Clarity Research Group

North Central Region HealthCare Coalition
Focus Groups Themes
Hospital Surge: Identifying Needs and Behaviors that Drive Medical Surge During Disasters
Summary of Findings
June 2019

Background and Methodology

In November 2018, Clarity Research Group, LLC (CRG) was contacted by the North Central Region Healthcare Coalition (NCRHCC) Regional Planner regarding an opportunity to conduct focus groups with various providers to gain insight about Access and Functionals Needs (AFN) individuals during a disaster or crisis situation. The second purpose of the focus groups was to identify needs and behaviors which drive medical surge during disasters and identify necessary support resources to reduce stress on hospitals.

Clarity Research Group submitted a proposal to work with NCRHCC to conduct community provider conversations, *Hospital Surge: Identifying Needs and Behaviors that Drive Medical Surge During Disasters*, LPHA 2018-2019 deliverable. This proposal was reviewed by the NCRHCC Governance Board and CRG was awarded the contract in January 2019. CRG conducted three in person focus groups and two focus groups by telephone.

The original study design was to conduct four in-person focus groups with professionals from different disciplines who worked with AFN clients, including pediatric providers, ancillary healthcare, home health care, behavioral health and hospitals. The development of a web survey based on the focus group findings to collect additional information was also included in the original study design. Due to difficulties recruiting participants for the hospital focus groups and low attendance for the other groups, two focus groups (one hospital focus group and an additional ancillary focus group) were conducted via telephone conference call. Additionally, an electronic survey with the original focus group questions was sent in an attempt to gain additional responses from more participants. The electronic survey also included two additional questions based on the responses from the other focus groups.

Focus groups were held at either the Trailhead institute in Denver, Colorado or at Jefferson County Public Health in Lakewood, Colorado. The focus groups were co-facilitated, observed and tape recorded. CRG, in conjunction with NCRHCC, developed a brief interview guide to structure the conversation for the focus groups. The focus group guide was adapted from the *Focus Group Conversation Guide* and *Note Taking Tool* created by the Colorado Department of Public Health and Environment. The interview guide covered providers' perceptions regarding what drives individuals to hospitals during emergencies, potential medical and non-medical disruptions that may occur during an emergency and ideas around possible healthcare delivery system supports that could prevent stress on hospitals during an emergency. In addition, the interview guide included questions about:

- Clients' assumptions about hospitals.
- Proposed ideas to ensure members of the community contact appropriate providers for emergency health and medical needs.
- Suggestions for community and regional planning to support community healthcare agencies.
- What services and resources agencies could provide to help alleviate the pressure on hospitals during an emergency.

A total of fourteen people participated in the three in-person focus groups. Due to an evacuation during the first home health and pediatric care focus group, the group had to be rescheduled at a later date. The initial group had five attendees

and the rescheduled group only had two participants. One individual attended the ancillary focus group and six individuals attended the behavioral health focus group. In addition, focus groups were conducted via telephone with six participants from the hospital focus group and five participants from the ancillary care focus group. Seventy-seven individuals responded to the electronic surveys that were sent out in June. Sixty of the respondents completed the non-hospital survey and fifteen (25%) of those individuals had attended one of the focus groups that were held earlier. Seventeen of the respondents completed the hospital survey and three (18%) attended one of the previously held focus groups.

Analysis of the responses was completed by three researchers who compared the themes they had identified in notes and transcripts. The two researchers conducting the focus groups used notes from the groups and interviews to assign themes under each question on the interview guide and an alternate researcher reviewed and coded the audio recording assigning themes using constant comparative analysis. Themes were identified across questions and groups since there was substantial convergence of themes. Quotations are included to illustrate key perspectives related to each theme.

Themes Emerging across Focus Groups

The majority of immediate health and medical needs reported for AFN individuals in the case of disaster or crisis situation can be met outside of a hospital.

The needs most commonly reported by the focus group participants in an emergency situation were:

- Back- up generators or batteries in case of electricity/power loss. This is needed for assisted devices and medical equipment (e.g., oxygen, ventilators, or other breathing devices, beds, wheelchairs, refrigerators, heat)
- Food and water
- Medications (and the ability to refrigerate them if necessary), including Medication Assisted Therapy
- Communication devices (cell phones, radio, walkie talkies, interpreters, etc.)
- Transportation (to or from medical or dialysis, shelter, home, etc.)

> *"Power outages are our biggest risk, no power means we can't run patients; same goes for water supply issues."*
>
> *"Power outages are a problem. Some communities might have generators, but they are not required. Most skilled nursing communities have (generators), but some may not."*
>
> *"Power outages impact our residents with oxygen - we don't have a generator, so we need to switch residents from concentrators to portables/liquid oxygen when we lose power."*
>
> *"We don't have many medications on site so if people needed more meds because they couldn't access the ones they had, that would be hard."*

There are some populations like behavioral health and/or ancillary care facilities who may require more assistance in the case of an emergency due to the stress of the disaster itself. This at-risk population is more prone to have additional medical and health concerns or needs, such as the need for dialysis or risk of heart attacks and/or strokes. Participants also noted safety concerns due to heightened mental health symptoms.

> *"Safety concerns can trigger psychosis, panic attacks and escalation. Need staff to assist or accommodate with individuals if they are being transported, relocated or sheltered. Clear communication and a lot of bodies to help, weighted vests or weighted items for sensory issues because of overstimulation. They need more one on one support."*
>
> *"In these environments it is unclear whether medical needs during a disaster can be met at a community level. We don't have a lot of licensed staff that can assist with medical emergencies that occur during a disaster- it is at risk population sometimes heart attacks, strokes happening during stressful situations."*
>
> *"Dialysis services… if there is a disruption in dialysis services- 3 to 4 times a week. We will need to get them to the hospital. It cannot be handled in my environment."*

Some participants mentioned additional needs during a disaster including, assistance with evacuation, extra staff, emotional and psychological support, basic first aid, evaluation for injuries and or primary care health complaints, laboratory testing, consultations with providers.

Many facilities and/or access and functional needs individuals who are cared for at home, are well prepared to stay home or be cared for outside of the hospitals for short lengths of time.

Participants reported that the majority of AFN home health, pediatric, and ancillary care facilities are well prepared to stay home or be cared for outside of hospitals in the case of an emergency. This is particularly true if the emergency only lasts a few days. Emergency preparations include providing clients with an emergency preparedness checklist, educating clients, practicing the plan, having extra ventilators, extra medication, food and water supplies, and back-up generators (some clients and facilities have back-ups if they can afford them). There are also contingency plans with family, neighbors, fire departments and other facilities.

"Our patients are incredibly equipped to remain at home. No generators because they are so expensive. There are programs that help buy generators, but most people do not know them."

"We make every effort to communicate the emergency plans with the residents and we are required to review emergency plans with the residents on a regular basis. This information is known in advance but it still all depends on the individuals. We do communicate that the systems are strained, and they will not likely get the care they need."

"OFTEN YOUTH HAVE CAREGIVERS OR FAMILY MEMBERS THAT ARE CAREGIVERS AND GENERALLY THEY ARE PROVIDING SERVICES."

"Most patients have set up resources such as with the local fire department that will allow them to charge medical equipment."

However, when an emergency extends past 72 hours, issues are likely to arise due to lack of power and/or lack of supplies like water, food, oxygen and medication. Many facilities do not have generators or all the resources they need for more than a few days. Additionally, transportation services may not be available and deliveries may not be an option depending on the circumstances (e.g., snow accumulation or flooding). Without resources, a surge of these clients may be seen in hospitals if conventional means of support cannot be met in the community.

"Most communities can function for 3 days; we are required to have food on hand for 3 days."

"Ventilator dependent individuals will have 2 ventilators which will last for about 12 hours."

"Power outages (extended) - patients cannot be treated if they cannot get to center r/t weather, they cannot treat patients if the center doesn't have water, we have to divert. Our patients do have a 3-day emergency diet to follow in those situations, but still may end up in the ED."

"We do not hold anything in the clinic and we are not allowed to transport patients. The transportation companies close when the weather is bad."

More resources are needed for emergencies lasting for longer periods of time or in cases of evacuation.

There are many resources that are needed for hospitals, home health, assisted living and other facilities serving AFN individuals, including electricity, power, medications, food, communication services, translators, transportation and staff as listed above.

> *"Staffing may be an issue – often staff may have to deal with issues with their own life and with their families."*

"PLAN AND CONTINUOUSLY COMMUNICATE ABOUT THE EMERGENCY PLAN AND WHAT TO DO IF THE FACILITY IS EVACUATED. COMMUNICATE THAT AMBULANCES ARE NOT GOING TO BE COMING TO YOU IN A DISASTER. NO 911 RESOURCES."

Medication shortages may occur during disasters lasting more than a few days since it is not possible to stockpile medications. Some agencies have a Memorandum of Understanding (MOU's) with some major retail pharmacies but the procedures are unclear.

> *"It is important to have MOU's with agencies that could help like if we need water, or fuel for a generator, food company, have these set up ahead of time so if they can get to you, they will."*

> *"If everyone is experiencing the same event then resources will be scarce."*

Due to the complex nature of pediatric clients, most shelters and emergency evacuation sites are not able to take in disabled pediatrics.

> *"In an emergency, some shelters would not accept these special needs children and because of the equipment and dietary needs and medical needs."*

> *"There is nowhere that takes disabled pediatrics. Facilities would have to be LTAC (long term acute care) and skilled nursing."*

Focus group participants also relayed that there are not transportation services available for pediatric patients. The only options for these clients/patients are home health care or the hospital.

Clients need to be prepared for longer lasting emergencies and/or evacuations in order to remain at home, in facilities, or in shelters. One focus group participant talked about working with the American Red Cross to develop a "Go Bag List." The "Go Bag List" includes all the items (e.g., blanket, glasses, medications, etc.) which individuals need to take with during an evacuation so that they are not a burden. It is common for individuals to present at Red Cross sites with nothing. While Red Cross can set up quickly to meet immediate needs, they may not have access to all the individual needs required to serve AF

> *"Red Cross can usually meet sheltering and mass care needs within a couple of hours. Medical and psychological support may take a little longer and is limited by volunteer staff available, route access, etc."*

Changes in non-medical and medical conditions or other health concerns during prolonged disasters could motivate clients in the community to go to the hospital.

Participants listed some non-medical conditions that would drive their clients to a hospital. These included problems with the building or where they are sheltered such as lack of heat, equipment breakdown, depletion of supplies, excessive hot or cold weather, homelessness, mental health symptoms including fear and/or anxiety triggered by the disaster event or worry that something (disease) is spreading through the community.

There are also medical symptoms and health concerns that could lead to a hospital visit such as shortness of breath, chest pain, numbness, need for dialysis, increasing severity of illness, injuries or any other conditions that the public health agency, shelter, or local clinics do not have the ability to treat. Participants reported a range of who determines if the individual should go to the hospital, including the patient and/or patient family, facility administrator, nursing or medical staff and/or a primary care provider.

> *"Any acute symptoms as determined by Health or Mental Health Services staff or shelter staff - severe injury, high fever, seizures, etc.; Pediatric or obstetrical concerns out of the scope of practice for Red Cross volunteers. The question is asked from the perspective of the client and they are free to make own determination but staff would try to contain as appropriate."*

Some participants reported that the individuals with access and functional needs they work with prefer not to go to the hospital.

Hospital aversion was discussed by the focus group participants across each group. For a variety of reasons, many clients prefer not to go to the hospital. One reason for this is that immune-compromised individuals will be more at risk in a hospital. These individuals, especially children, have already spent too much time in hospitals and the hospital will not have the ability to meet their needs.

> *"Although it is a bad idea for them to go into the hospital because they already have compromised immune systems, even being in a waiting room is dangerous for these kids."*

"THERE IS ALSO HOSPITAL AVERSION. SOME CLIENTS MAY REFUSE HOSPITALS EVEN IF THEY NEED TO GO BECAUSE THEY HAVE BEEN TRAUMATIZED IN A HOSPITAL AND DON'T LIKE THE HOSPITAL SETTING."

> *"Having a place for these patients to go. They need Hoyer lifts and shelters are not ideal because the majority of the patients are immunodeficient. A lot of patients have sensory integration issues; new environments could send them into a sensory episode. The environment alone could be so negatively impactful that a shelter would likely not be better than a hospital. Hospital is always the last resort."*

The electronic survey respondents were asked an additional question regarding if they shared the same belief about this population being "hospital adverse". The responses were mixed. Some of the respondents noted that the hospital is scary for these individuals and past experiences may influence their desire to go to the hospital even when necessary.

> *"If by "hospital adverse" you mean not wanting to engage in hospital services, I can agree somewhat. An already frightful population can be intimated by a hospital. Hospitals are big, busy and are often a place where they do not feel comfortable."*

Some of the respondents talked about how service providers may do everything they can so their clients/patients do not go to the hospital, but this should not be confused with hospital aversion.

> *"I am not hospital adverse, although our organization strives to prevent hospitalizations. I think it's the idea of waiting for care and possibly catching something while waiting for care."*

The high cost of seeking medical treatment may be why individuals are hesitant to go to the hospital as well.

> *"I don't believe that people are naturally "hospital adverse" if a care need arises. I believe they can be "hospital adverse" due to limited funds to cover associated care. I also believe that these potential patients, may have encountered a negative situation at some point within a hospital setting (i.e. told some issue/concern was minor when it was not, etc.) which would make them less likely to utilize a hospital if needed."*

Additionally, some participants reported having both clients who do not want to go to the hospital and clients who always do.

> *"Sometimes our residents are hospital adverse, but we often also see many Elders who want to go to the hospital when it's not needed. Sometimes as result of mental illness, hoping to get pain medications as a coping mechanism, etc."*

> *"Before we got a local clinic, hospitals and EMS were the only places our residents thought they could get medical care. They usually let issues go until they were critical. Some of this population did not have transportation to go to a doctor down the hill, thus the call to EMS."*

The idea that the hospital is the safe place or the first place to go during an emergency still exists.

Participants reported existing assumptions about the idea that hospitals are the safe place to go in an emergency because they are open twenty-four hours a day, seven days a week. The perception is that they will help, they will not turn you away and they (hospitals) are the only place that can provide appropriate care for AFN patients and take care of all physical needs.

> *"The hospital is still viewed as the savior place. They fix everything and they will take care of you. For this age group, that is where you go for help."*

> *"I think the community expects the health and public safety community to take care of them regardless of the situation."*

Participants from the behavioral health/pediatric group discussed that sometimes parents will use hospitals for middle acuity when the parent can't take it anymore and the kid can't take it anymore. The problem is not getting resolved in outpatient treatment and they move to a hospital for therapy needs. Additionally, hospital focus group participants reported that clients sometimes assume the hospital can take care of anything and assume that housing and transportation can be arranged at not cost.

"I see that people who show up to DH in general think the hospital want help with housing, home care and sometimes beds and recliner chair delivered to home."

"That we have all the items for the specific AFN needs immediately available. Typically, we have to rent these items and have them brought for their stay unless is it something we use a lot, then we purchase them for on hand access."

Focus group participants talked about doing a lot of outreach to get individuals to the appropriate level of care, like urgent care instead of the emergency room, but it is still a problem. Individuals still view the hospital as a safe place and the place to go to receive optimal care. It is assumed that hospitals will have appropriate staffing, food and services. These assumptions may not be accurate depending on where the hospital is located (rural versus urban) and the nature of the emergency. It is perceived that individuals will go where they are familiar.

"Clients may assume that every hospital has the same capacity and capabilities to diagnose and treat. For example, many hospitals don't have the ability to provide rabies post-exposure prophylaxis so we have to coordinate where a client should go to receive those services."

Most hospital participants reported that individuals with access and functional needs have not presented with a problem to hospitals in this region.

Participants from the hospital focus group generally held the opinion that, although they are prepared to handle individuals with access and functional needs during an emergency, they have not had previous experience with AFN individuals flooding the hospitals in the past. Services hospitals can provide for AFN individuals include specialized inpatient room equipment, special call lights, bed side equipment, bariatric equipment, lifts, occupational and speech therapy, care management resources, wheelchair accessible, and interpretive services.

"In Boulder, when - flooding, shootings and bombings variety of things over the years- we have always been able to accommodate people with special needs- individuals with special needs flooding the system has never been an issue."

"At National Jewish, it has not been an issue. All our evacuation is lateral as opposed to having to get people on an elevator or down a stairwell which aids in accommodating people with special needs and our buildings are connected so it has been easy to evacuate."

"As a Hospital System we get these types of patients on a regular basis but 1 or 2 at a time, the challenge in a real event with Several AFN persons presenting at one time would be the resources needed to support that process. We have limited number of like resources for AFN persons in large quantities at any one time."

"There was a small surge of people who were unable to get their routine dialysis/infusions during weather related incidents this year. Also surge of homeless needing to get out of extreme weather and those who traveled to UCH for treatment or outpatient therapies who were unable to get back home."

Hospital participants reported that the homeless and transient population tend to present the biggest problem during emergencies. Some of the homeless population may have access and functional needs, but that is not the reason they are presenting to the hospital. Most of them are tired and looking for a place to stay.

"If you can categorize homeless and the transient population as access and functional needs patients, then we deal with them every day. There are community resources they could utilize but

they can show up at the hospital intoxicated and choose not to utilize these community resources. The largest group of people with access and functional needs showing up is this population. Some of them are on oxygen, in wheelchairs, etc., but not all of them. The surge of homelessness patients – we had to change our security, staffing etc. because we were not equipped to deal with it daily much less in disaster situations."

"All hospitals serve homeless people if it is cold outside- we try to help out give them somewhere warm- it creates a security issue- perception that the hospital is not safe if there are homeless people sleeping in the lobby- security issues for patients, staff, feeling of lack of safety.

Additionally, individuals from the public showing up at hospitals can cause surge problems, whether that's individuals trying to help or trying to locate family members.

"Community members try to help and volunteer and that creates more of a struggle- even if you try to corral them- you have a lobby full of people to help and they don't leave. They add extra bodies and stuff that you don't need- you have to have a whole team to manage donations."

"In a mass causality you get a large influx of phone calls and people showing up trying to find out about their family members- an influx of 1000 calls in one day- especially when loved ones can't find family member."

"THE SHELTERS DO NOT PLAN FOR BEHAVIORAL HEALTH - FOR INSTANCE THEY NEED MORE THAN ONE QUIET ROOM, SENSORY ITEMS, SMALL ITEMS - THEY ARE NOT THINKING THEY THINK ABOUT PEOPLE WITH SENSORY DISABILITIES."

Education, community preparedness, accessible shelters, clinics, urgent cares could all help relieve stress on hospitals during an emergency.

Participants provided several suggestions on how to best serve AFN individuals during a disaster that would help relieve stress on hospitals and provide services outside of hospitals. This included clear communication about the disaster, education on preparedness plans and providing public shelters, community identified safe places, and/or other alternative care sites. Several participants also discussed the needs that shelters would need to be able to adequately serve AFN individuals. This includes ensuring that shelters have adequate resources like food, water, and medication; ensuring that shelters are wheelchair accessible; are well staffed with interpreters, behavioral health responders, and medical staff. Participants also suggested having partnerships with local clinics or urgent care in order to provide diagnosis, medication, vaccinations, dialysis, and other medical needs that don't require hospitalization. It was also suggested that area resource centers are available to provide information for those who are worried and want to make sure their family/friends are okay.

"Clear, concise, and well-advertised communication re: Shelters, locations, and services available including reunification. Co-locating with urgent care facility or other partnerships able to provide more additional medical care. Triage at hospital for diverting non-critical needs and providing transportation to other facilities or shelters."

"Training on communication with people with disabilities and Deaf people. Ensuring that all emergency shelters are ADA compliant in all aspects. Collaboration with disability organizations like Centers for Independent Living, ARCs, and disability advocacy organizations."

Education and communication on where to go during emergencies can be better.

The need for more training, education and improved communication was emphasized among focus group participants, particularly on where to go and what to do during emergencies. This communication includes informing individuals what resources are available and where they can go for help instead of hospitals. Several participants stated that providing public services announcements, phone and email lists of facilities, and information about what resources are available and where they can and cannot access specific services is important in ensuring that community members reach out to the appropriate provider during an emergency.

"If we go on divert it is not communicated to the general population, but it is communicated to emergency services and local law enforcement etc."

"Public service announcements geared to the type of emergency that instructs people how and with whom to seek health care. Our facility will have announcements for our existing patients posted on the entrances if we are closed on where to go - ER or perhaps to one of our other campuses."
"Provide more community education/materials for public awareness."

"Better communication and training with them in advance about what to expect and what services are available. Dedicated number they can call to get support in an emergency."

The discussions also entailed the desire for a variety of communication methods to reach the clients as well as the greater community including radio, mailers, text, cell phone, TV ads, newspaper, newsletters, social media, health fairs and other community outreach events. Clearly communicating with clients is extremely important so that they are well prepared for emergency situations. It was also suggested that this information is available in several languages including Spanish, Russian, and Vietnamese.

"Clear concise messages on multiple channels to get the message out to people in a timely manner."

"More frequent communication, the content of the communication is accurate and consistent, and communication that is appropriate for the community that you're trying to reach. Recognizing that the same type of communication may differ between different groups in the community."

"I think messaging needs to be changed about the seriousness of the event and what they can do. I think community organizations providing services to these individuals also need to have a message to help individuals understand what they need to do and where to go during an event."
"Utilizing "grassroots" efforts and mass communication systems (e.g., Everbridge)."

"Maybe some info can be shared with AFN folks when/if they are signing up for reverse 911/emergency alerts. That is where we ask people to indicate special needs from the community (e.g., if they're wheelchair-bound, need priority restoration of electrical power due to medical equipment, etc.)."

There is a need for clear communication of resources available and communication between providers on how they can share and/or provide resources.

Focus group participants conveyed how important it is for service providers and community members to know what resources are available. It is also important for service providers and community members to be able to access resources and be knowledgeable about what help is available.

> *"Get the message out that you can call the state, they have resources that they can deploy to your shelter, not all centers are the same - identify shelters that are staffed by community members or shelters that have skilled professionals."*

> *"It is difficult to get the word out to churches or any other disaster relief setting that they can call various mental health centers and they have resources they deploy help if they can. Some centers do not have the capacity, and some do. We need get the word out so that all resources are being utilized."*

> *"We need clear delineation of who is responsible for AFN needs, i.e. with power loss who supports these people?"*

Participants from agencies were very willing to share resources they knew of like fire departments having oxygen, but it was clear that resources are not known across all agencies or providers. During one focus group there was a discussion about clients not having generators, which prompted one participant to share a resource with another participant regarding obtaining free generators.

Additionally, several participants across agencies reported about ways they could help in case of an emergency. Some agencies are limited in their ability to help based on if it would interfere with them being able to care for their own clients first, however there were a wide range of services that could be provided across agencies. This included being able to provide volunteers or staff for health, medical or behavioral health support and/or translators. It also included provided basic first aid, patient monitoring, lab and imaging services, dialysis services, supplies, coordination, information sharing, shelter, transportation and other care services. However, participants were unsure of how the process of accessing this help or these services worked.

> *"If we are part of a coalition, we should know resources, services, etc., but there is such separation and no clear way this gets communicated. Also, not even knowing if it is appropriate to reach out for help or to who."*

> *"As ESF 8 we would be available when activated by Emergency Management. Our clients in our Health Department would be contacted by the program they are served by."*

> *"At TCHD, we have a robust emergency preparedness program that can provide services even during adverse events. Our communicable disease team is also available on nights, weekends, and holidays to respond as needed. Our communicable disease team can help coordinate remotely, but may not be able to be on site at all times."*

Many participants felt that training, disaster planning, preparedness and information sharing would help their organization better support their clients in an emergency situation.

> *"Information sharing, agency organization and the willingness to help one another out-relationships/partnerships."*

"Meeting with emergency planners at each others facilities to get a first hand look to see what the others are facing as challenges and how we can help each other out."

"Having resources available and having easy access and communication with the local hospitals, emergency preparedness, first responders, etc."

"Disaster training, continuity plan, participating in drills and planning for the worst."

Summary

The focus group and survey participants conveyed that AFN, pediatric and behavioral clients do not surge the hospitals during emergency events. The main themes that emerged are:

- Clients/patients are well prepared to stay at home during an emergency, particularly if the emergency is only a few days.
- Facilities and staff in our community are also well prepared for emergency situations. This could be improved with increased resources like generators, increased supplies, and resources for shelters to address special needs.
- There is a preference to not go to the hospital for the majority of this population, especially for those who are immune compromised due to the additional risk of disease/illness.
- Increased education and communication to the community, AFN individuals and providers will continue to ensure that clients reach out to the appropriate provider for their emergency health and medical needs.

The majority of individuals who do present at hospitals during emergencies are those who have changes in health that cannot be managed in the home or at a shelter (e.g., dialysis, ventilators, medications, physical injury, behavioral health crisis).

All of the focus group participants also discussed the need for improved communication between organizations/service providers, with clients/patients and with the greater community. The ability to share resources among providers would be extremely valuable. Along the same lines, increasing client/patient and community training was identified as a need for improving emergency preparedness. Some additional recommendations by the survey respondents for improving communication and reaching the greater community are:

The focus group participants and survey respondents emphasized the need for improved access to resources during emergencies such as food, water, medications, durable medical equipment (DME), oxygen, transportation and even generators.

In conclusion, having access to and knowledge of additional resources and improved communication/training will further aid community service providers in hospital surges during emergencies.

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Appendix A: Focus Group Guides

Focus Group Conversation Guide & Note Taking Tool: Hospital Group

Date of Conversation: _____ Location: _____

Facilitator:_____ Note taker: _____

# of participants: _____ Group engaged: _____

Before we get started, I want to tell you a little bit about this conversation, what you can expect and how we will use what we learn. I want to thank you for taking time out of your busy schedule to share your thoughts with us.

These conversations will usually run about 60-90 minutes. Feel free to get up as you need to. (Let them know where the nearest bathroom is). This is going to be an informal conversation.

Introduction

Our healthcare coalition brings health partners together from across our region to figure out how we can work together to be ready for health needs during disasters. This includes knowing what issues affect our community's health during disasters and what they expect or need from health care services.

In particular, we would like to talk about when and why people use hospitals in our region, and what resources might help to support people's health needs during disasters. A surge of people going to hospitals during disasters is something we try to prepare for as health care coalition partners, so we want to look for both medical and non-medical reasons that might happen, and how we might come together to reduce stress on hospitals and still meet the needs of the community.

- As your facilitator, my job today is to help you have a productive conversation. I'd ask that we focus on what happens in our community and look for places to work that are specific to this area. Bigger systems are important, but today we want to figure out what's most important to this part of Colorado. Can we agree to stay focused locally?

- Sometimes I may ask you to clarify your comments to better understand your point. If you're not sharing much, I might invite you to share your thoughts, and if you've said a lot, I might ask you to make room for others. If I do, it's just to help make this conversation productive and inclusive, so we get the full benefit of everyone's experience and perspectives.

- I want to introduce our note taker, Devi. This conversation's focus is on learning, so notes are helpful to make sure we get it right. This conversation will also be recorded so we can make sure we catch all information we may have missed when we are summarizing our findings.

- We find some basic ground rules can be helpful.

- **Have a "kitchen table" conversation:** Everyone participates; no one dominates.
- **There are no "right answers":** We want to understand your experience and perspective. You don't need to be an expert on any given issue; you are already an expert on your experiences with these issues.
- **Listen with an open mind:** Listen to others and try to understand their perspective. Don't jump to conclusions.
- **It is okay to disagree, but don't be disagreeable:** Be polite, kind and respectful of others.
- **We are going to have one conversation, together:** Please avoid side conversations. Help the conversation stay on track.
- **Step up/Step back:** If you find yourself jumping in first to answer every question, take a step back and make room for others. If you're more introverted, challenge yourself to step forward and speak up.
- **Have fun:** This conversation is a chance to share your thoughts with, and learn from, other people from your community. Enjoy it.
- **If you have any questions or comments throughout the panel discussion or need more clarification regarding a comment or discussion point, please let us know.**
- **Are there other ground rules that we should add for our conversation?**

- In the interest of setting realistic expectations, I want to let you know what we'll be doing with what we learn and what to expect moving forward. These conversations first and foremost are about learning. At this point, we cannot promise any new policies or programs – but we want to use what we learn moving forward. I can pledge to you that:
  - We will follow up with you to share with you what we learned from this conversation.
  - And we'll tell you how we're using what we learned moving forward

- This is an informal conversation. You don't have you raise your hand and we can use first names. **Let's go around the table and please introduce yourself** starting with your name, your organization, and the services your organization provides.

Questions: *Hospital* (start with the primary question, and add follow-up questions to help discussion if needed.)

1. Please introduce yourself starting with your name, your facility, and your role within your facility.

2. During any real-world events, what has been your experience with individuals with access and functional needs presenting at your facility?

3. Have you experienced a surge in patients with AFN presenting at your facility during disasters?

4. What services do hospitals offer to patients with access and functional needs?
    a. What assumptions do patients have about the help they can get at hospitals?

5. In addition to medical needs, disasters can disrupt other basic services as well. What non-medical concerns could bring community members to your facility during a disaster? How would this impact your facility?
    a. What changes to medical conditions or other health concerns could bring individuals in the community to the hospital?
    b. What nonmedical concerns could eventually cause health problems that would bring individuals to the hospital?
    c. Why would people come to a hospital without medical concerns?

6. Thinking about what we've talked about, what supports (medical and nonmedical) could help relieve stress on hospitals?
    a. What services could be offered outside of hospitals?
    b. What gaps in training, services, resources, etc. could be fixed so people don't need to go to the hospital?

7. What community/regional planning considerations may help better support the health and medical needs of those with AFN during an emergency situation?

8. What can be done to ensure members of our communities reach out to the appropriate provider (i.e., appropriate for the level/type of care needed) for their emergency health and medical needs?

9. In an emergency/surge event, what services and/or resources could be provided to help alleviate the pressure on hospitals or other responder agencies?

Next steps questions

1. Thinking about what we've covered, who else should we talk to?
2. Do you have any questions for us? Anything else you want to make sure we understand?

3. After this we will pull together our notes and create a regional report. This report will inform regional initiatives focused on supporting those with access and functional needs during disasters. Please share your email on the sign in sheet if you would like us to share this with you. We will not use it for anything unrelated to this conversation. We will use this email to let you know how we're going to use what we learned.

Immediately after the meeting, note taker and facilitator should take 10 minutes to capture the following reflections:

1. What were the key drivers you learned about what brings people to hospitals?
2. What ideas or comments really seemed to resonate and move the conversation forward?
3. Where did people think we could get started in taking action?
4. What was the mood of the conversation?
5. What surprised you?

Focus Group Conversation Guide & Note Taking Tool: Non-Hospital Group

Date of Conversation: _____ Location: _____

Facilitator:_____ Note taker: _____

# of participants: _____ Group engaged: _____

Before we get started, I want to tell you a little bit about this conversation, what you can expect and how we will use what we learn. I want to thank you for taking time out of your busy schedule to share your thoughts with us.

These conversations will usually run about 60-90 minutes. Feel free to get up as you need to. (Let them know where the nearest bathroom is). This is going to be an informal conversation.

Introduction

Our healthcare coalition brings health partners together from across our region to figure out how we can work together to best address health needs during disasters. This includes knowing what issues affect our community's health during disasters and what they expect or need from health care services.

In particular, we would like to talk about when and why people use hospitals in our region, and what resources might help to support people's health needs during disasters. A surge of people going to hospitals during disasters is something we try to prepare for as health care coalition partners, so we want to look for both medical and non-medical reasons that might drive use, and how we might come together to reduce stress on hospitals and still meet the needs of the community.

- As your facilitator, my job today is to help you have a productive conversation. I ask that we focus on what happens in our community and look for places to engage that are specific to this area. Bigger systems are important, but today we want to figure out what's most important to this part of Colorado. Can we agree to stay focused locally?

- Sometimes I may ask you to clarify your comments to better understand your point. If you're not speaking much, I might invite you to share your thoughts, and if you've said a lot, I might ask you to make room for others. If I do, it's just to help make this conversation productive and inclusive, so we get the full benefit of everyone's experience and perspectives.

- I want to introduce our note taker, Devi. This conversation's focus is on learning, so notes are helpful to make sure we get it right. This conversation will also be recorded so we catch all information we may have missed when we are summarizing our findings.

- We find some basic ground rules can be helpful.
    - **Have a "kitchen table" conversation:** Everyone participates; no one dominates.
    - **There are no "right answers":** We want to understand your experience and perspective. You don't need to be an expert on any given issue; you are already an expert on your experiences with these issues.
    - **Listen with an open mind:** Listen to others and try to understand their perspective. Don't jump to conclusions.
    - **It is okay to disagree, but don't be disagreeable:** Be polite, kind and respectful of others.
    - **We are going to have one conversation, together:** Please avoid side conversations. Help the conversation stay on track.
    - **Step up/Step back:** If you find yourself jumping in first to answer every question, take a step back and make room for others. If you're more introverted, challenge yourself to step forward and speak up.

- **Have fun:** This conversation is a chance to share your thoughts with, and learn from, other people in your community. Enjoy it.
- **If you have any questions or comments throughout the panel discussion or need more clarification regarding a comment or discussion point please let us know.**
- **Are there other ground rules that we should add for our conversation?**

- In the interest of setting realistic expectations, I want to let you know what we'll be doing with what we learn and what to expect moving forward. These conversations first and foremost are about increasing our knowledge. At this point, we cannot promise any new policies or programs – but we want to use what we learn moving forward. I can pledge to you that:
  - We will follow up with you to share with you the outcomes from this conversation.
  - And we'll tell you how we're using the information we gather moving forward

- This is an informal conversation. You don't have to raise your hand and we can use first names. **Let's go around the table and please introduce yourself** starting with your name, your organization or community role, and the services your organization or you provide (if applicable).

Questions: *Non-Hospital* (start with the primary question, and add follow-up questions to help discussion if needed.)

1. In an emergency what are likely to be the most immediate health and medical needs of the clients you regularly serve?

2. Please explain why your agency might/might not be able to provide services to meet those needs. Think about events such as: snow storms, power outages, severe weather, etc.

3. What services do hospitals offer to the clients that you regularly serve?
   a. What assumptions do your clients have about the help they can get at hospitals?

4. In addition to medical needs, disasters can disrupt other basic services as well. What non-medical concerns could bring community members to your organization during a disaster? This includes individuals physically presenting at your facility and/or requesting services outside of your facility. How would this affect your organization?
   a. What changes to medical conditions or other health concerns could motivate your clients in the community to go to the hospital?

b. What nonmedical concerns could eventually cause health problems that would bring your clients the hospital?

c. Why would people come to a hospital without medical concerns?

d. Who determines when/if a client should go to the hospital?

i. How is that determination made (e.g., specific criteria)?

5. Thinking about what we've talked about, what supports (medical and nonmedical) could help relieve stress on hospitals by reducing the number of clients presenting to the hospital?

a. What services could be offered outside of hospitals?

b. What gaps in training, services, resources, etc. could be fixed so people don't need to go to the hospital?

6. What community/regional planning consideration may help your organization better support the health and medical needs of your clients will be met in an emergency situation?

7. What can be done to ensure members of our communities reach out to the appropriate provider (i.e., appropriate for the level/type of care needed) for their emergency health and medical needs? Members of the community can include staff, clients, client families, etc.

8. In an emergency/surge event, what services and/or resources could your organization offer to help alleviate the pressure on hospitals or other responder agencies?

Next steps questions

4. Thinking about what we've covered, who else should we talk to?
5. Do you have any questions for us? Anything else you want to make sure we understand?
6. After this we will pull together our notes and create a regional report. This report will inform regional initiatives focused on supporting those with access and functional needs during disasters. Please share your email address on the sign in sheet if you would like us to share the results with you. We will not contact you for anything unrelated to this conversation.

Immediately after the meeting, notetaker and facilitator should take 10 minutes to capture the following reflections:

6. What were the key drivers you learned about what brings people to hospitals?

7. What ideas or comments really seemed to resonate and move the conversation forward?

8. Where did people think we could get started in taking action?

9. What was the mood of the conversation?

10. What surprised you?