Improving Emergency Management Standards

Where to go from here?

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Overview

- New Standards for 2008 and 2009
- Review of debriefing of recent disasters
- What are next challenges?

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A Brief History of Emergency Management Standards

- Pre-2001 Standards
  - Legacy Standards
  - Disaster Based (before “all hazard”)
  - Emphasis on response phase
  - Minimal community planning
- 2001 Standards
  - Heavily influenced by DoD and VA
  - Growing international/domestic threats
    - HVA,
    - All Hazards,
    - 4 phases,
    - Community coordination,
    - hospital leadership

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2008 Standards

Developed after reviewing 5 years of disasters

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Debriefed Multiple Hospitals & Communities:
Sample of Debriefings

- First - Tropical Storm Allison – June/2001
- **9/11 – September 2001**
- Power Outage – Summer 2003
- San Diego Wild Fires – Summer 2003
- Hurricane Isabel – Fall 2003
- SARS (Asia/Toronto) - Spring 2003
- Multiple hurricanes in Gulf and Florida- 2004-05
- Katrina/Rita - 2005

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6 Critical Parameters
Became structure of 2008 standards

- Communications
  - With staff; suppliers; EOC
- Supplies
  - Unclear inventory, lack of reliable supplier
- Security
  - Protection of assets (drugs, fuel, vaccine);
  - Ability to maintain operations
- Staff
  - Housing; pay; family; mental health; safety; leadership
- Utilities
  - Fuel; electricity; water (potable and others); sewage - others (ventilation, medical gases)
- Clinical Activity
  - Vulnerable populations, changing patient needs; ongoing assessment;
  - (altered standards of care)

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2008 Standards Overview

- Planning to Manage Consequences (EC.4.11)
- Emergency Operation Plan (EC.4.12)
- Critical Parameters
  - Communications (EC.4.13)
  - Supplies (EC.4.14)
  - Security (EC.4.15)
  - Staff (EC.4.16)
  - Utilities (EC.EC.4.17)
  - Clinical Activity (EC.4.18)
- Exercises & CQI (EC.4.20)

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Expanded and New Requirements

- Highlight in RED postponed from 1/08 to 1/09

- In that dialog with field, suggests the state of preparedness of the country

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EC.4.11 Managing Consequences of Emergencies

- Hazard Vulnerability Analysis (HVA)
  - Broad review of threats
  - In sync with community
  - Prioritize events
- Communicates to community, needs & vulnerabilities
  - Recognizes unresponsive communities remain
- For each event in HVA, define
  - Mitigation activities
  - Preparedness activities
  - Response strategies
  - Recovery strategies

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EC.4.11 Managing Consequences of Emergencies

- **EP#9** - Document inventory of onsite assets & resources; to include
  - PPE
  - Staffing
  - Water, fuel
  - Medical, surgical, pharmaceuticals
- **EP#10** -Methods for monitoring quantities of assets and resources during emergency
- Scope, objectives, performance of emergency management planning is annually evaluated

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EC.4.12 Develop Emergency Operations Plan (EOP)

- Develop & maintain Emergency Operations Plan
- Emergency Operations Plan (EOP)
  - Establishes ICS consistent with community's
  - Identifies staff reporting relationships
  - **EP#6** – The Plan identifies capacity and establishes response efforts in 6 critical areas when organization cannot be supported by community for at least 96 hours
    - Evacuation is an acceptable strategy but reallocation preferred
  - Identifies alternative sites for care

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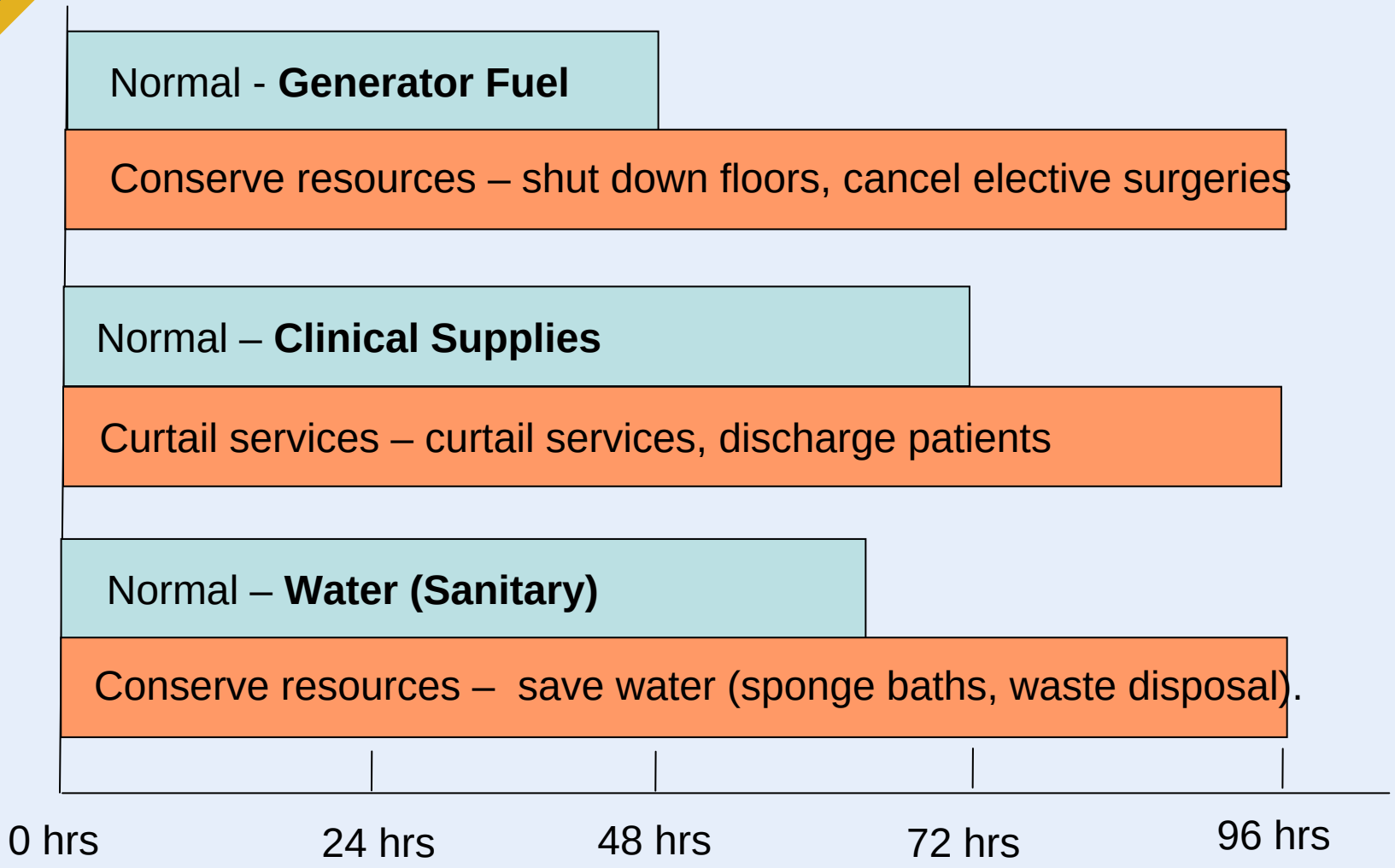
Striving for more….



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EC.4.13 – Emergency Communications

- Internal planning with staff, external authorities, patients and families
- Communicating with suppliers and services during emergency

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EC.4.14 – Managing resources and assets

- Potential sharing of resources and assets with HCOs outside of community
- Transporting patients with supplies and staff to alternative care site

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EC.4.15 Managing safety/security

- Identifies role of community security and coordination with agencies

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EC.4.16 – Defines & manages staff roles

- Roles and responsibilities are defined for all critical areas
- Training for roles
- Communication to physicians and other licensed independent physicians and to whom they report

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EC.4.17 Managing utilities

- Identifies alternative means of providing fuel for building operations or essential transport

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EC.4.18 Managing services

- Clinical services of vulnerable population served by organization
- Mental health services of patients
- Mortuary services
- Documenting and tracking patient clinical information

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EC.4.20 EOP: Scope of Exercises

- **EP#3** - One exercise is escalated to evaluate performance when community cannot support the organization

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EC.4.20 EOP: Scope of Exercises

- **EP#11-13** - 6 critical functions monitored
- Exercises are critiqued
- Completed exercises are critiqued through multi-disciplinary process
- EOP modified in response to critiques
- Improvements to EOP are evaluated during next exercise
- Strengths/weaknesses are communicated to responsible multidisciplinary team

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And the disasters continue…

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Disasters Debriefed Since 2005

- Southern California wild fires - 2007
- Hurricane Gustav 8/2008
- Hurricane Ike – 9/2008

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What is Important?
Preserving Community's Medical Care

- Maintain medically frail in community
- Preserve hospital beds for seriously ill

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The Threat to Medical Care

-Decrease supply of hospital alternatives
-Increase demand for hospital beds

- Long Term Care (only segment with expected resiliency)
- Home Care closed
- Dialysis Center closed (no generators)
- Threat of loss of Ventilators/Oxygen
- Physician Offices closed
- Outpatient Pharmacy closed
- Discharged patients (wouldn't leave)

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Debriefing of 2nd Assault

- San Diego
  - Wild fires – 2003
  - Wild fires - 2007
- New Orleans
  - Hurricane Katrina & Rita – 2005
  - Hurricane Gustav– 2008
- Houston
  - Tropical Storm Allison – 2001
  - Hurricane Rita – 2005
  - Hurricane Ike - 2008

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Focus of Second Debriefings

- Most important improvements
- Resilience of other healthcare providers
- Able to protect surge capacity
- Improve decision to evacuate or shelter in place
- Handling of 6 critical parameters
- Communication with:
  - Staff
  - Citizens
  - HCO
  - Community

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Some Highlights from Debriefings

- San Diego – Hospital Association
- Houston - Hospital
- New Orleans – Charity/University reps

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Coordination of Emergency Planning

- San Diego – County level
- Texas – Regional level
- New Orleans- cooperation of public hospitals

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Communication Systems

- Reverse 911 – landline
- AlertSanDiego – registration of cell phones
- 211 – where to seek services; could register
- Emergency Alert System (EAS) – ongoing communication to population – when to return home
- RSAN Roam Secure Alert Network- 2008 purchase
- WebEOC – hospitals
- Local media
- New Orleans – minimal new city sponsored communication to citizens

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Staff, Families, and Pets

- San Diego & Houston
  - Able to handle pets off-site and even horses (San Diego)
  - Houston- needed food, water,leash, and crate
  - Set up help for children and elderly of staff but needed to bring own supplies
- New Orleans – Public hospital
  - No pets or support of family
  - Given time to make other arrangements

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Security

- Not an issue in any cities though New Orleans public hospital security now equipped & trained with assault-style rifles
- Houston – hired extra security – implemented armbands for family – dedicated security for childcare (since Allison)

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Evacuation

- Not needed in Houston
  - Increase expectation that LTC can “shelter in place”
- San Diego did successfully evacuate 3 hospitals and many LTC facilities
- New Orleans – no evacuation

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Special Needs

- Walgreens and CVS brought in pharmacy trucks and access to national network
- Community told to bring pill bottles
- Much more attention paid to oxygen – who needed it, where it was needed; rationing was required
- Dialysis remains a national problem – patients refused transporting to distant site

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What Determined Best Results?

- Second disaster similar to first (wild fire/hurricane)
- Systematic improvement driven by after-action
- Improvement with community-wide communication
  - Reverse 911, 211, WebEoc
- Improved coordination of multiple facilities
  - Government-based better than system inside of system
- Hospitals are integral part of community planning

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Conclusion

Debriefings and Org discussions

- Significant improvement possible in 3 years (same disaster)
- Community-based communication better and important
- Need to harden multiple parts of delivery system
  - Long Term Care
  - Access to pharmacy
  - Increase use of shelter for special needs
- Community planning is preferred over aggregation of hospitals
- Inadequate experience:
  - With less warning of disaster e.g. terrorist attacks
  - When evacuation not possible (quadrant 4) – e.g.. Pandemic
- Unknown results of disasters with
  - No warning e.g. terrorist attacks
  - Evacuation not possible e.g.. pandemic

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Questions?

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