

Emergency Management 101 for Health Professionals

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Managed Emergency Surge for
Healthcare (MESH)

Four Phases of Emergency Management

Principles of Emergency Management

- Foundation upon which emergency management is built
- Applicable to an “all-hazards” approach to disasters
- Should be a part of any healthcare emergency management plan
- Specific reference in JC EM02.01.01

Cornerstones of Emergency Management



Mitigation

- Planning
- Analysis of weaknesses and identifying gaps (HVA's)
- Testing and Practices
- Learn from mistakes and make improvements
- Institute practices and policies
- Collaboration

Preparedness

- Exercise
- Training
- Resource management
- Planning

Response

- Supplies
- Staff
- Procedures
- Relationship cooperation
- Unified management of disasters

Recovery and Resiliency

- Internal effort within an organization to ensure that mission critical business and service functions are resistant to disruption
- Business Continuity/COOP
- Recovery Plans
- Insurance Coverage
- Continuity of operations
- Continuity of services

Standards, Regulations, Guidance

Which Ones to Know?

- Agencies that regulate healthcare emergency management procedures, capabilities, and requirements
- Organizations that establish healthcare emergency management standards
- Healthcare non-regulatory agencies that provide guidance to healthcare industry
- Standards and regulations that pertain to healthcare during disaster situations

Accrediting Agencies

- Accreditation Association for Ambulatory Health Care
- Accreditation Association for Ambulatory Health Care Facilities
- Commission on Accreditation of Rehabilitation Facilities
- Community Health Accreditation Program (home health and hospice)
- National Association of City and County Health Officers
- American Public Health Association
- Public Health Accreditation Board
- The Joint Commission

Joint Commission

- 2009 Emergency Management Chapter - Standards
 - EM.01.01.01 Planning and strategies
 - EM.02.01.01 Emergency Operations Plan
 - EM.02.02.01 Communication during a disaster
 - EM.02.02.03 Manage resources and assets
 - EM.02.02.05 Manage security and safety
 - EM.02.02.07 Management of staff
 - EM.02.02.09 Manage utilities
 - EM.02.02.11 Manage patients
 - EM.02.02.13/15 Management of volunteers and licensure
 - EM.03.01.01 Evaluates the effectiveness of its planning activities
 - EM.01.01.13 Evaluates effectiveness of its EOP

Regulatory Agencies

- Occupational Safety and Health Administration (OSHA) - 29 C.F.R. 1910
- Centers for Medicare and Medicaid Services (CMS)

Centers for Medicare and Medicaid Services

- Long-term care—42 C.F.R. §483.75(m)
- CMS Intermediate Care Facility for the Mentally Retarded (ICF/MR)—42 C.F.R. §483.470(h)
- CMS End Stage Renal Disease (ESRD)—42 C.F.R. §405.2140(d)
- CMS Critical Access Hospitals (CAH)—42 C.F.R. §485.623(c)
- Rural Health Care Clinics – 42 C.F.R. §491.6©

Standard-Setting Organizations

- National Institute for Occupational Safety and Health (NIOSH)
- American Society for Testing and Materials (ASTM)
- National Fire Protection Agency (NFPA)

National Institute for Occupational Safety and Health

- Establishes standards that are adopted by regulatory agencies
- Guidance organization only
- Provides nonbiased recommendations
- Guidance for protecting building environments—Identifies actions to be implement without undue delay

American Society for Testing and Materials

- ASTM 1288—Planning for and responding to a Multiple Casualty Incident (prehospital)
- Standard guide for developing model emergency operations plans in response to all-hazard events
- Including chemical, biological, radiological, nuclear, or explosives (CBRNE)

National Fire Protection Association

- NFPA 99-Health Facilities
- NFPA 101-Life Safety Code (LSC)
- NFPA 110-Emergency and Standby Power Systems
- NFPA 111-Standard on Stored Electrical Energy
- Emergency and Standby Power Systems
- NFPA 1600-Disaster/Emergency Management and Business Continuity Systems

Nonregulatory Agencies

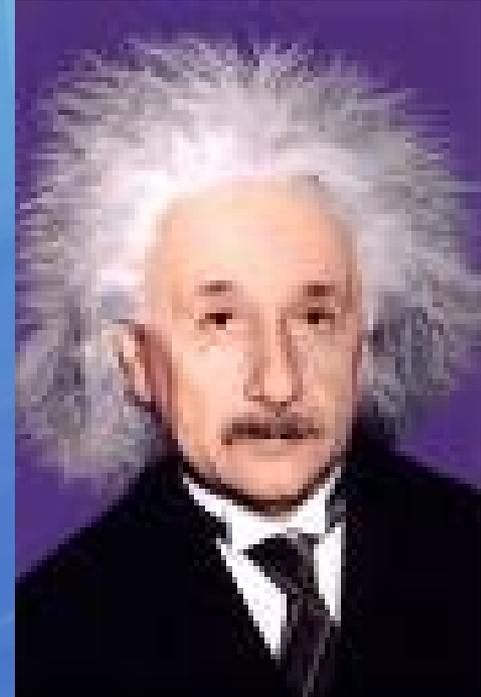
- Department of Health and Human Services (HHS)
Centers for Disease Control and Prevention (CDC)
- Healthcare Resources and Services Administration (HRSA)
- HHS-Agency for Healthcare Research and Quality (AHRQ)
- DHS-Federal Emergency Management Agency (FEMA),
- National Integration Center (NIC), Incident Management System Division
- ASPR

Professional Organizations

- American Hospital Association (AHA)
- American Society of Healthcare Engineering (ASHE)
- American Nursing Association (ANA)
- American Medical Association (AMA)

Conclusion

- Numerous regulatory and standard setting organizations
- It is important to know which standards apply to you
- As Einstein said “I don’t need to know everything, I just need to know where to look it up at”



Emergency Management Programs

Objective

**List key components of a
healthcare facility/system
Emergency Management
Program**

**Why does my facility need
an Emergency Management
Program ???**

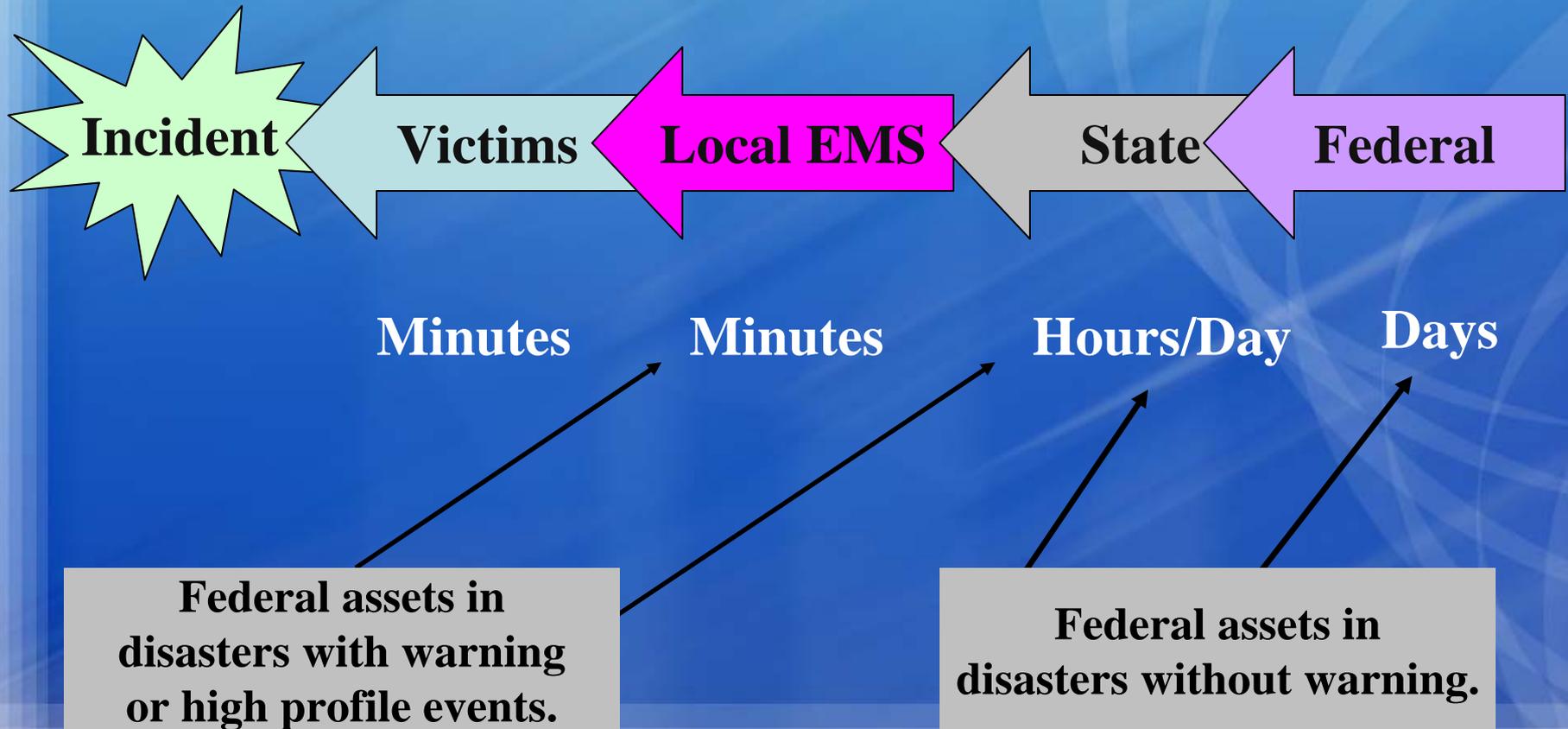
Drivers and Influences

- **National/Federal guidelines and initiatives, e.g. ASPR, CDC, DHS.**
- **State/local guidelines and initiatives.**
- **Regulatory – e.g. JC, OSHA, NFPA.**

**All disasters start
as local incidents.**



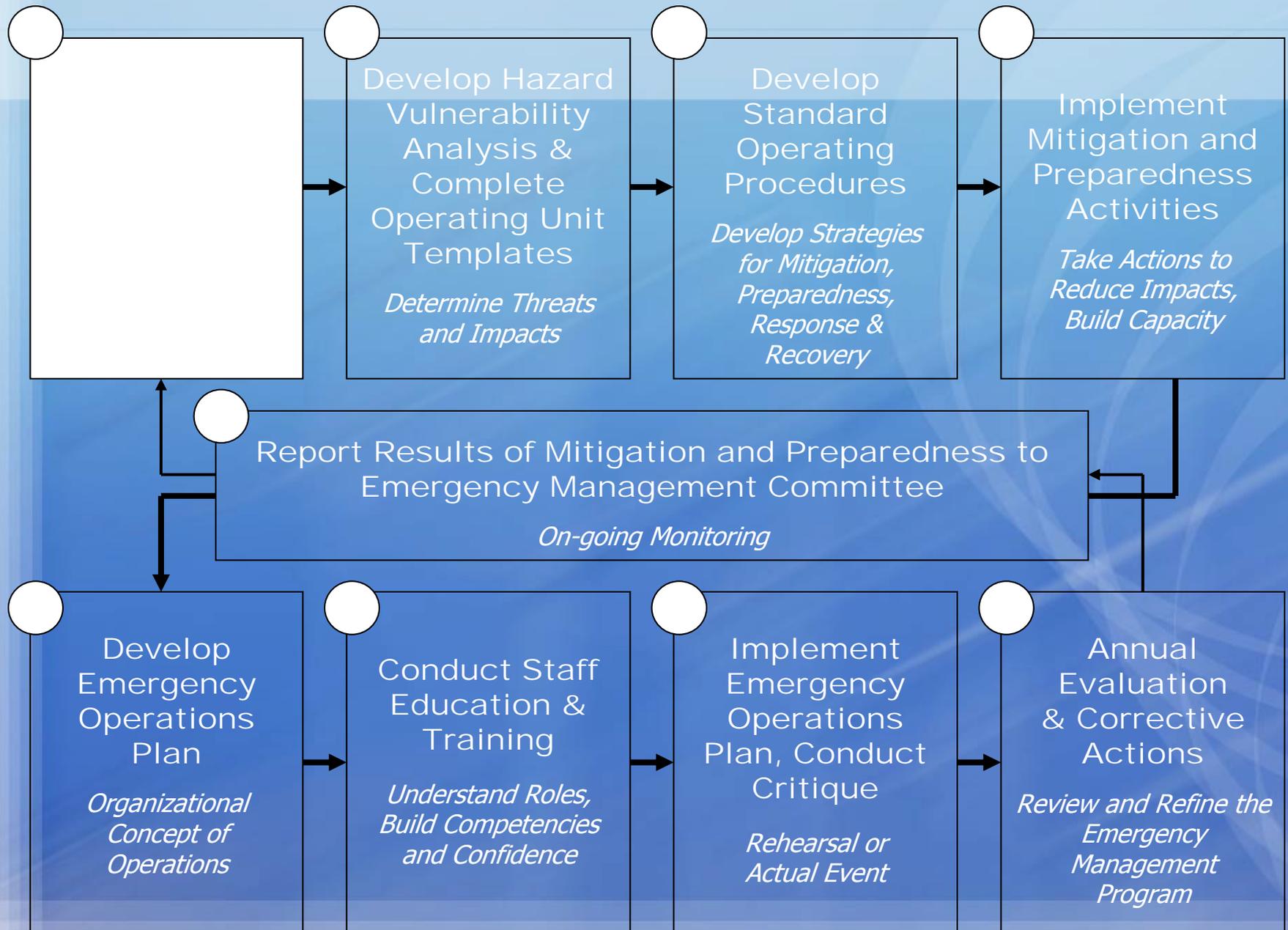
Timeline for Disaster Response



EM Program Goals

- Continuity of care.**
- Safety of patients, families and staff.**
- Support to community (and Nation).**

Nine Step Process



Nine Step Process

Steps 1 – 5

**Focus on Developing an
EMP**

Nine Step Process

1.) Form Emergency Management Committee

- CEO – Appoint Chair (preferably, emergency coordinator) and members representing key ICS/IMS functional areas.**
- Establish regularly scheduled meeting times, goals, milestones and tasks.**
- Record minutes to share with staff and brief to management (and board, as appropriate).**
- EM Committee representative should also represent facility/organization at external**

Nine Step Process

- 2.) Develop Hazard Vulnerability Analysis (and complete operating unit templates, as appropriate).**
 - (Operating units = patient care areas, support and admin; templates = tools for assessment of area's potential hazards, utilities & support, as well as impact on unit and plans to mitigate/manage.)**

Hazards Vulnerability Analysis (HVA)

- **3 Categories:**
 - **Naturally Occurring**
 - **Human Related**
 - **Hazardous Materials**

Assess:

Probability

Human Impact

Property Impact

**Operational
Impact**

HVA

- Is no “required” HVA template
- Examples of widely-used templates can be accessed at:

<http://www1va.gov/emshg/page.cfm?>

(Department of Veterans Affairs)
or

<http://www.qnyha.org/eprc/ge>

Nine Step Process

3.) Develop Standard Operating Procedures (SOPs).

- Develop SOPs based on HVA results.**
- Include strategies on four Comprehensive Emergency Management (CEM) phases (mitigation, preparedness, response recovery)**

SOP TEMPLATE

- Description of the event - impact on mission
- Critical systems
- Responsible operating units and key personnel



SOP Template

- **Notification procedures**
 - Within facility, system
 - Other - (gov, external etc.)
 - OSHA



- **Specialized staff training, references and further assistance**
 - Texts and manuals on specific issues/procedures
- **Review date**

Nine Step Process

4.) Implement Mitigation and Preparedness Activities

- Implement mitigation actions to prevent or reduce impact of structural and non-structural hazards (enact building repairs, utility checks, safety standards, redundant communication, security procedures, etc.)**
- Implement preparedness actions (develop training programs, conduct supply inventories, formalize agreements, enhance communication, etc) to build capacity**

Nine Step Process

5.) Report Results of Mitigation and Preparedness to Emergency Management Committee.

- EM Committee should monitor and direct activities.
- Conduct routinely scheduled briefings and updates to management.
- Make recommendations for improvements to EM Program.

Nine Step Process

Steps 6 - 9

**Focus on Response and Initial
Recovery**

Nine Step Process

6.) Develop Emergency Operations Plan (EOP)

- Apply ICS/IMS concepts throughout.**
- EOP focus is on response and early stages of recovery phase.**
- Includes a Base Plan, containing Concept of Operations (organization's mission and actions during response and recovery) and Systems Description (the organization of assets during response and recovery).**

EOP Components

- **EOP Base Plan – Includes purpose, scope, policies, situation, planning assumptions and concept of operations**
- **EOP Functional Annexes – Include procedures and guidance aligned with ICS/IMS functional areas (management, planning, operations, logistics, finance). Examples: Specific guidance on patient care in a response or location and set-up of the facility Emergency Operations Center (EOC).**

EOP (cont.)

Attachments to Functional Annexes may include checklists and brief guidance / documents.

Examples:

- Mobilization checklist
- Call-back roster
- Job Action Sheets

Nine Step Process

7.) Conduct Staff Education and Training.

- All staff should be trained on potential roles in competency-based emergency management. (Also—All should be familiar with EOP, location of procedures, activation processes, etc.)**
- Those expected to perform ICS/IMS functions should take IS 100, 200, 700 (NIMS) and 800 (revised) (NRF).**
- Access these and other training: <http://www.fema.gov> and through local / State departments of health and emergency management agencies.**

Nine Step Process

8.) Implement EOP; Conduct Critique.

- **Exercise or actual event.**
- **Successful exercise includes:**
 - ✓ **Assessment of need (HVA, regulatory guidance, past After-Action Reviews (AARs), external involvement, EOP review, personnel/facility change)**

Nine Step Process

9.) Annual Evaluation and Corrective Actions

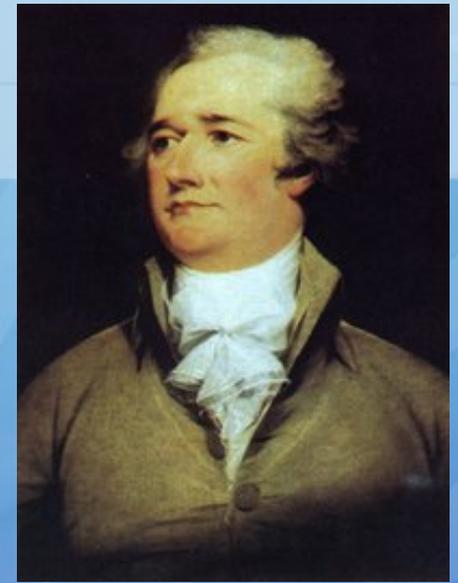
- Review and Revise the EMP**
- Address exercise (or actual event) AARs, training programs, competencies, HVA, SOPs, EOPs, interface with community and external agencies, formal agreements, staff roles and facility's/system's mission and roles.**

Summary -EMP Should Be:

- All-hazards
- Comprehensive Emergency Management
- Dynamic and continuously updated
- Compatible with standard EM concepts, yet unique to the particular facility
- Include involvement with community and external entities
- Fully supported by management

“Men often oppose a thing merely because they have had no agency in planning it, or because it may have been planned by those whom they dislike.”

Alexander Hamilton



...How do we motivate others to support Emergency Management Programs?

Exercising, Educating, and Maintaining your Plans

WHY DO WE BOTHER TO TRAIN?

- Because we are required to!
- A plan on paper is meaningless
- Must be useable, realistic, applicable
- How do you know it works?
- Because people react the way they were trained



Training Tips

- Partner with others to obtain grants, share costs
- Look for consultants and training programs that “Train the Trainer”
- Command (management) needs to “buy in”
- If you don’t make improvements from “lessons learned”, don’t bother

Exercises

- How do I know what needs to be exercised?
 - Regulatory Requirements (JC EM01.01.13)
 - HVA
 - Previous exercises
 - New staff, policies, facilities, equipment
- How do I know what kind of exercise?
 - Scope
 - Resources
 - Finances
 - Time
 - Liability and Safety Issues



Finding the Right Type of Exercise

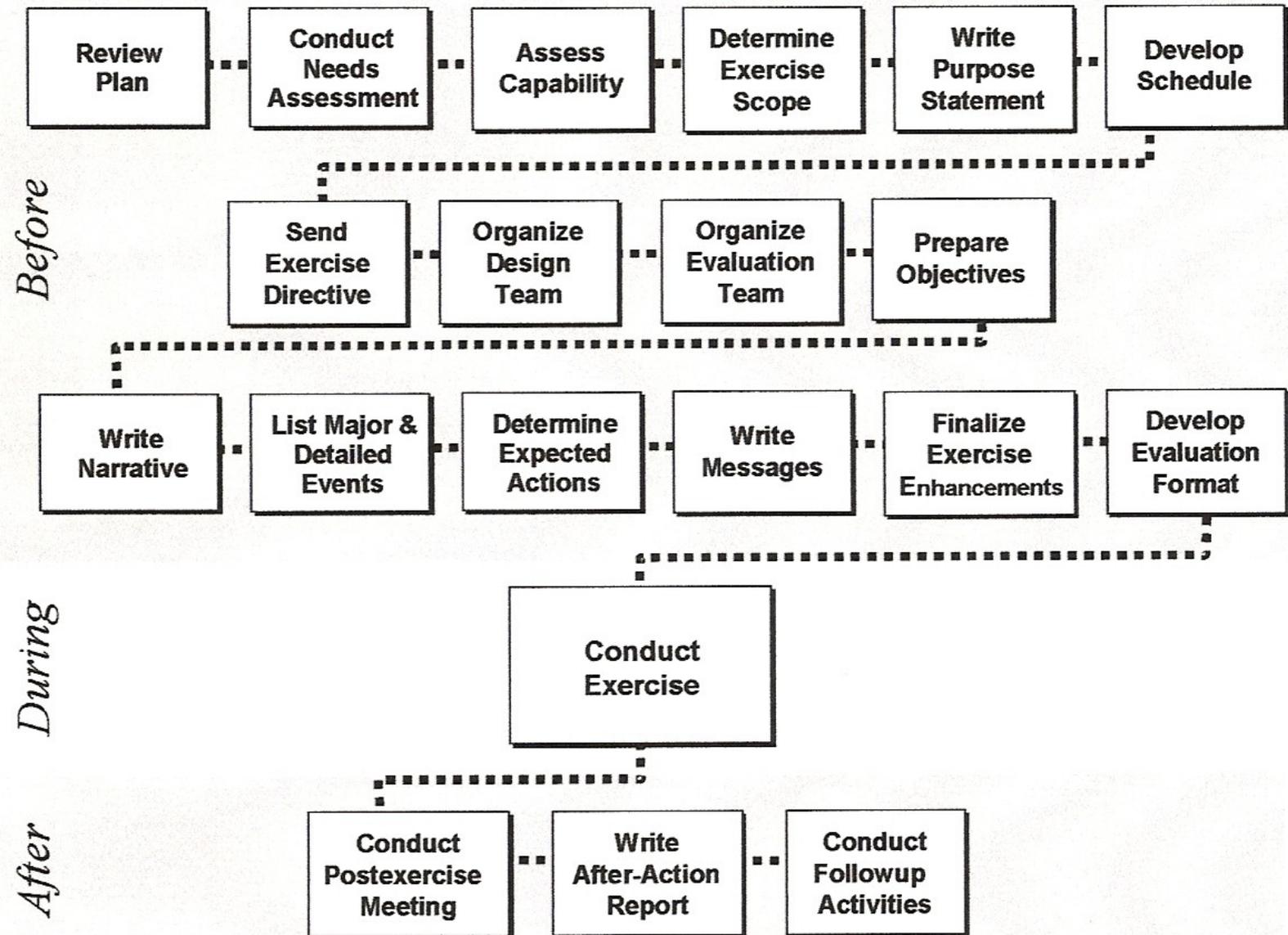
- Which exercise is the right one?
- Tabletops
- Functional Exercises
- Full Scale Exercise



Developing an Exercise

- Decide size, scope, purpose and type of exercise
- Determine who needs to participate in exercise
- Gather Design Team
- Develop objectives for exercise
- Develop scenario and activities to test those objectives (exercise flow)
- Evaluation should match objectives

Sequence of Tasks for a Successful Exercise



Evaluation and The Improvement Plan

- Evaluation process is critical
- After Action Reports
- The Improvement Plan
 - Set review periods
 - Named responsibility
 - Should include “lessons learned”
 - Use Improvement Plan to help develop next exercise

BREAK

Medical Surge

Objectives

- Define medical surge, medical surge capacity and medical surge capability.
- Discuss planning and strategy initiatives associated with medical surge.
- Describe factors, e.g., diversion and patient tracking, that influence successful management of medical surge.

Medical Surge

A sizable increase in demand for services compared to a baseline demand.

Dimensions:

- Influx (volume rate)**
- Event (type, scale and duration)**
- Resource demand (consumption and degradation)**

Medical Surge Capacity

The ability to evaluate and care for a markedly increased volume of patients – one that challenges or exceeds normal operating capacity.

- ✓ **Refers to more than “just” beds, personnel, pharmaceuticals, supplies and equipment.**
- ✓ **Is primarily about the systems and processes that influence specific asset quantity.**

Medical Surge Capability

The ability to manage patients requiring unusual or very specialized medical evaluation and care.

- ✓ **Spans the range of specialized services (expertise, information, equipment, procedures, personnel).**
- ✓ **Not normally available at location where they are needed.**
- ✓ **Patient problems that require special intervention to protect staff, other patients and integrity of facility.**

Of Major Disasters Studied...

- 10-15% of total casualties required admission to a hospital.
- 6% of hospitals suffered supply shortages.
- 2% had personnel shortages.
- Also - Over 60% of disaster victims will go to the most near-by and "familiar" treatment facility.

Type of Incident...

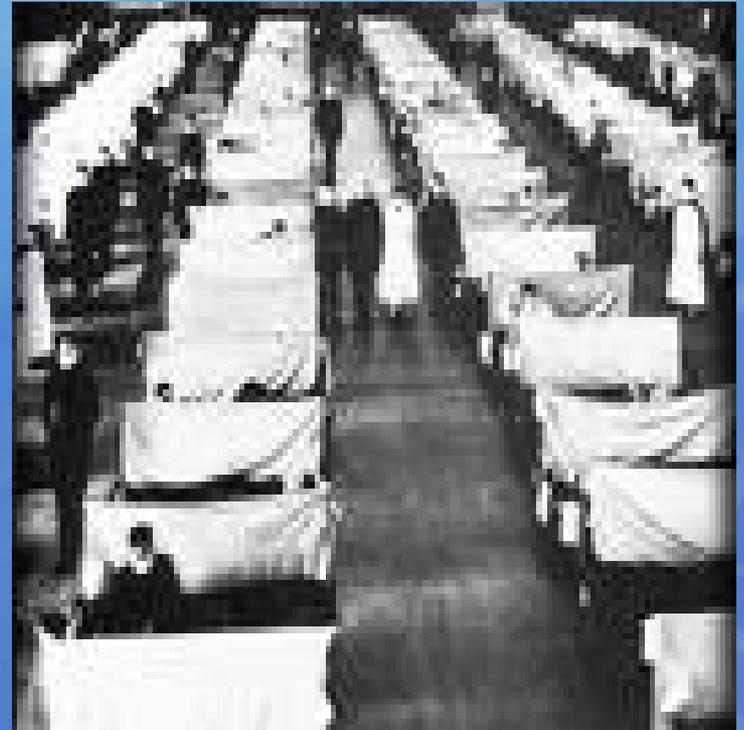
...will impact medical surge capacity and capability requirements, resources and management.

Implications of:

- Disaster with or without warning?
- Terrorist incident?
- Contamination?
- Infectious agent?
- Short or prolonged response/recovery?

Other Issues Re: Surge

- **Diversion**
 - When to implement?
 - Who decides?
 - Plans/agreements/MOUs
- **Tracking**
 - Of patients
 - Refer to ASPR Guidelines



Other Issues: Surge (cont.)

- **Who and How Do You Treat?**
 - **Specializations, e.g., burn, SCI.**
 - **Functional needs populations**
 - **Special populations (homeless, non English speaking)**

Disaster Research

- Organizations and units which plan and exercise together, have significantly better response outcomes.



*Quarantelli, Dynes,
and others*

**Crisis Standards of Care
for Use in Disaster
Situations & MCI
Management**

Objectives

- Discuss how standards may become “crisis” standards in a disaster
- Examine examples of crisis standards in disasters
- How to effectively manage an crisis standard of care
- Review guidance material

Questions

- What circumstances will trigger a call to activate the use of crisis standards of care?
- Who has authority to make that call?
- Under what legal authority should that call be made?
- To what extent can you (and will you) alter your standard of care?

Acceptable Exceptions

- Granting of extraordinary powers (MSEPA)
- National Declaration (Incident of National Significance)
- EMTALA/HIPAA deviation
- Ability to extend healthcare facilities
- Waiver of licensure restrictions via EMAC's/ESAR-VHP
- Cohorting patients
- Reduced technology sophistication (O2 Sat monitor vs. telemetry)
- Expanding staff capacity
- Scope of Practice - Just in Time Training

Grey Areas

- Infection control standards (reusing needles and disposable items)
- Working outside the scope of practice
- Alternative care means
- Safety and health standards (universal precautions)
- “Expectant” casualties

PRIORITIZING CARE

- Field triage in MCI's is based on most survivable, not most critical (greatest good vs. quality of life)
- AMA's model – likelihood and duration of benefit, change in quality of life, urgency of need, amount of resources required
- AHRQ – patient need, potential to return to baseline state, overall resources needed by patient, age and functional assessment, underlying health, prognosis
- Emergency Severity Index – five groups (most urgent to least) based on acuity and resources needed

Palliative Care

- To provide the greatest comfort and minimize suffering to those whose lives will be shortened
- Palliative care is **not** abandonment, euthanasia, or hastening of death
- Palliative care patients might be:
 - Those expected to die (too sick/injured to live)
 - Already existing palliative care population
 - Vulnerable population who become palliative care due to lack of resources during or after event

Challenges To Palliative Care

- Those least likely to understand palliative care may be the ones to deliver it
- Lack of literature available on subject
- Identifying and securing funds
- Lack of understanding within disaster management planning
- Lack of public awareness regarding limitations of health care systems in disasters

Guiding References

- AHRQ - Altered Standards of Care in Mass Casualty Events
- ANA – Adapting Standards of Care under Extreme Circumstances
- Medical and Health Incident Management (MaHIM) System (Barbera and Macintyre)
- Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies (Health and Human Services)

Resource Management

Objectives

- Describe concepts and principles that support resource management.
- Identify types of resources that support medical surge capacity and capability.
- Discuss elements in the management of volunteers.

Concepts and Principles of Resource Management

- Uniform methods of identifying, acquiring, allocating and tracking resources.
- Use of pre-arranged agreements and all relevant sources.
- Credentialing of personnel resources.

Resource Typing

- Classification of resources whether human or otherwise. In ICS, “type” refers to a designated resource’s capability. Type 1 is generally considered to be more capable than Types 2, 3, or 4, respectively, because of size; power; capacity; or, in the case of incident management teams, experience and qualifications.
- Resource typing also involves categorizing the resource by its kind (e.g., what the resource is, snow plow, strike team, etc.). Therefore, resource typing involves designations of “kind” and “type.”

Mutual Aid

- Mutual aid is an agreement between organizations that they will assist each other in an emergency.
- Resources are provided following a formal request.
- Terms can be in-kind or reimbursement.
- An organization providing personnel retains responsibility for their pay, insurance, etc. even though they are under the operational control of the requestor.

Personnel

- **Certification** – Competence through testing or evaluation –through discipline’s certifying entity. (In ICS, can also apply to equipment.)
- **Credentialing** – Verification of minimum required training, experience, currency and physical /medical fitness.
- **Privileging** – Credentials and qualifications “match” specific incident’s needs – May be unique to specific incident or location.

Trends in Health Care

- Inpatient to ambulatory care
- Shorter stays
- Reduction in staffing
- Supplies ordered daily
- ??

Ramifications for Disasters

- Reduction in capacities useful in large disasters
- More patients at home who are dependent upon utility services
- “Just in time” delivery of supplies
- No “reserve” healthcare staff for demands disasters can create:
 - Special Needs Shelters
 - Medical Surge

Types of Resources that Support Medical Surge

- Beds
- Isolation Capacity
- Healthcare personnel
- Pharmaceutical caches
- Personal protective equipment
- Decontamination
- Behavioral health
- Trauma and burn care

Managerial Strategies to Achieve Surge

- Maintaining quality and increasing capacity.
 - Re-distribution of authority and responsibility throughout the organization, as needed.
- Managing the degradation of services.
 - Deliberate selection of critical activities at the expense of other services.

“Engineered (Managed) Degradation”

- A strategy for a system under stress is to identify and select priority activities that should be preserved, while allowing less critical services to degrade.
- The guiding principle is the preservation of functions important to achieving organizational goals.



Efforts to Provide Medical Surge

- Many current initiatives involve the development of standby response assets, such as:
 - Adequate numbers and specialty types of hospital beds.
 - Personnel.
 - Pharmaceutical supplies.
 - Equipment and supplies.

Pharmaceuticals & Supplies

- Strategic National Stockpile
 - 12 hour push packs
 - CHEMPAKS
 - Vendor-managed inventory
- Pharmaceutical caches (VA)
- Other ??



Problems with Efforts to Provide Medical Surge

- Problems with these focused approaches include:
 - Cost
 - Shelf-life
 - Exclusive use
 - Difficulty in determining the amount of resources that may be needed



C'mon, c'mon - it's one or the other.

The Need for a Management System

- The National Incident Management System (NIMS), if applied as envisioned to all agencies and organizations that respond to disasters, will significantly improve medical surge capacity and capability through:
 - Enhanced internal coordination
 - Fewer necessary standby resources
 - Optimal integration of “outside” resources.

Senate Bill 3678: The Pandemic and All-Hazards Preparedness Act

- Establishes Office of Preparedness and Response, headed by an Assistant Secretary.
- More streamlined management of functions and programs and clearly delineated specific public health emergency management elements.
- Titles : Title I: National Preparedness and Response, Leadership, Organization and Planning; Title II: All-Hazards Medical Surge Capacity; Title III: Public Health Security Preparedness; and Title IV: Pandemic and Biodefense Vaccine and Drug Development.

A little about...

Volunteer Management



Volunteer Management

- Why needed?
 - Standards
 - Safety
 - Security
- Issues:
 - Identification
 - Credentials, specializations & training
 - Liability
 - Who screens, assigns and manages?

Volunteer Management

- ESAR - VHP
 - ASPR directed
 - States Depts. of Health managed
 - Know your State's program
- Other potential volunteer sources
 - MRC, CERT
 - NDMS and ESF #8 (and 6 and 9)
 - Local / State initiatives
 - Other – e.g., faith-based

“There are usually enough resources...The problem is the *absence of appropriate management of resources.*”



*Katrina
2005*

Mass Fatality Planning

Objective

- Define Mass Fatality
- Examine components of Mass Fatality Planning
- Examine pitfalls and complications of mass fatality management
- Examine healthcare organizations role in mass fatality planning



Mass Fatality

- Situation where more deaths occur than can be handled by local medical examiner/coroner resources, and may overwhelm state's mutual aid system and requires extraordinary support from state, federal, and private resources
- Medical examiners and coroners make up medico-legal death investigation system and are lead agency in mass fatality management
- Ultimate purpose is to recover, identify, and effect final disposition of deceased in a timely, safe, and respectful manner
- Covered under ESF #8 of NRF
- Mandated for ASPR funding under the Hospital Preparedness Program (objective #3)

Factors Affecting A Mass Fatality Incident

- Number of fatalities/size of incident
- Decedent population (open or closed)
- Conditions of Remains
- Ease of identification
- Type of Incident (public health issues , crime scene, political acts)



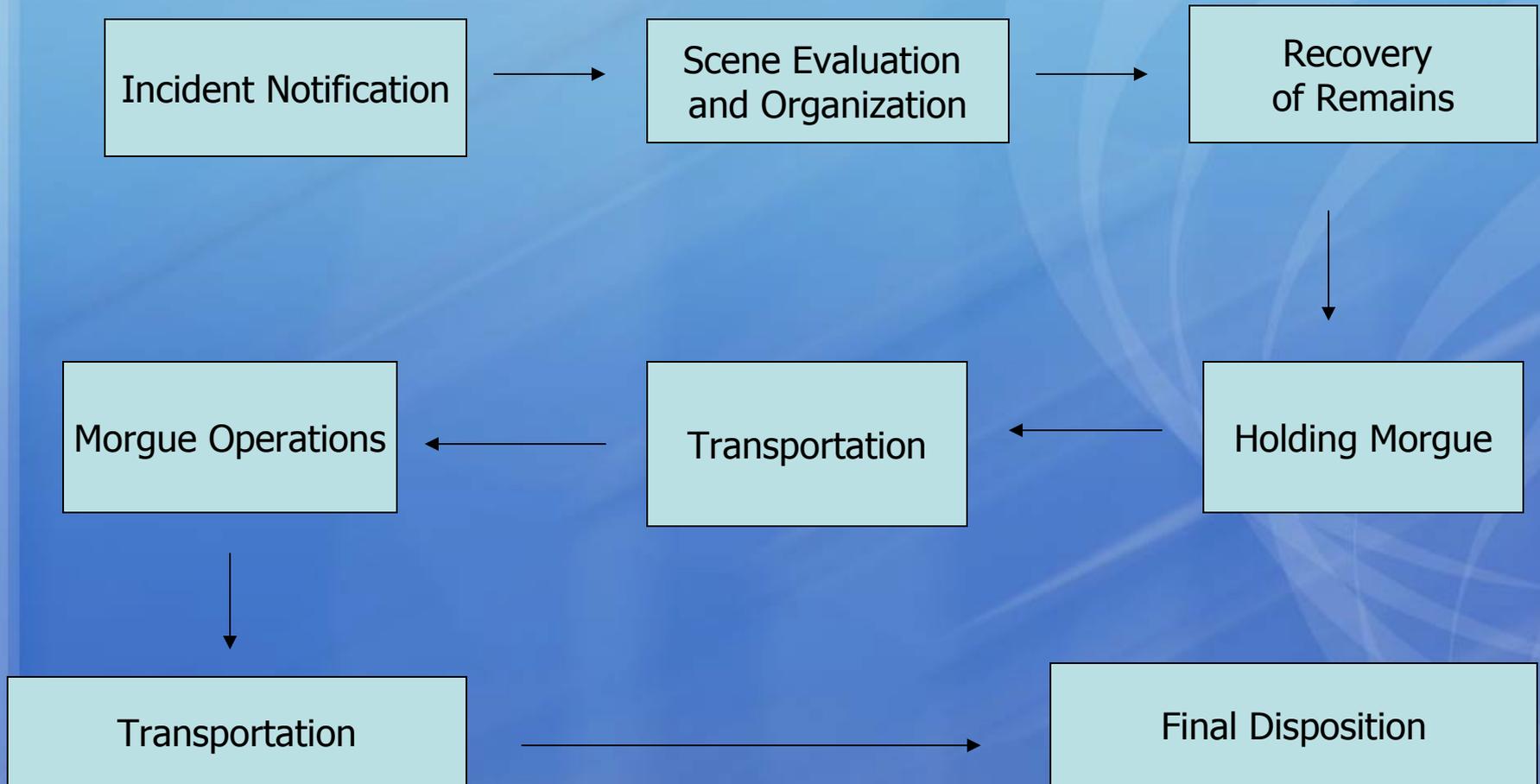
Healthcare Role in Mass Fatalities

- Hospitals may have to hold bodies until medical examiners can take them
- Infection control and security issues
- Need to understand forensics principles (chain of custody, preservation of evidence)
- Public Health will be involved in investigation (epidemiology) if a public health crisis

Guiding Principles in Mass Fatality Response

- Respect the deceased and the bereaved
- Maintain a sensitive approach to family and loved ones
- Follow procedures and protocols that will lead to confirmed identification of decedents and avoid mistaken identification
- Provide honest and accurate information at every stage of operations

Flow of Management of Remains



Setting Up a Mass Fatality Plan

- Involve all potential stakeholders – identify relationships of jurisdictions
- Plan must be scalable
- Build on cooperative relationships and MOUs
- Train people on the plan and exercise your plan
- Identify expectations of plan (be realistic)
- Determine scope – large scale may need DMORT teams

Template of Mass Fatality Plan

- Identify responsible agencies and parties
- Specific command, control structure, and authorities
- Define criteria for activation
- Identify decedent operational areas
- Formulate guidelines for decedent operational areas
- Provide logistics' system for supplies, staffing, and facilities
- Provide guidelines for safety, infection control, and other health threats
- Describe how plan will be maintained, updated and exercised

Unique to Mass Fatality

- Emotional toll on bereaved and loved ones
- Need to respect cultural and religious beliefs
- Media attention
- Staff stress
- Politics
- Resources



MOU's and Interagency Cooperative Efforts

Objectives

- Discuss why we need to have MOU's and cooperative efforts
- Examine where to find your partners
- Review agencies and partners at the local, state and federal levels

Why Do We Need to Develop Cooperative Efforts?

- Mandates (NRF, JC)
- Limited Resources
- Disaster size
- Overwhelmed response system
- Because it doesn't work otherwise!



How do you start?

Requires the four “Cs” of emergency management:

- Communication
- Cooperation
- Collaboration
- Coordination



Local Partners

- LEPC
- Interhospital Coordinating Councils
- Regional Area Councils
- Public Health
- Infrastructure support
- Private businesses
- Disaster organizations
- Social service organizations
- Public safety—First responders
- Education

State Partners

- Public safety
- Education
- Transportation
- Natural resources
- Agriculture
- Human services
- Health resources
- Infrastructure
- National Guard

State to State cooperative efforts are formulated through EMACs

National Level Resources

- The *National Response Framework (NRF)* organizes resources through 15 Essential Support Functions (ESF)
- Mass prophylaxis plans
- Strategic National Stockpile (SNS) plans
- ESAR-VHP
- DMATs, DMORTS, VMATS
- FMS

Alternate Care Sites

Objectives

- List potential uses of an Alternate Care Site (ACS).
- Cite factors in selecting an ACS.
- Discuss issues surrounding management of an ACS.

Potential Uses of an Alternate Care Site (ACS)

- Primary triage
- Primary care of victims
- Care of patients discharged “early” from hospitals
- Temporary nursing home care
- Special needs care
- Ambulatory chronic care
- Shelter care
- Quarantine
- Palliative care
- Mass prophylaxis/vaccine distribution center

Selecting an ACS

- Buildings of opportunity
 - Advantage of pre-existing infrastructure support
 - Schools, hotels, convention centers, surgery centers, community health centers
- Portable or temporary shelters
 - Flexible, but could be costly
- Advise identifying/arranging site in advance

Selecting an ACS (cont.)

- Basic environmental support.
 - HVAC, lights/power, plumbing, comm, etc.
- Space – patient care, families, pharmacy, mortuary, food prep, storage
- Advise identifying/arranging site in advance
- Security – establish and maintain
- Parking and access –patients, supplies, EMS

Managing an ACS

- Command, control and “ownership”
- Decision process to open/activate ACS
- Supplies, equipment.
- Staffing and personnel
- Documentation of care

Managing an ACS

- Communication (internal and external)
- Rules and operational policies
- Exit / demobilization procedures
- Training and exercises

"Prepare and Prevent or Repair and Repent" Snowshoe Thompson 1894



Legal and Ethical Issues and Trends

ETHICS?

- A system of moral principles or values
- The rules or standards governing the conduct of the members of a profession
- The study of the general nature of morals and of the specific moral choices made by the individual in his relationship with others
- Morals vs. ethics

ETHICAL VS. LEGAL

- Can a thing be legal and not ethical?
- What are examples of law and ethics not coinciding?
- What happens when the law and ethics clash?
- When has this occurred in medicine? In disasters?

LAW AND ETHICS IN U.S. HISTORY

- Constitution sought to balance power between federal government and states
- Guaranteeing the individual liberties vs. insuring domestic tranquility
- Balancing act between providing for the common defense and blessing of liberty
- Considerations include fairness, transparency and accountability, inclusiveness and equality, proportionality and reasonableness

FORMULATING LEGAL PRINCIPLES

- Employ the least restrictive means
- Equitable, necessary and relevant
- Provide reasonable measures for compliance (second languages)
- Establish mechanisms to review decisions and allow for due process

THE CHANGING FACE OF DISASTER MANAGEMENT

- The new terrorism
- Large scale natural disasters and climate changes
- Shrinking, interdependent world
- Larger urban environments
- Potential for wide spread infectious and emerging diseases



DISASTER ASSUMPTIONS

- Resources will be overwhelmed
- Medical facilities already at capacity levels
- Federal government will not be able to help
- Decisions will have to be made at the local level
- Established lines of authority may not exist
- Despite all our planning, situations will arise that are not anticipated



INDIVIDUAL RIGHTS VS. PUBLIC GOOD

- Refusal to cooperate with evacuations, quarantine, immunizations
- Civil and constitutional liberties – right to assemble, freedom of speech, travel
- Respect for cultures and customs (recovery of dead after Katrina)
- Confidentiality issues (HIPAA) in disasters
- Fairness to All? (VIP's)

DUTY TO PROVIDE CARE

- Does healthcare provider has a social contract, assumption of risk?
- Involuntary immunization
- Worker's Compensation and liability
- Labor laws, unions, subcontractors

AMA Code of Ethics

1847 - 1977

"... In regard to measures for the prevention of epidemic and contagious diseases; and when pestilence prevails, it is [physicians'] duty to face the danger . . . even at the jeopardy of their own lives."

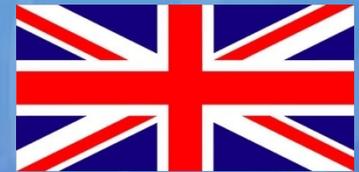
HOSPITAL'S RECIPROCAL DUTY TO WORKERS

- Consider staff safety and well being
- Provide for family concerns
- Provide liability and other protection for healthcare workers and volunteers
- Discuss issues with staff before the disaster. EDUCATE STAFF



OTHER COUNTRIES

- Family involvement in care
- Public relies less on government support
- Standard of care differs
- Customs, cultural, and religious beliefs
- Civil liberties viewed differently – state vs. individual rights



BE PROACTIVE

- Understand your legal environment - regulatory requirements
- Understand your emergency management plans
- Clarify the process for leadership. Identify decision makers and lines of authority
- Discuss potential ethical and legal issues that could arise before they happen

WORK TOGETHER

- Build and maintain relationships (MOUs, MAAs)
- Establish clear channels of communication to link the public health community
- Establish state, regional and local multi-agency coordination
- Devise, model and exercise response plans as a community
- Involve media in planning process
- Involve the legal and ethical experts



WORK WITH THE PUBLIC

- Educate public
- Understand your special needs populations
- Give public tools to cope in a disaster
- Keep the public informed during a disaster



SUMMARY

- Major disasters and pandemics will continue to occur
- We need to be prepared for such eventualities
- Planning needs to take into account legal and ethical issues
- Use of preplanned strategies can save lives and improve the quality of life for disaster survivors

QUESTIONS?

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