among the issues waiting for more complete answers are the following:

- How far will the virus spread?
- Why did so many people die in Mexico, as opposed to the U.S.?
- Why do younger people get the H1N1 virus, while older people—the typical victims of seasonal flu—don't? (June 2009 evidence from the CDC revealed the majority of H1N1 cases have occurred in people between the ages of 5 and 24, with few cases occurring in people over the age of 64.)
- Under what circumstances and in what settings should vaccines and medications be given?
- What is the responsibility of hospitals and physicians in communicating accurate H1N1 information and updates to the public? Should that responsibility be shared with government, business, schools, churches and other not-for-profit associations?
- Have hospitals, outpatient and long-term care facilities adequately prepared for potential supply chain problems by adjusting just-in-time inventories, ordering additional supplies and working with vendors to ensure supply delivery in a crisis?
- What kinds of supplies will be especially necessary? Lab test kits? Masks? Gloves? Goggles? Medications? Water? Fuel?
- Will vaccines be effective in combating H1N1? Will enough vaccine be available for targeted, recommended populations?
- Are businesses and healthcare providers adequately prepared to manage employees and family members?
- Are providers ready to quickly adapt to changes within the most affected age groups?
- Are testing methods adequate to quickly determine if patients have H1N1? Are facilities and processes in place to conduct necessary tests?
- How well will CDC guidelines be updated to reflect changing realities and new and emerging scientific evidence?
- How can public health officials, the media and providers help to control patient and consumer panic and foster adherence to behaviors such as calling ahead to physicians' office to discuss symptoms?
- How can businesses, including hospitals and healthcare providers, compel staff members to practice behaviors that will help prevent

H1N1 and curtail subsequent spreading of the virus?

Of course, the only thing we can be sure of is change, as a prominent psychiatrist once said. As recently as July 2009, the CDC announced that H1N1 could affect as many as 40 percent of Americans, assuming that one worker will stay home to care for family members.

Even more troubling is evidence from the Government Accountability Office (GAO) (<http://www.gao.gov/new.items/d09909t.pdf>), which reveals that while federal agencies have taken action on 13 of GAO's 23 recommendations, 10 of the recommendations that GAO has made over the past three years are still not fully implemented. The GAO and other experts now suggest the following:

- Clarify, test and exercise leadership roles and responsibilities for an H1N1 pandemic. Who does what when and how?
- Develop coordination mechanisms such as infrastructure coordinating councils to better coordinate efforts by federal, state, and local governments and the private sector in pandemic preparation and response.
- Continue efforts to improve surveillance and detection of pandemic-related threats in humans and animals.
- Obtain more complete information from developing countries before offering assistance to countries that are theoretically at greatest risk.
- Address gaps in pandemic planning and exercise at the federal, state and local government levels.
- Address capacity available to respond to and recover from an influenza pandemic.
- Review requirements for added capacity in patient treatment space, and the acquisition and distribution of medical and other supplies, such as antivirals and vaccines.
- Encourage federal agencies to continue to provide guidance and pandemic information to state and local governments, along with advice on border closures and other issues.
- Strengthen performance monitoring and accountability for pandemic preparedness. The May 2006 National Strategy for Pandemic Influenza Implementation Plan fails to establish priorities among 324 action items or information on financial resources required for implementation.

Fortunately, HHS and the National Institutes of Health (NIH) have already taken several steps in response to H1N1.

Vaccine distribution: The government will distribute vaccine through schools and daycare centers as soon as it becomes available—ideally in mid-October 2009—with some vaccine provided through physicians' offices, community health centers and schools.

Grant funding: The government has released \$350 million in H1N1 preparedness grants to all states and territories. While \$260 million will go directly to state health departments to prepare for a vaccination campaign, \$90 million will help hospitals handle an expected surge in patients.

Information: The government has upgraded <http://www.pandemicflu.gov>, while also sending out PSAs about the virus and tapping into other social media vehicles.

International summits. The government has participated in a variety of international summits designed to ensure better coordination among nations.

Nevertheless, the government remains concerned over numerous issues:

- **Hospital readiness:** Hospitals must be prepared to handle patients who may come in through emergency departments, but who will need hospitalization.
- **Lack to access to basics:** Many Americans still lack access to preventative care, a health or medical home and a primary care physician.
- **Public complacency:** The general public may believe that the virus has subsided or disappeared, negating the need to engage in prevention and vigilance.
- **Public misinformation:** People may not regard influenza as a serious disease. However, seasonal flu kills an average of 36,000 people every year in the U.S. As of July 31, 2009, the H1N1 outbreak had led to more than 5,500 hospitalizations and more than 350 deaths in the U.S., according to the CDC.
- **Viruses morph:** The H1N1 virus may change and become more severe in the fall of 2009.
- **H1N1 is global:** As of Health August 2009, southern hemisphere nations such as Argentina, Chile, Australia, and much of Asia and Africa, had already revealed significant infection rates.
- **Vaccine lag:** Flu cases could emerge in early fall before the vaccine becomes available in mid to late October of 2009.
- **ED overload:** The American College of Emergency Physicians believes that if more than 30,000 cases develop in the fall and early winter of 2009, EDs could experience 150 percent of normal volume.
- **Community response:** Many communities are unprepared to communicate or enforce "mitigation strategies" such as social distancing, rejection of public transportation, handwashing and requirements that people stay home.
- **Supply chain problems:** Pharmacy, materials management, transportation, food services, and workforce will all be hit by an H1N1 pandemic.

Lessons Already Learned About H1N1

Following are just some of the strategies that have already been used to cope with the H1N1 virus.

Restrict employee travel: Caterpillar Inc. implemented its emergency response plan by restricting employees from traveling to Mexico

and monitoring the outbreak for further interruptions (<http://manufacturing.net/News-Caterpillar-Restricts-Mexican-Travel-Over-Swine-Flu-042809.aspx>). Other companies that have limited travel to Mexico include General Electric, DuPont, and Emerson Electric.

Plan ahead: Abbott Laboratories started planning for pandemics after the outbreak of avian flu in Asia during 2006. Abbott instructed its employees traveling within Mexico to leave the country on April 24, 2009 and continues to screen all Mexican employees for flu symptoms.

Build teams: Kimberly Clark created cross-functional teams with representation from medical, healthcare, human resources and product supply to minimize potential disruptions to business operations (<http://www.dallasnews.com/sharedcontent/dws/bus/stories/DN-fluworkplacecopy.State.Edition1.1394c2b.html>).

Think labor: Prepare for more patients and fewer staff given the reality of single parents and one parent who may need to stay home, advises Bruce Cadwallender, director of safety and emergency management for the University of Michigan Hospitals and Health Centers. Also consider the potential role and contribution of volunteers who have been turned away in previous crises such as Katrina and the mobilization of teams of physicians and nurses, suggests the ACEP's H1N1 Task Force.

Prepare to handle inpatient demand: Look at the potential expansion of ambulatory capacity, consolidation of staff in larger locations, closure of some locations and availability respiratory isolation rooms and equipment.

Consider stockpiling: The University of Michigan's Cadwallender suggests storing respiratory masks, pharmaceuticals and bottled water to ensure availability and prevent rationing. Also consider gloves, gowns, ventilators, antibiotics and IV equipment, advises the ACEP's H1N1 Task Force.

Use varied means of communication to deliver updates: Consider new and emerging communication vehicles such as online videos for both staff and the public on patient care and prevention issues. Also review the value of online blogs from key physicians and voice mail messaging for staff communications.

Integrate: Balance the use of new and emerging communication vehicles such as Twitter with more traditional means of communications such as brochures, patient handouts and articles in local newspapers.

Provide training: Make sure that both staff and the public understand how to use and access newer communication vehicles. Consumers should understand prevention and home treatment, while providers should learn how to perform varied tasks related to triage, testing, and treatment.

Beware of caregiver stress: Develop trained teams of counselors to work with staff under severe stress, as was discovered post 9/11 and in the aftermath of Katrina.

The Pandemic Flu: Lessons from the Frontlines

(<http://healthyamericans.org/assets/files/pandemic-flu-lesson.pdf>), a report from Trust for America's Health, features 10 early lessons learned from the response to the H1N1 (swine) flu outbreak, as well as 10 ongoing core vulnerabilities in U.S. pandemic flu preparedness. The 10 early lessons learned from the 2009 H1N1 outbreak in the report include the following:

1. Investments in pandemic planning and stockpiling antiviral medications paid off;
2. Public health departments did not have enough resources to carry out plans;
3. Response plans must be adaptable and science-driven;
4. Providing clear, straightforward information to the public was essential for allaying fears and building trust;
5. School closings have major ramifications for students, parents and employers;
6. Sick leave and policies for limiting mass gatherings were also problematic;
7. Even with a mild outbreak, the health care delivery system was overwhelmed;
8. Communication between the public health system and health providers was not well coordinated;
9. WHO pandemic alert phases caused confusion; and
10. International coordination was more complicated than expected.

Key Recommendations on Coping with the H1N1 Virus

Trust for America's Health also offers some 10 recommendations to prepare for a potential flu pandemic:

1. **Maintain the strategic national stockpile:** Make sure enough antiviral medications, vaccinations, and equipment are available to protect Americans. This includes replenishing the stockpile when medications and supplies are depleted;
2. **Develop and product vaccines:** Enhance U.S. biomedical research and development to develop and produce required vaccines;
3. **Vaccinate all Americans:** Make sure Americans can get inoculated in a reasonable period of time;
4. **Plan and coordinate:** Improve coordination of federal, state, and local governments and the private sector in preparation and planning, taking into account how the flu threat changes over time;
5. **Engage in community-wide prevention:** Use school closings, sick leave, and community mitigation strategies to limit the spread of the disease; ensure working Americans have sick leave benefits; prepare communities to limit public gatherings and close schools;
6. **Coordinate globally:** Build trust, technologies and policies on an international level to encourage scientifically-based, consistent decision making across borders;

7. **Mobilize resources:** Provide enough funding for an on-the-ground response, which is already under funded and overextended;
8. **Ensure a strong workforce:** Stop layoffs at state and local health departments and recruit the next generation of public health professionals;
9. **Develop surge capacity:** Support healthcare providers in managing a massive influx of patients; and
10. **Care for the uninsured and underinsured:** Ensure that everyone will receive care during an emergency to limit the spread of the virus to others; make sure hospitals and health care providers are compensated for providing care.

The American College of Emergency Physicians (<http://www.acep.org/WorkArea/DownloadAsset.aspx?id=45781>) recommends the following for hospitals:

- Identify lead officers to coordinate preparedness and response.
- Plan surge staffing for the entire organization.
- Prepare to secure supplies of personal protective equipment.
- Augment post-mortem and mortuary services.

The Government Accountability Office (GAO) (<http://www.gao.gov/new.items/d09909t.pdf>) recommends the following:

- Clarify the roles and responsibilities of the Departments of Health and Human Services, Homeland Security, the Homeland Security Council, the Federal Emergency Management Agency, as well as roles and responsibilities of state and local government on border closures and vaccine distribution.
- Ensure better coordination and collaboration between and among state and federal governments and the private sector.
- Address issues of strategy, costs, targeting of resources to achieve maximum benefits and balancing risk, benefits and costs.
- Develop measures to protect the state and federal government workforce.
- Create altered standards of care guidelines, including how to deliver care while allocating scarce equipment, supplies and personnel to save the largest numbers of lives.

Both vendors and provider organizations should provide customers, vendors, partners and authorities with assurances that they will take the following actions:

- Monitor H1N1 through multiple sources, including the World Health Organization, CDC, PandemicFlu.gov, HHS and local authorities.
- Provide regular communications with employees through established traditional and online communication channels.
- Avoid travel to high-risk areas while preparing employees to reduce the risk of becoming sick with the virus.
- Prepare for H1N1-related absences through cross training, succession planning, automation and telecommuting.
- Work with other vendors and organizations to ensure development and maintenance of an active pandemic plan.
- Find replacement or similar vendors to eliminate supply failures and rationing.
- Create social distancing mechanisms through flexible work schedules and telecommuting.

The CDC also released its own advice for vendors and employers:

Develop a business continuity plan: Make alternative plans to ensure the organization can remain operational in the face of potential absenteeism and supply chain disruptions.

Educate employees: Keep staff well-informed about new policies and procedures; request that they develop emergency plans for themselves and family members.

Cross-train: Make sure the organization facility is prepared to operate with even a 20 to 40 percent reduction in staff.

Advise workers to stay home: Educate staff to monitor their own health and refrain from working or caring for patients if they exhibit flu-like symptoms.

Provide free staff immunizations

Plug into community resources: Coordinate with hospitals and public health services identify sources of information on community outbreaks and response activities.

Executives from Scripps Health, the University of Pittsburgh Medical Center and Clarian Health have offered recommendations targeted to supply chain professionals. Among them:

- Get together with other providers to test vendor memoranda of understanding, advises George Mills of the Joint Commission. Having multiple organizations order the same supplies within a limited period of time will surface potential supply chain problems.
- Communicate with medical staff leaders, infectious disease specialists, emergency departments and physician offices and clinics.
- Track the number of flu tests, as well as the costs of testing and inpatient costs related to H1N1 diagnoses. Having this information available may generate reimbursement.
- Don't count on local or county public health officials to mobilize resources or perform specific functions. Depending on the strength of the public health infrastructure, hospitals and other healthcare providers may need to take on at least some of this role.
- Check capacity for ambulatory and inpatient care, isolation and respiratory disease treatment.

- Develop plans for managing employees and families.
- Be prepared for ongoing changes in CDC guidelines for care. Check these guidelines frequently.
- Consider testing of a surge model by requesting that vendors estimate required numbers of respirators, gowns, gloves and goggles.
- Live through a 24-hour pandemic scenario to determine usage of masks, gloves, goggles and coverings, as well as the time needed to perform basic tasks.
- Examine requirements in light of staff and population size, number of area providers and equipment needs.

Resources

SciDev.Net Health: Swine Flu
<http://www.scidev.net/en/health/swine-flu>

CDC H1N1
<http://www.cdc.gov/h1n1flu/>

Pandemicflu.gov
<http://www.pandemicflu.gov/>

Interim Guidance for Infection Control for Care of Patients with Confirmed or Suspected Swine Influenza A (H1N1) Virus Infection in a Healthcare Setting
http://www.cdc.gov/h1n1flu/guidelines_infection_control.htm

Antiviral Drugs and H1N1 Flu (Swine Flu)
<http://www.cdc.gov/h1n1flu/antiviral.htm>

H1N1 Flu Clinical and Public Health Guidance
<http://www.cdc.gov/h1n1flu/guidance/>

World Health Organization
<http://www.who.int/csr/disease/swineflu/en/index.html>

The Association of State and Territorial Health Officials
<http://www.astho.org/programs/infectious-disease/h1n1/>

Influenza Pandemic (Government Accountability Office)
<http://www.astho.org/programs/infectious-disease/h1n1/>

Pandemic Flu Preparedness: Lessons from the Front Lines (Trust for America's Health)
<http://healthamericans.org/assets/files/pandemic-flu-lesson.pdf>

Swine Flu Guide (WebMD)
<http://www.webmd.com/cold-and-flu/swine-flu/>

H1N1 Influenza Center (New England Journal of Medicine)
<http://h1n1.nejm.org/>

H1N1 Flu (MedlinePlus)
<http://www.nlm.nih.gov/medlineplus/h1n1fluswineflu.html>

Swine Flu: The Pandemic of 2009 (New Scientist)
<http://www.newscientist.com/special/swine-flu>

Disaster Recovery: Experiences from Past Disasters Offer Insights for Effective Collaboration After Catastrophic Events
<http://www.gao.gov/new.items/d098111.pdf>

CONCLUSION

The Fall IDN Summit Disaster Preparedness Peer-to-Peer Learning Exchange Lunch took place at the Gaylord Texan on Wednesday, September 23rd from 11:30 am - 12:30 pm. The session was attended by supply chain executives from various stakeholders: health systems, GPOs and suppliers. The session was facilitated by Rick McFee, Associate Vice President for Operations and Support Services at The University Of Texas Medical Branch. Below, please find the edited transcripts of the discussions that took place during the exchange.

TRANSCRIPT

MR. MCFEE: I'm Rick McFee, and I'm going to be your facilitator today. This is a round-table discussion, open discussion between all our IDNs and providers, as well as if we have any vendors here also. The topic today is around disaster preparedness. Obviously our focus is very much on the H1N1 pandemic potential that we have. And what we really want to do is just kind of have everybody share what you're doing in your facilities; if you're with a vendor population, what's your company's doing, both in preparation within your own company around your staff, any policy changes, any supply change - type changes you may have made, as well as anything that you've done relative to your policies for supply deliveries and filling orders. And so, all that we're going to be going through. I've got the original sign-in sheet. I'm just going to pass this around. If your name is on it, just put a check next to it. If your name is not on it, if you would fill out your name at the bottom. We also have a court reporter stenographer with us here today who will be trying to capture all of the 23 comments that are made so that we can have post session information provided back out to you all. Her request is that she can only capture one comment at a time, so please try to allow the individual to finish their comment and then we'll move forward from there. Any questions before we get started?

MR. MCFEE: As I said, I'm Rick McFee. I'm associate vice president for operations and support services at the University of Texas Medical Branch on the coast. We're one year out from our impact by Hurricane Ike where we lost 1.4 million square feet of our first floor space of our facility. So disaster preparedness is something that we're living still today in just trying to recover, and we're in that recovery phase from Hurricane Ike, and obviously in the FEMA rebuilding stage right now. But at the same time, we reopened as our hospital. We're back up to a 400 bed hospital; and we, you know, are going to get impacted by any kind of pandemic flu or any other kind of emergent disease that we might have, so here we are. What I'd like to do is if - some folks just came in. Does anybody else need one of the informational handouts? This document was prepared by the IDN Summit folks and is a collection of research information around the current thinking.

MR. MCFEE: Okay. Great. So let's - we'll kind of start off in, I guess, asking, you know, some questions and just having you all kind of respond back. How many of y'all have a committee that's been established within your facility specifically to address reaction to H1N1? (Show of hands)

MR. MCFEE: And just, you can shout out, but who is involved in that committee? Who do you have represented there?

Participant: We have a cross-section of individuals from all aspects, but because we are a physician only, physician operated facility, very high involvement in physicians, from emergency med to infectious control to pathologists. So there's about 25 people that are involved, and we have a steering committee of about 12.

Participant: We also have a marketing person just because of the relationship of the community as well, and our employee health is involved.

MR. MCFEE: Good. Others? Who is involved in your current disaster committee or preparedness committee that's looking at H1N1?

Participant: Ours started out as an outgrowth of our general disaster readiness committee; and only recently, as in two weeks ago, they decided to - it had been fairly high level. And then they realized that they have to get involved the buyers and supply chain and warehouse, so...

MR. MCFEE: Two weeks ago?

Participant: Yeah, two weeks ago, pretty much.

MR. MCFEE: Good deal. We're always the last ones to know.

Participant: It was exciting.

MR. MCFEE: All right. How many have the chief medical officer for your facility chairing that committee? Is that where you're seeing that? Anybody have the CEO or COO chairing the committee?

Participant: We do.

MR. MCFEE: You do?

Participant: We have our chief medical officer and COO co-chairing.

MR. MCFEE: Okay. How many had a committee of this nature three years ago? (Show of hands)

MR. MCFEE: Okay. In dealing with the SARS or what - what prompted you to create it, or was it just a standing?

Participant: It was pretty much a standing. It was really our environment of care. We have an employee health committee, and we have - one of the people on there that we, you know, represent for the central disaster team, so he's kind of been going back and forth on that. It was a continuation. And when we really started out, we really didn't; and now we've really got that as our main focus.

MR. MCFEE: At UTMB we've got an environmental care committee that looks at all the different elements of the JCHO requirements, but in this particular case, we actually created a full task force that's chaired by our chief medical officer, and it's very, very specific to preparations for a pandemic situation. We have a lot of our normal players and representatives there, you know. It's very focused towards that one reaction. - what are the primary functions that you looked at or concerns that you have looked at on those committees? What - what's been the focus?

Participant: Well, mainly it's getting word out not just to the public but also our employees, because the employees go home and watch the news, and they get kind of worked up. But really, just trying to cross-train them a lot. We worked with - a few of us are members on the medical subcommittee on our local health department or disaster preparedness group, and mainly finding out what our state is going to do about vaccine, how much is going to be available, how much is going to be available to us, and

also deciding which one of those – how we're going to treat our – who of our employees will actually get vaccinated if we get enough to do that.

MR. MCFEE: So clearly, in that case, a preparatory stage in which you're looking specifically how you're going to inoculate your employees and staff. Have you taken operationally, then, how you're going to manage the triage of patients coming into the hospital, into the clinics, which one of those patients will receive either prophylactics or whatever else relative to the flu? I guess my question really is: How far has your committee gone with looking at how you're going to deal with this? You know, do you – do you have supplies stockpiled; have you defined how much you're going to need; have you defined how that's going to be used in your clinics? Those are – those are some things that we're dealing with, I know. Yes, sir?

Participant: Our committee was really involved or really concerned about patient access, because we have 40-some facilities, so where do we send patients that may be infectious. And so, we spent a lot of time working on access. It was also on supply, both the medical, surgical supplies, as well as pharmaceutical. We stockpiled just in the med surge side, PPI, \$700,000 worth of supplies, but we've had that for about six years now, and –

MR. MCFEE: That's 700,000 for your entire organization?

Participant: For our system, yes.

MR. MCFEE: And that's how many hospitals?

Participant: Well, we have – we have one hospital but we have over 800 physician employees and about 7,000 employees total.

MR. MCFEE: Okay.

Participant: One of the major issues that we dealt with was communication, both internal communication as well as external communication. That was a challenge.

MR. MCFEE: Okay.

Participant: I'm from Maine Health Care Systems, one of the systems I have from the supply side was we had a really aggressive team looking at all the different processes of moving patients and we have – we have major operations in six hospitals that we own that we fill with more critical patients. And two things were happening: One, we were talking on the respiratory subcommittee for eval, without question, each one talked about did they refer – send their patients to our main hospital. And I kind of called a time out and suggested we look at triaging it a different way – I'm a Navy foreman from way back – that major hospitals are going to be full. The other thing that really concerned me was, we were talking about the extra supplies for the pandemic kind of situation, especially with the flu this year. Everybody's talking around about it, don't want to talk about the money, nobody's willing in the state to come up with money. Only recently have we requested our stockpile from many different companies. A lot of them don't have it. It's been a real problem for us. So I think the stock for us has been a real concern.

MR. MCFEE: How many of have what you consider adequate stockpiles sitting in your facilities right now today, by show of hands? (Show of hands)

Participant: Can I ask a question?

MR. MCFEE: Sure.

Participant: How did you determine that?

Participant: Yeah, what's that?

Participant: How did you determine that you have an adequate stockpile? I'm asking because I'm in Southern Louisiana.

MR. MCFEE: And what, you guys don't know those things?

Participant: We have no clue how to measure it. I mean, we're trying to stockpile everything from –

Participant: I don't think there's an easy answer for that. It's really just a guess, but it's a guess based on how – how long we anticipate a problem is going to go on; and then how many kind of like – how often we have to change the N95; how many face shields do we think we're going to have during a period of time. And so, we came up with a rough estimate. In fact, it happened before I got there, but we came up with some rough estimates and built it from that. Right now I have about just under 700,000 N95s in stockpile.

Participant: What would be your estimate patient load in the event of a disaster? We saw our flagship hospital in Baton Rouge during the hurricane, the patients went up 300 percent, because other hospitals closed down. We had to set up emergency tents outside to triage patients coming in. If we get into a situation that's pandemic that we have to break into all the N95 masks, you have to change 1 that mask for every patient.

Participant: CDC is thinking about changing that.

Participant: The hospital next to us, they've elected to use an N95 mask and put a surgical mask over that. If you can imagine how hard that is to breathe through. So they can reuse their N95 mask. There's now an N99 mask on the market as well; although, I don't know if anybody wants to buy them, they're about \$6.00 apiece.

MR. MCFEE: On average, what's your number of days' supply that you think you have?

Participant: Well, right now, I would anticipate that we've got about a 30-day supply.

MR. MCFEE: Okay.

Participant: Anybody have 30 day supply? Just show of hands. (Show of hands)

MR. MCFEE: And obviously it will keep going up. 60-day supply? Anybody with 90-day supply sitting in their warehouse?

Participant: And the recommendation is six months. So that's not – I think something interesting here, our control nurse suggested and so we just ordered \$4,000 for major hospitals, 4,000 of the masks. And one of the arguments came out and said we may have to require that visitors to wear that mask. Well, there's no budget in there for that. So that's like another – there's all kinds of stuff there.

Participant: How do they get to recognize 52, as far as the fit? We actually have one that – our state has med surge caches. And we have what's at our hospital a lot of stuff, there's a lot of N95 masks that didn't come with a fit. Also, they're not the same as the N95 we stock within the hospital. So that's kind of an issue that's come up.

MR. MCFEE: And the question's going to be, who is going to authorize you to use that cap?

Participant: That's the problem we have.

MR. MCFEE: You're not going to have permission to use that until the state allows you to use it, so it can be sitting right there in your warehouse and, you know, you may not be able to access it.

Participant: It's like antivirals.

Participant: Just a question: The mask that you have, are those one brand, one stop? I think the other recommendation is you need to be fit tested for every different type and style you have.

Participant: Our employees are fit tested 100 percent as of September 15th.

Participant: For all the different styles that you have in stock?

Participant: Yes.. And we have hampers as well. One of the issues we found, even when we had that first come in there, is that there's no supplies in the pipeline.

Participant: That's right. That's what I was going to ask you, how did you get those?

Participant: One – we already had them.

Participant: You already had them, okay.

Participant: But in reordering anything, there's – I mean, the supply pipeline just totally closes up.

Participant: The problem is that all – a vendor's only giving you what's in the allocation, and has based that allocation on history. We've used the 3M one, so that's all you need for allocation. But now we need in Midland, we'll need whoever else is out there, we never bought them before. Because you have no (inaudible).

MR. MCFEE: Right. Right. We're experiencing that same issue. And of course, we got hit pretty hard with the earlier H1N1 scare, and so our stockpile which we'd felt pretty comfortable with got depleted at that time, and distributed out to all our clinics. Right now, we believe our clinics have quite a bit of product sitting out there ready to go, but we're working right now on trying to account for that in our overall numbers. Our stockpile is anticipated to be a 90-day stockpile and about \$1.3 million; so, it's expensive to do that. And we're experiencing that exact same issue with a closed down supply chain that's – you know, we've got orders out there that are being cancelled and allocated. And in UTMB's situation, we've been closed effectively for six months out of the past year as we came back from our hurricane, and so our volumes that we have out there are very small in those type of products, and so they're trying to point at that usage rather than the usage of 2008 which would have been substantially higher, so...

Participant: Your 90-day stockpile, is that based on normal usage or –

MR. MCFEE: No, the 90-day stockpile is based on a calculated number that the task force put together based on the process that they established at each one of our clinics. You know, that our greeters that are there, the financial screeners and processors, they'll be wearing an N95. They've got all these different processes that they put in place, and they've analyzed each one of those based on current volumes and anticipated volumes, and then calculated what the 90-day supply is. Just to give you a feel, it's – it's about 4,800 percent greater than what we have in place for SARS and the Avian flu previously, because the H1N1 is a respiratory droplet transmission, whereas the other ones - had different means of transmission, so...

Participant: That was one of the concerns at the supply chain, was that I truly don't think if somebody sees this, I apologize, I don't see the CFO's are reluctant to authorize the expenditure. I think it's a real pushback, it's not unique to our system. I've talked to different people in our business across the country. I'm hearing the same things from everyone, and it really concerns me. It sounds like your facility has got it, and that's great. A month's supply is – would be gone, unless you really have some good vendors will be gone in a couple of weeks.

Participant: I suspect most the C suites do get it, but it's an economic issue, and you just can't spend \$4 million on supplies that sit around and do nothing. And that you're only going to assume that you might need sometime down the future. So I think it's an economic issue. And how many hospitals have margins that allows for that?

MR. MCFEE: For the most part, a lot of your PPE that's out there may be product that you're using currently. How many of y'all have a rotation process that you have in place to rotate that stock into that? ♪ (Show of hands.)

MR. MCFEE: That's one of the ways you can kind of counter your CFO argument, is that you're rotating your gloves, you're rotating your masks, and they're not sitting there stagnant; but they do become an excessive amount of inventory. Any of you all maintaining that inventory as a part of your inventory, asset inventory, versus having it already expensed out somewhere?

Participant: We do a little bit of both. We've got some stockpile just as expensed and we do have some in inventory. One of the bigger challenges that we faced when we had the initial surge, we have surges constant from the State of Wisconsin, really pretty heavy surges in the spring, and we found out that a five-week supply of normal usage was a week's worth during the surge. Before we started to get some resupplies in, we had like one and a half case level of supplies. So what we did is for this anticipated surges, we took the half of April and half of May and looked at that initial surge, calculated some numbers from that, and that's how we came up with our current stockpiles in the case. As everybody here knows, it's getting increasingly difficult to get stuff because things are being put on allocation. One of the things that we treat – keep trying to bring up the food chain is that somebody in the organization needs to triage to a different mask if we can't get N95s, because it's a real possibility that's going to happen, and there's a lot of reluctance for anybody to make that call. But at some level, it's got to happen; and that's our frustration.

MR. MCFEE: Has anybody put into your stockpiles the reusable cartridge masks instead of the N95s as a book-up?

Participant: For hampers We have a large supply of hampers and we're still waiting for a lot more.

MR. MCFEE: They are still kind of available out there. And they they help with the CDC recommendation for, you know, changing it out between every patient because you can continue to wear that since it's a cartridge. One of the things that we experienced in the earlier outbreak scare issue was being able to manage and control the outflow from the stockpile in an allocation method, if you will. Have any of you-all had your clinics or your clinic administration come up with a parlor of order or something that's pre-established rather than just letting – if you had one clinic come and ask for three-quarters of your alcohol gel, are you going to allow them to do that? And what's your basis for saying no if you have to preplan that. So, groups out there that have done that?

Participant: We're – that's an issue. We're just in the process of going on level. We have a centralized warehouse, and when that happened last spring, suddenly people were ordering ridiculous amounts and the warehouse didn't know what to do. We're actually creating a committee of clinicians and key people to work together to say how are we going to do this if somebody will ultimately, of course, ultimately agree that a certain volume will be needed if it's above certain thresholds.

MR. MCFEE: I highly recommend that you do that. The concept of making sure that everybody gets what they need and having that preplanned ahead of time is just so critical. It relieves one issue you're going to have in the warehouse of trying to figure out who gets what and how to establish those orders, but it also gets everybody in agreement up front that you're only going to get 100 boxes of this particular item, even if you think today, oh, I'm going to need 500. It's already been pre-established. And then the resupply begins to a new process. We had a significant problem with that with our flu tests, and also with our vaccines and other things that we were trying to distribute during that previous storm. And what we – and the issue was, we had – each one of our clinics was placing their old orders through purchasing for the product, and so, you got every one of these clinics saying theirs was the highest priority, they had to have it, and they wanted a thousand of them; and in theory, if we'd done that collectively as an order, we probably wouldn't have sent a thousand of those tests out to a particular clinic. Their volumes didn't dictate it, or others. We've since changed that, it will be a centralized order with a pre-established distribution quantities already. So I highly recommend that you look at that and make a game plan for that distribution. The other challenge you'll have is you'll have one clinic manager that decides they want to start it today, and another clinic manager that will say I think we can wait until next week. And by the time next week comes around, that first clinic has grabbed everything and there's nothing left for the other clinics. So it also kind of helps with that, if you can kind of coordinate the decision that says we are now implementing our H1N1 policy, we're going to implement whatever practices we've established within our clinics, the supply chain goes out at that time.

Participant: And implementing the policy, especially if you have a centralized policy like we do, have a written implemented policy gives your warehouse customer service people the power to tell, you know, the head – heads of them.

MR. MCFEE: Absolutely. We had our Dean of the School of Nursing write an email on last Friday because we told her she couldn't have our entire stockpile of alcohol gel. Because she was planning on giving one out to every student that she had in the School of Nursing for them to use. Now, we're making arrangements to get her her own little stock of, you know, small Prell or something along that line; but, the whole world is coming to an end kind of attitude. So having that information done ahead of time is so important. All right. Let's change gears a little bit away from supply chain and let's talk about operational impacts. Just today in the U.S.A. Today they had an article back in the business section that says, firms urged to prep for swine flu. Did anybody read that article? How would you operate your operation if 50 percent of your staff was not there? All right. That's what this article talks about. And firms that are revenue-based, that are specifically looking at being able to answer calls, take orders and things along that line, and 15 percent of your staff is home either because they're sick or because they're a single parent or, you know, care provider and they've got somebody else that's sick, what are your contingencies? What are your plans in place to either scale back your operations or determine how you're going to push those extra activities to a smaller group of people to provide? Go ahead.

Participant: Just to let you know that in one survey of one professional health group, 45 responded that if there were a SARS outbreak or the bird flu, that they probably wouldn't show up to work if there was that type of outbreak. And if you look at the SARS outbreak in Toronto, that really didn't happen; but the magnitude of that did occur. So one strategy that was seen, cross-training of a lot of people within the hospital system with basic care. Because at the lowest level of triaging, you're not going to have the higher level of clinicians and the RNs and physicians; they're usually handling the work. And so, cross-training is one application that I've seen applied.

MR. MCFEE: Right. And it actually states that here, is that in the past, during Katrina and other major disasters that we've had, we've been very suspect about accepting volunteers into our organizations for all kinds of certification reasons and looking at, you know, 2 what they can and can't do. And this article says, you may want to rethink that.

Participant: Hi, I'm Steve with CHRISTUS Health. I'm coming in late, so hopefully I'm catching up quick. We take disaster preparedness pretty seriously; obviously, being in the red zones, as we call it, for the hurricanes, we've got our facilities all over the Gulf Coast, so we've gone through those experiences of storms, Katrina, and Ike last year. So we have developed kind of a resource pool out of our IDN of folks that have volunteered to move to areas where they're needed within our own organization. So – that's all specialties, including physicians. So I think the H1N1 is going to be a very different circumstance, especially if – in the event that all regions become impacted. Then it has to be a question, and we're trying to answer that question now, as we continue to work on our preparedness plan.

MR. MCFEE: That's a challenge. This is a different type of disaster than one that's very geographic based; and, you know, you rustle your resources and move them to where they're needed. Even the federal government has recognized that they probably do not have the necessary resources to be able to react to all of this. And I work with the disaster medical assistance team, Texas 3, out of Houston, we've been trained to go out and give shots and a lot of other things; but I guarantee you that if it's in the Houston area, we're not deploying. We're all committed to our jobs and we're not going to go somewhere else. And so, those are

challenges and those are the type of volunteer resources that are out there today. And almost every state is doing something similar to that to be prepared; but at the same time, recognizing that if it's extensive in their area, this retraining and having additional people trained to do certain things is going to be real important. You know, you probably need to look at having your patient transporters learn how to do a blood pressure, you probably need to look at, you know, what other resources do you have in your hospital where they can help do some of the minimum, you know, caretaking, and pass that information along. If you're going to be operating with 50 percent of your staff. How many have looked at your personnel policies and made changes to them in the last six months relative to the H1N1? Yeah, Chris, tell us what -

Participant: Sorry. We have. In fact, just yesterday, their normal policies about doctors excuses for being sick or not being on your shift are being lucid and they're not being required. So just knowing that, we have to learn how to do things differently than normal just affects us.

MR. MCFEE: Has anybody established a seven-day off time policy?

Participant: Yeah.

MR. MCFEE: Has anybody heard that? You've heard the seven-day off time?

Participant: Another thing we added was we have a paid leave time component, so part of their vacation is typically part of their sick time before extended illness goes into effect, and that's been waived.

MR. MCFEE: So you've got a paid time off situation and -

Participant: They'll go into extended.

MR. MCFEE: - and carved that out for extended?

Participant: Yes - Give them time to get the vaccine.

MR. MCFEE: Yes. similar to what the other gentleman said, we have an unscheduled leave policy that's pretty strict. If you haven't scheduled your leave off and you have so many of those within a particular time, you're subject to disciplinary action; and one of the changes we've made is that's waived throughout this process. And doctors notes also have been eliminated. How - anybody else doing anything unique around the personnel policies or anything else on that line? How about requiring vaccinations? Anybody have mandatory vaccinations? Show of hands.

Participant: We did.

MR. MCFEE: Mandatory vaccinations. Are you private or -

Participant: No.

Participant: For swine?

Participant: For flu.

Participant: Will you mandate the H1N1 too?

MR. MCFEE: Yeah, and we talk -

Participant: I'm sorry, when I say required, either you do or you have to sign a declination form and see the films and all this and that. We are still - it's still working to try to somehow make that a 100 percent mandated unless there's some sort of medical or religious reason they can't, that they need to have that vaccination. Right now, you either need to be vaccinated or have a declination form.

Participant: We've done a 100 percent mandate, but if people elect not to get an inoculation, they have to wear a mask.

MR. MCFEE: Okay. For how long?

Participant: From November 1st until the end of the flu season, whenever that is.

MR. MCFEE: We've implemented a very similar policy. But we're a state organization and our lawyers are pushing back on the mandatory requirement. The real question is, is if they refuse to take the vaccine, are you going to allow them to work? And what is going to be required of them if they have decided not to do it? And the mask is one of the things that we've implemented.

Participant: Is that for all employees?

Participant: All employees.

Participant: Virginia Mason, I think, has addressed the legal aspect of it already.

MR. MCFEE: Who did?

Participant: Virginia Mason. If you can connect with them.

MR. MCFEE: Good to know.

Participant: Anybody doing anything different about reassignment of pregnant health care providers?

MR. MCFEE: We're doing that also.

Participant: Yes

MR. MCFEE: The first step that we're doing is we've been very, very clear in our policy and our guidelines that we've established and communicated to our employees of what those risks are, and what the CDC and others have identified relative to pregnant staff. You know, many of your staff don't even want to tell you that they're pregnant.

Participant: Many of them don't know right away.

MR. MCFEE: And some may not know.

Participant: And when does that suggest for the PPE requirements for other staff? Does it suggest that it's not adequate because it's pregnant lady might get something anyway?

Participant: Yes

MR. MCFEE: Anybody else addressing that in any special way? All right. What haven't we talked about? What else is out there that's related to preparation for this? How are you managing - we've talked about staff. We've talked about supplies. What about the patients? How are we dealing with our patient population differently than we may normally?

Participant: One of the issues that we dealt with is where do we send them when they come, because we have so many doors of access to some of our clinics that we don't want them coming into just any door. We need to have them ready specific. Some of the clinics – we don't even encourage them to go to some of the clinics because they have certain – we refer them immediately to another clinic in the area where we hire triage for most of those patients.

MR. MCFEE: Where are you doing that triage, out in the parking lot?

Participant: Right by the front door.

MR. MCFEE: Front door? Anybody putting in the kiosks up outside of your clinic, rather than inside your clinic, and asking the patients to put their masks on out there?

Participant: It's kind of hard to do that in Wisconsin in February.

Participant: Been there, done that.

Participant: Ours are in the – what's that room called, there's the door and little room and –

Participant: Foyer area?

MR. MCFEE: Foyer area.

Participant: We've got dozens of buildings, and every single one has a little sign in the front, if they're not staff – we have too many doors – if you have a cough, put on a mask. And then the people –

MR. MCFEE: Is it just a cough or a cough and a fever?

Participant: Right now, if you have a cough, put on a mask.

MR. MCFEE: Okay.

Participant: One of the things we did – we're all spread out, our clinics are, we can't do them – we talked about that, was does get to that point, all our clinics are going to be closed down for a couple of reasons. First of all, try to get them into the hospital; second reason is, security reason, which is another big issue. You don't have a security force, and if it gets to that point there's always the anticipation that people going out there for drugs or for masks or for whatever reason, so we are going to close down our clinics and have them come into the hospital and filter through the right channels. And that brings up the other whole issue, is security. You know, if you tell somebody they can't come in to visit a dying or sick relative, they decide they're going in there one way or the other, how do you stop them? You know, that kind of poses another problem. We really haven't been able to answer that.

MR. MCFEE: Okay.

Participant: As we talk about the patient, we also have to look at some of the statistics that are coming out. There's some models that you can run on number of deaths Per thousand based on certain criteria, and the numbers are pretty staggering if it indeed turns out to be that. How about handling the deceased? How are the doors going to handle the potential influx, but then the state would probably kick in. These are all the things that we don't think of today become discoveries during the crisis and then, it's going to be tough.

MR. MCFEE: Well, what's your hospital's capacity for deceased bodies before you'd run into a problem of having to stack them up somewhere else? It's not much. It's not much.

Participant: Refrigerated trucks.

Participant: I called a few companies that have refrigerated trucks to see if we could get them and/or rent them. I had one company. Rest of them all said no. I had one company that thought about it and called back and said, I'm sorry, we can't do that. So they're very, very reluctant to lend out or loan or lent refrigerated trucks for the purpose of stacking bodies.

Participant: Is anybody going a step further in triage? I hear Joe said they're going to close his clinics and refer them to the hospital, which I kind of cringe because you want to go the other way so that they're triaging at the clinics. Are you considering even taking over a local high school gymnasium, that we would actually have guards. If it really gets severe, we would have security people at the hospital referring that non-emergent patient that's not bleeding to death to that location to be triaged there, because I see hospitals filling up very quickly. We don't have a lot of, which means there's 25 beds. They're going to be overnight, they could be inundated and I just – I don't hear a lot of people talk about that from a remote triage.

Participant: You get to that point, the National Guard is going to be involved, and you would have to follow direction through the National Guard. They will commandeer as they need. That would be the process we would follow.

MR. MCFEE: That's very true, except you could easily have that be a very isolated situation, and it would not trigger those federal resources or even state resources. And so, I think that the challenge here – and this is an excellent point – is what is your contingency if you're on your own and you need those extra resources, do you have them within your own facility? Can you convert an auditorium or somewhere else to do that kind of a Can you create a – some kind of a mutual aid agreement or some other memorandum of agreement with somebody else within your community – maybe the high school – for use of that? And if you have those in place and you've activated them and then the Feds come, all they really do is take over your agreement that you already had in place; and in theory, you've already established that, it's already up and operating, and they just come in and take that over for you. But if you haven't done it at all, you're on your own until somebody at the state level declares this as a disaster that activates federal resources.

Participant: One of the things we're doing right now is the 28th, we're going for the massive table top because we're all asking these questions and this is one of the reasons I decided to come to this, to see how I could augment what we're doing back at West Care, and if you don't table top this and find out what your contingency is for operating. Our contingency is operating 60 percent strength. And to find out what you could do – whether it's H1N1 or whether it's something else, find out what you can do at 60 percent strength and what you would do at normal strength. Ask those questions of each of the department managers, all the senior management, get those questions, and work with your state and local agencies in the event it becomes something that

has to move to an instant command type situation. So if you have to table top this scenario, I think it's very hard to determine what course of action we'd do. I sat on the committee, but until we decided let's table top this, let's – let's set up a scenario that we are at 60 percent strength, I don't think you really grasp it until you get it there. We decided to do that because we just kept asking the questions in circles and kept coming back with something more, and it became bigger than you could even imagine. So I would – how many people in here are table topping this type of scenario? 15 (Show of hands)

MR. MCFEE: not only have we table topped it, but we also critiqued what occurred in May and June and came up with these changes that I mentioned, which has become kind of inbred in our organization now with the number of hurricanes that we've had hit the coast. You know, where we have the incident, and then we find out what went well, what didn't, and redo our plan.

Participant: We actually used our conference center to do a surge. We did a surge exercise. We set up the cots and everything, and I think that we learned a lot from that; because, first of all, everybody had an idea of how many beds we could set up. But then you think of, oh, well, they may have a visitor with them, they probably might need a chair beside the cot. That cuts down on the 5 number of cots. What do you do about privacy? You may have people in there that need a procedure. So we had to think about some screens. There were a lot of things we didn't think about until we actually went through it and saw where everything was.

MR. MCFEE: Here's one other thought: When we talk about capacity and volume, is having a triage to home policy established. And what would you send with that patient and family that you might be able to provide to make that more feasible, and that your staff, your professionals would feel better about that. Have they been given Tamiflu; or something else that is going to help them recover. But they're recovering out of your facility, and with instructions that if they have severe respiratory issues that they're to report back and they're very directed as to what to look for. It's a little bit of education going on. Anybody doing – thought about any of that? All right. Good stuff. Good stuff.

Participant: Could I ask, has anybody looked at visit – visitor –

MR. MCFEE: Restrictions?

Participant: – restrictions? There's been discussions about even restricting 16 and under in the hospitals, or 18 and under. Has that – have they done that?

Participant: We've just gone to restricting. If we move to the next category, we'll restrict children, and we'll restrict non-immediate family members, and anybody who is going to see patients. Also, there would be a mini triage of visitors as they come through, and masks will be handed out in a situation like that.

Participant: The question about the masks. Given that this is viral and the surgeon mask is – I assume, is it's not a foolproof method, I assume, put a mask on.

Participant: Surgical, it isn't –

Participant: What kind of mask are we talking about?

Participant: Talking about recommending that visitors wear masks. That's what we're talking about, the approval.

Participant: Fit test everybody?

Participant: There's a waiver for fit testing. They just have to wear the mask.

MR. MCFEE: We're not looking at putting anything on a visitor other than a surgeon mask.

Participant: I agree.

MR. MCFEE: And we originally went with tie masks, based on what our infectious control folks said. Now we're getting requests from the clinics and we're asking the patient to quickly put them on, and most the patients don't know how to tie the masks on. Now we're asking them to try to get a stockpile of the ear loop ones. But I think that's a good question. CDC has not recommended that you put N95s on anybody other than health care providers. You know, they're there to protect the health care provider, not to – not to prevent the patient from spewing out. The only reason you're putting that on the patient is to try to prevent that droplet from getting out into the atmosphere. So it's kind of like a catch facing, if you will. It's not a filtration, you know, type mask. And most of those masks really only filtrate one way. They're not a two-way filtration.

Participant: The challenge, you make policies like using N95s for visitors, when we need them for our health care providers, there's already a shortage and rationing, 2 so it's going to be more huge. I think – I would hope we would all think about that.

Participant: I have a question for anybody: Do you have a plan for how do you track, if you did actually get federal, strategic national stockpile things? I think it was rushed. Right now, we do have an antiviral, which is a limited thing, which is fairly limited, who we give the drugs and knowing that, but if you're kind of in a situation, let's say the mass casualty or we really had a big surge and had to get things like IV fluids, because you can't charge for those, how are you going to track those 14 resources through and, again, what information are the Feds going to want? Are they going to want to know where did you use the drugs, who got this, and how do you build an almost parallel system in there to keep from charging the patients for a bag of normal saline that you might have got out.

Participant: Is he talking about just government disbursement of stuff? Or all? Because I can charge for those things if it's my supply.

Participant: You can charge for those stuff as long as you're –

Participant: You do.

Participant: So just replace it back.

Participant: There's a highline as to how – when you use that.

Participant: You just have to put it back.

MR. MCFEE: Did everybody hear that? The answer over here was that you can charge for things that are coming out of the national stockpile as long as you're replacing it.

Participant: Right.

Participant: So the key is, you have to track how much you get from the national stockpile.

Participant: Exactly.

Participant: Right.

Participant: Is there a timeline involved in that?

Participant: I think – I was told that State of Wisconsin was a year, you have up to a year to replace it. You have liability after the surge, and I'm not sure, I think the CDC has gone –

MR. MCFEE: And there's a federal stockpile, and then there's also state stockpiles, and there's state health departments also have drug caches too that they hold onto.

Participant: One of the things about that stockpile is the stockpile we have is sitting untouched for such a long period of time. We started taking things out of that stockpile just to rotate and use it so that fresh stuff – where the elastic band on some of your bubble masks and whatever you've got the bubble, N95, that they weren't rotten. So, you know, use the stuff up and buy some more stuff and replace it. That was one good thing.

MR. MCFEE: We talked a little bit about stockpiles earlier, and one of the issues there was you can go ahead and use your stockpile and rotate that stuff, but everybody's experiencing the lockdown of those supplies and allocations, and so, replenishing your stockpile has been difficult .

Participant: We actually had – four or five years ago we built a pandemic trailer for just – it was a big, old container that we packed with stuff and they locked it and lost the key. -

MR. MCFEE: Obviously they didn't get your maintenance folks over there, because they can get into anything.

Participant: They didn't discover they lost the key, though, until earlier this year when, hey, we're having a pandemic, where's the trailer?

Participant: If you really want to complicate this, I don't know if anybody has international exposure, but we have international exposure in New Mexico. Of course, we have had the first experience of it this past late spring, early summer when we first had all that in Mexico. So it's a whole different world down there, and certainly another country's going to have a different approach on how you deal with this.

MR. MCFEE: Yes Anybody from the Texas Valley? Or Southern California? You know, the question will be is, what do you do with those that have come across the border seeking health care for the H1N1? And there's not been a clear-cut policy established by the U.S. Customs and Border Patrol as to whether or not they're going to be doing any triaging at the border to allow those folks to come across or not come across. So there's potential impact there. Well, we're almost out of time. You know, I think we probably all feel that we could probably talk about this for another hour or so. But so be it. Anybody want to make any closing comments or suggestions or thoughts? Yes, sir?

Participant: I would have a very significant concern about the supplier coming – being able to supply us in the event of a real true disaster or true pandemic. I don't have any confidence that we would be supplied in time for it.

MR. MCFEE: And I think the other question is, is what are the policies they're following, and it's not consistent.

Participant: I don't know that there are any.

MR. MCFEE: Well, supposedly there are, but they're not consistently being applied, that's for sure.

Participant: I'm a supplier, and our policy for N95s, every time this comes up, we service our existing customer base first.

Participant: I'm not faulting suppliers, because they have to do what they need to do to make a buck too. But I think that's a fact.

Participant: - we can't keep up with everybody. That's exactly right.

MR. MCFEE: And it's not just distributors, it goes all the way back to the manufacturers.

Participant: Yes

MR. MCFEE: You know, our situation with Cargill right now is we're placing orders with Cargill but then we're having to call them and get their purchase order to the manufacturer and go work our deal with the manufacturers in order to get the volumes and quantities that we need. And quite frankly, that's not a very acceptable supply chain method. And this is with a company that we have established a strong MOA already in place around providing us supplies, with established quantities and everything else, that they've committed to, that they're now not living up to. And if there's any Cargill reps in this room, that's not negative that's just to kind of describe the process that everybody's going through. And, there needs to be some guidelines and a different pipeline or chain, rules and policies in place that, are put in place when these situations occur.

Participant: Yes, we use a range of suppliers, because they have a range of health care protective policies they sell so their policy is only in a lockdown only to acute care hospitals. The problem is, I want to order 10,000 cases of Prell, they won't ship it to me. They're not going to try to ration it all, only going to ship to health care. So, that seems like the other extreme there too.

MR. MCFEE: There was a sheet running around with everybody's name on it. I don't know where it ended up. Those of you that came in late, if you would please just sign in on that sheet.

Participant: When the pipeline is dry, what do we need to do.

MR. MCFEE: Right, there needs to be a plan in your process. We just sent an email to our task force chair saying here's where we're at with our stockpile, here's what we have on order, we can guarantee you you're not going to have enough N95s, you all need to talk about what the plan's going to be. And now they're talking about allowing the reuse of the N95s, even though CDC says something different.

Participant: Get that plan in place now so you're not scrambling when it happens.

Participant: Think about it, that all the manufacturers require human resources to make the products, so they're going to be part of the problem.

MR. MCFEE: Thank you all for participating. Appreciate it.



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