



NBSB National Biodefense Science Board

Integrating Clinical Disaster Response Training with Community and State Based Emergency Planning

May 13, 2020



ASPR
ASSISTANT SECRETARY FOR
PREPAREDNESS AND RESPONSE

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On September 11, 2019, the National Biodefense Science Board (NBSB) approved the Disaster Medicine Working Group (DMWG) recommendations on best practices to improve national training and readiness for health care providers (clinicians of various disciplines) to deliver appropriate care during disasters. These recommendations were intentionally focused on training for providers in the healthcare delivery system and others most closely associated with direct patient care (and not training for public health and community response system practitioners). The creation of this report included extensive deliberation among DMWG members, review of the literature and presentations by subject matter experts (see appendix 1). Although this report was initiated prior to the Coronavirus Disease 2019 (COVID-19) pandemic, the current recommendations still reinforce the urgency of the need of practitioners to receive training to better prepare for future disasters.

NBSB commends the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) in launching the Regional Disaster Health Response System (RDHRS) project and advises HHS to continue to support and strengthen that effort in a way that brings together clinical practitioners and civil disaster management authorities. Regional leadership and coordination brings together healthcare organizations and providers, local health departments, incident command systems, emergency medical services, and community-based organizations and others, fostering greater trust among those groups, with the potential to improve capacities to prepare for, mitigate, respond to, recover from, and ultimately evaluate, the effects of disasters.

NBSB recommends HHS to:

1. **Include public health professionals, medical practitioners and emergency management representatives in the training of clinicians** and cover specific content about how clinicians can function effectively within the public health response to disasters.
2. **Encourage, guide, and (where feasible) facilitate sharing of resources in the regions.** For example, regional coalitions can benefit from sharing emergency alert systems, durable equipment, personnel and expertise, and stockpiles to address regional gaps.
3. **Formulate incentives and grant programs to ensure that coalitions have the flexibility needed to adapt resource utilization and response practices** to their unique geographic settings, the strengths and weakness of respective partners, and the unique requirements for partnership arrangements in each state.

4. **Strengthen engagements with health system leaders, communicate return on investment from emergency preparedness programs at the facility level, and establish incentives** where needed to ensure that front-line practitioners are involved in preparedness activities and receive the training needed to provide skilled care during a disaster.
5. **Address ongoing gaps identified through joint exercises and provide reimbursement for joint simulations of disaster events** to heighten awareness, with an emphasis on patient populations with special needs and vulnerabilities. Catalogue gaps identified through different types of exercises. Provide follow up support at the local, regional, and national levels to address such gaps.
6. **Provide “Just-in-Time” Training.** National “Just-in-Time” Training opportunities, tools, and reference material—combined with capacities for remote consultation—should be made available to coalitions from ASPR and allied HHS organizations. Ideally, this should be pre-evaluated and pre-tested during training exercises for feasibility and effectiveness of implementation, and include in-person, on-line, and written options.
7. **Address need for special contingencies to provide medical care in shelters or designated alternate care sites.** Guidance and support should be provided at the national level on staffing for medical contingencies, such as the operation and management of medical logistics for shelters or designated alternate care sites, especially in resource-poor settings (e.g. rural areas).
8. **Evaluate outcomes from exercises and real-world events to assess the effectiveness of clinical preparedness on patient care.** Key outcomes evaluated should focus on coordination of assets and response rather than individual patient care outcomes. Create *“after action reports”* on every event, including smaller events, consistent with Homeland Security Exercise and Evaluation Program (HSEEP).
9. **Address needs of vulnerable populations.** ASPR should work with national associations to determine how to address vulnerable populations’ needs during crises (e.g. if they have equipment needing electricity). Pediatric and geriatric practitioners are examples of groups that should be incentivized to participate in regional disaster coalitions to ensure that they identify specific needs relevant to these groups.
10. **Formalize, organize, and promote disaster medicine as a specialty.** Work with organizations such as the American Board of Medical Specialties, American Medical Association, and the American Association of Medical Colleges. There is a strong desire for nationally mandated crisis standards of care.

Appendix 1: Speaker Presentations

September 11, 2019.

- **Vision for the Pediatric Disaster Care Centers of Excellent Cooperative Agreement Discussion of new topics.** *Tara Holland, MPH, CHES, Program Analyst for Medical Services, National Disaster Medical System, ASPR*

December 3 - 4, 2019.

- **Integrating Clinical Disaster Response Training with Community- and State-based Emergency Planning.** *Dele Davies, MD, MPH*
- **Integrating Clinical Disaster Trainer with Local Emergency Response Systems.**
 - **Perspectives from West Virginia.** *Donnie Haynes, Office Director, Center for Threat Preparedness, Bureau of Public Health, West Virginia Department of Health and Human Resources*
 - **Perspectives from Nebraska.** *Eric Sergeant, PhD, PMP, Administrator for Public Health Preparedness and Response, Nebraska Department of Health and Human Services*
 - **Perspectives from Federal Medical Response Planners.** *Rich Catharina, Chief Medical Officer, National Disaster Medical System, Office of Emergency Management and Medical Operations, ASPR*

February 27, 2020.

- **Perspectives on the linkages and disconnects between disaster medicine/clinical training and community-based emergency management.** *Marc S. Rosenthal, PhD, DO, FACEP, FAEMS, Chair, American College of Emergency Physicians (ACEP) Disaster Preparedness and Response Committee*

Appendix 2: NBSB Working Group (WG)

Disaster Medicine WG

- H. Dele Davies, MD, MSc, MHCM, Working Group Chair,
- Carl Baum, MD, FAAP, FACMT
- Virginia Caine, MD
- Mark Cicero, MD
- Joelle Simpson, MD, MPH
- Marc Shepanek, PhD, NASA Aerospace Medicine and Behavioral Health (*ex officio alternate*)
- David Schonfeld, MD, FAAP

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