

About the Speaker- Dr. Eric Toner, Principal Investigator, HPP Project Team.

A) Discussion Topics/Presentation Points: Dr. Toner

- The fundamental question that we were asked by ASPR was: are hospitals preparedness programs working?
- To know if the HPP is working we had to come up with a descriptive framework for preparedness. We are proposing a definition for the future, which is a work in progress along with our vision for the future.
- The HPP Assessment Project has five phases:
 1. Create a descriptive framework of healthcare preparedness for mass casualty events (delivered 12/07).
 2. Use that framework to evaluate the current state of healthcare preparedness and to assess the impact of ASPR's HPP (delivered 1/09).
 3. Build on the framework, informed by the evaluation, to propose a definition and strategy for healthcare preparedness for the future.
 4. Propose future assessment criteria for healthcare preparedness that is consistent with the definition of preparedness.
 5. Evaluate the Healthcare Facility and Emergency Care Partnership Programs.
- The three major deliverables of the HPP Assessment Project are:
 1. A descriptive framework for mass casualty events of any kind, that occurs for any reason, that requires the coordinated response of more than one hospital. This will help create the definition of the preparedness.
 2. Evaluation report. This will entail assessing the progress that has been made in healthcare preparedness for mass casualty disasters in the past five years (2002-2007).
 3. Preparedness report. This will include proposing a functional definition of healthcare preparedness for mass casualty disasters for the future.

B) Results/Key Findings/Conclusions: Dr. Toner

- To Come up with this framework we need to:
 1. Review literature of past approaches to hospital disaster preparedness programs.
 2. Review the lessons learned from actual mass casualty events-most of these were in Europe/Asia, but there is a lot we can learn from these events.
 3. Study the implications of potential catastrophic events.
- From these events in Europe and Asia we learned that:
 1. Preparedness must be community based.
 2. Preparedness is a process and must be practiced so improvements can be made.
 3. Hospitals need clear triggers for initiating an emergency response and there need to be specific plans in place for who is in control and who makes decisions.
 4. Planning needs to be based on specific hazard assessments.
 5. All hospitals need to be prepared.
 6. Reliable communication channels need to be in place and situational awareness is critical for all those involved.
 7. Patients and resources will need to be continually triaged.
 8. The private sector has to be involved.
 9. Healthcare workers and their families need to be prepared and protected.
 10. Healthcare facilities and their local communities need to work together.

- The framework is organized into three tiers and the members of each tier have their own specific functions and duties.
- Tier One - Individual Healthcare Institutions. There is no standard of preparedness among healthcare institutions and preparedness efforts will vary among institutions. Healthcare institutions will be overwhelmed and should place resources in key locations. These institutions will experience a surge in patients and they will have to care for their usual patients as well as victims of the disaster and people who cannot access their regular sites of care.
- Tiers Two and Three- Community Based Healthcare Coalitions. Coalitions of healthcare are needed in every community to help address catastrophic events and mass casualties arising from disasters because cannot plan things without sharing with your neighbors. Also these coalitions need to collaborate and pool resources as needed. The definition of the word community needs to be flexible because coalitions are different everywhere and they all have different needs.

C) Question and Answer Session: Open to all participants:

1. Q: In an event when people are at risk the chance of people responding is less. Is there a time when we have seen alternate care facilities work and if so, how do we transition from the primary care facilities to the alternate care facilities? R: [Staffing is the main issue. I don't think alternate care facilities can do everything that people have imagined, but they can do screening, triaging etc. I think part of the issue is what kind of care you intend to provide at the alternate sites. Can you use non- medical personnel, such as nursing students or volunteers? They will not be useful without providing information about what services the alternate sites will be offering.](#)
2. Q: Hospitals are accredited, would you say that many of them are demonstrating compliance? R: [Accepting certification is not sufficient enough to say that the hospital is prepared.](#)
3. Q: If you are Joint Commission or an accredited body that is focused on preparedness certifications, if you (hospitals) are using NIMS guidelines-does that meet the intent? If we are not compatible with the purpose of NIMS, could you show us where the shortfall is? R: [Hospitals are concerned about NIMS compliance and working on the issue.](#)