2016 VOLUME 1 ISSUE 1

the EXCHANGE

ASPR
ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

Welcome to the Exchange

ASPR TRACIE officially launched on September 30, 2015, and serves as a national knowledge center for healthcare preparedness. As part of this effort, we welcome you to the inaugural issue of *The Exchange*. This newsletter will provide insightful articles from experts and those in the field on the most pressing healthcare system and emergency preparedness issues, promising practices, and lessons learned. This year's theme is "Critical Issues in Healthcare System Preparedness"; the first issue focuses on Crisis Standards of Care (CSC). We rely on your feedback — please contact us with comments, questions, technical assistance needs, and resources to share. We look forward to our continued collaboration in 2016!

Shayne Brannman, Director,
ASPR TRACIE

John L. Hick, MD, Senior Editor

The ICF ASPR TRACIE Team:

Meghan Treber, Project Director
Audrey Mazurek, Deputy Project Director
Corina Sole Brito, Communications Manager and Technical Resources Lead
Bridget Kanawati, Assistance Center Lead

Foreword

Whether you work for a hospital, are part of a healthcare coalition, or are a healthcare provider, emergency manager, or public health practitioner, you are probably looking for a smarter way to keep the people who rely on you healthy, safe, and informed when disaster strikes. Finding information is easy – finding the right information can be a lot harder. That's where ASPR TRACIE comes in. Officially launched in September 2015, ASPR TRACIE is an information gateway that connects public health and medical professionals with the information that they need. ASPR TRACIE can help you quickly identify resources to get your planning started, build on the experience of your colleagues, prioritize activities for the future, make smart decisions, find training, and get answers to your questions. ASPR TRACIE is divided into three domains: Technical Resources (TR), Assistance Center (AC), and Information Exchange (IE). Every disaster teaches us something new, and disaster health is a complex, constantly evolving topic. Using ASPR TRACIE can help you and your organization plan for disasters more efficiently and effectively. Do you have ideas for improvements to the site, new topics that we could cover, or information that could make your work easier? Please send us your ideas!

Don Boyce, J.D., Director,
Office of Emergency Management

At a Glance

ASPR TRACIE staff interviewed Dr. Ernest Yeh, an emergency department physician who responded to the May 2015 Amtrak train derailment in Philadelphia. Dr. Yeh took us through the event, from the first notification to the lessons the team learned from the event and how they plan to implement them in the future. He noted challenges with the lack of triage in the field (leading to ED staff rushing to locate tags and perform triage) and ED staff using hard copy disaster packets to register patients (which lead to significant patient tracking issues). Dr. Yeh said that despite these challenges, the response worked well overall, as the hospital had enough space and equipment to accommodate the patients, and staff called in before reporting to ensure their services were needed. In his commentary, Dr. John Hick highlights the issues Temple University Hospital experienced that are common in mass casualty incidents.

In this article, Suzet McKinney discusses the actions taken by officials in Chicago and the state of Illinois to advance Crisis Standards of Care (CSC) planning across the state. Early discussions highlighted the need for close coordination with state health officials, which contributed to the development of a multidisciplinary core planning committee. Soon thereafter, ethical and legal subcommittees were formed and the group hosted several stakeholder engagement meetings in multiple regions of the state with members from the public health, healthcare, emergency management, and public safety communities. The planning committee identified common themes and plans to incorporate into their upcoming meetings with the general public. The two common themes were fairness related to being able to save large numbers of patients while stewarding scarce resources, and prioritization of care of the healthcare workforce that may be at greatest risk of exposure and illness.

Drs. Hick and Hanfling present a historic overview of CSC planning, and highlight common issues emergency healthcare providers must consider when developing their plans. They stress the importance of integrated planning and the need for all stakeholders to understand their roles. They also emphasize that plans should be as flexible as emergency situations can be. This theme carries into prognosis: traditional scores and other prognostic indicators may have value when comparing patients who need a resource, and they should be modified depending upon the nature of the event. CSC plans must specify a process for decision making (particularly regarding patient volume, the need for specific pharmaceuticals, and similar issues), and they must be practiced to allow providers to deliver the "greatest good" to the community members they serve.

Photo courtesy of HHS ASPR.

What's New With ASPR?

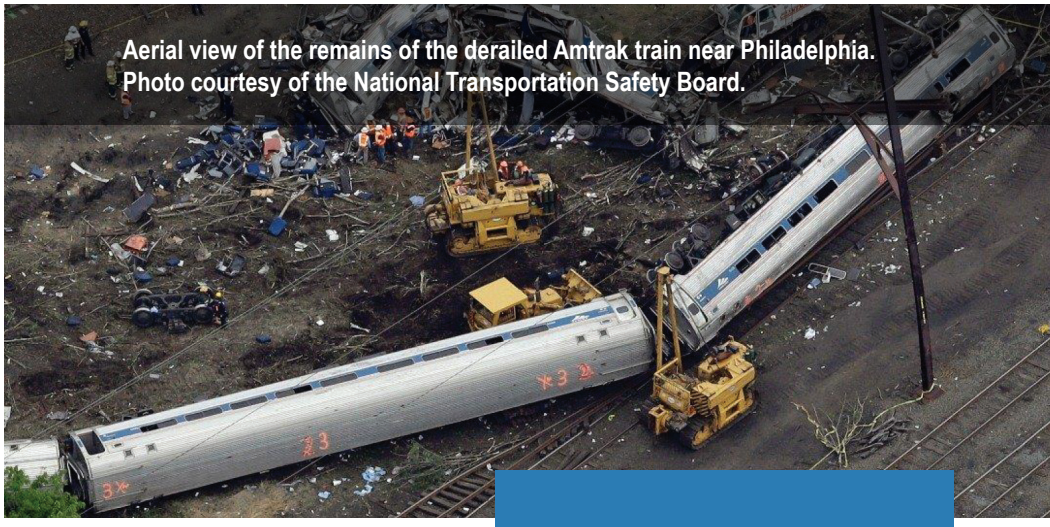
ASPR works closely with federal, state, local, and tribal agencies to address a wide spectrum of public health threats and medical emergencies. President Obama recently asked Dr. Nicole Lurie to head the federal response to the water crisis in Flint, MI; check out her ASPR blog entry where she shares her perspective and includes links to related resources. ASPR is also working hand in hand with others to collect and share the most current information on the Zika virus. In January, the U.S. Department of Health and Human Services launched a youth video contest on health preparedness for children under 18. These three examples and the recent launch of ASPR TRACIE highlight the breadth of ASPR's reach and its dedication to strengthening the nation's ability to prepare for, respond to, and recover from emergencies. For more information, check out the ASPR webpage and blog!

ASPR
ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE

Responding to the Amtrak Train Derailment: An Interview With Dr. Ernest Yeh

(Commentary Provided by Dr. John L. Hick)

On May 12, 2015, an Amtrak train traveling from Washington, DC. to New York City derailed and crashed in the Port Richmond area of Philadelphia at a high rate of speed. More than 200 passengers and crew were injured, and many of the injured were transported to nearby Temple University Hospital (a 550-bed Level 1 Trauma Center), where Dr. Ernest Yeh serves as the Physician Medical Director for the hospital's emergency preparedness committee (since 2002) and Emergency Medical Services Division Chief. ASPR TRACIE interviewed Dr. Yeh to learn more about how the hospital responded that night.



Aerial view of the remains of the derailed Amtrak train near Philadelphia. Photo courtesy of the National Transportation Safety Board.

Notification and Activation

Dr. Yeh was working a 3–11 p.m. shift in the emergency department (ED) when the Philadelphia Fire Department called on the ED notification phone, asking how many patients they could take from an incident (this is a relatively common call). When Temple University police officers shared that they had overheard the Philadelphia Police Department discussing the derailment on the police radio, Dr. Yeh and others realized the serious nature of the incident. Once the "HASTE" (or hospital alert system) sounded, staff began ramping up and the hospital administrator activated Level 1 (the lowest level) of the hospital disaster plan.

Temple University Hospital's ED averages approximately 90,000 ED visits per year, including pediatric patients. On the night of the derailment, there were four attending physicians and eight residents working in the ED. When patients began arriving, it was close to shift change, and employees were held over to tend to the injured.

The first patients were a large group that arrived in a police department van. Police often "scoop and run" shooting victims to the hospital, and they did the same thing with many train crash victims. Although this was a potentially good idea with penetrating trauma (and proof that "daily practice = disaster practice"), this presented issues for the following reasons:

- No triage had been done, and ED staff had to find triage tags and triage patients themselves.

> *"It truly was our emergency management planning for an all-hazards approach that helped the most, because we had done many of these things before."*
>
> *Dr. Ernest Yeh, Temple University Hospital*

continued on page 3

continued from page 2

- As often happens, these "walking wounded" did not have severe injuries, but were taken to the closest Level 1 center, occupying resources that might be needed by the later, more critical patients.
- Though the EMS system was aware of the number of patients going to area hospitals, police transports were "invisible" to the EMS system – generating patient tracking and distribution issues which could have created problems with nearby hospitals being overloaded.

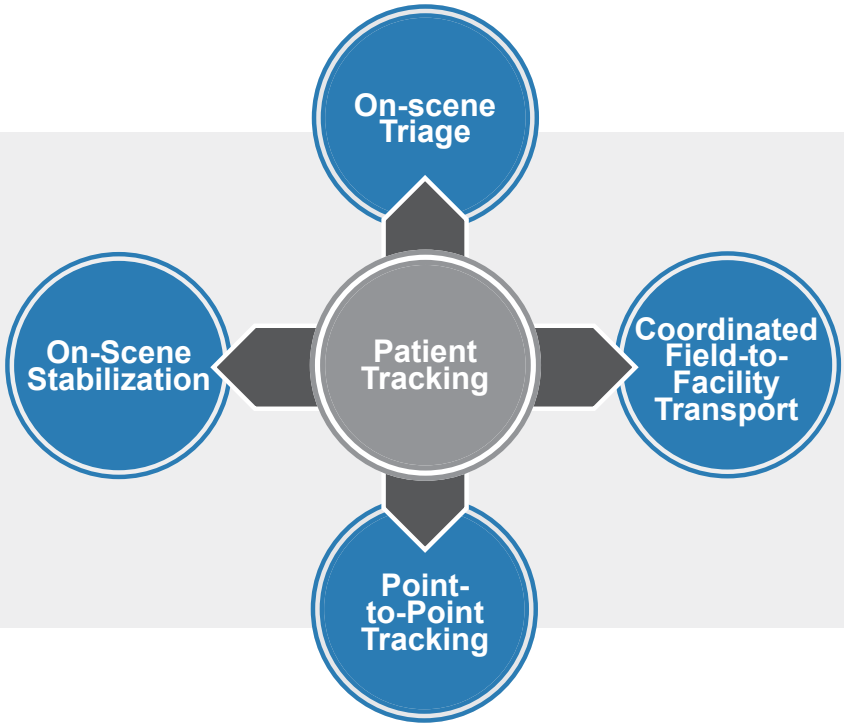
Once the first group of patients arrived, the hospital moved to Level 4 (the highest level) of their plan, calling in additional staff based on established guidelines, and holding over nursing and ancillary staff.

Response — Lessons and Challenges

As patients arrived, they were registered using the hospital's hard copy disaster packets and given identification bracelets. Dr. Yeh explained that the registration process proved to be the "biggest bottleneck." For a hospital that typically uses electronic records, paper registration posed several challenges. For example, digital x-rays could not be matched to the disaster registration. Family members had to wait a significant amount of time to find out if their loved ones had been admitted (while staff maintained and tried to simultaneously update several hard copies of patient lists; the same issue was experienced city-wide). Hospital registrars had to be encouraged to only collect basic information and not complete a full registration process. Until a patient was registered, they were only known by their disaster number, so in the early phase of the response, there was not a good way to know if a specific individual was there or not.

The hospital set up a family support center in a nearby university building. Staff soon learned that because the building was "non-clinical" and for security reasons those computers could not access clinical records, they had to go back and forth between buildings and maintain several hard copy lists at one time. There were also very few phones available at that location. Public relations staff handled calls from concerned family members and media. Hospital security evicted a few reporters who had posed as sick patients in order to gain entry to the ED. Hospital command

continued on page 4



CSC-and Mass Casualty Incident-Relevant Topic Collections:

Crisis Standards of Care

Disaster Ethics

Family Reunification

Fatality Management

Hospital Surge Capacity and Immediate Bed Availability

continued from page 3

center staff ended up working out of the ED, which—while not part of the plan and creating more congestion—saved time by allowing staff to make requests directly to senior administrators rather than over the phone. The fact that most of the patients were not local made things more difficult, and with patients spread to other hospitals in the area, coordination of patient lists took most of the night.

While staff had recently completed Psychological First Aid training at the satellite conference, no one remembered to formally apply it. That said, Dr. Yeh explained that the hospital hosted a debrief and offered counseling resources for staff; hot washes and after-action reviews took place regularly for some time.

Temple University Hospital is currently reviewing the hospital's Level 1–4 response system, since many of those who work outside of the ED may not fully understand it. They are also fine-tuning the number and content of messages being pushed out to increase comprehension.

What Worked Well

Dr. Yeh explained that the hospital normally sees up to 250 patients per day, making the train derailment "a high volume one or two-hour surge." Of the 54 patients they received, 24 were considered Level 1 trauma activations, and they were managed by trauma teams. The rest were managed by ED staff, allowing a good balance across resources. Fortunately, there were no shortages of operative space, and a third CT scanner was opened to decompress the two adjacent scanners in the ED.To ensure there was enough space for incoming patients, staff moved non-critical patients who were already in the admitting process to inpatient areas and made use of the beds in the ED's pediatric wing as well as spaces set aside for fast track and lower acuity patients.

Dr. Yeh said that instead of simply showing up for work, residents and nurses called in to ask if they were needed. Not only did this prevent additional crowding, it allowed for sufficient staffing levels the next day.

Overall, Dr. Yeh expressed that the response went well. Due to the significant amount of emergency planning for any type of hazard, communication processes went well, supplies were readily available, and staff were not overextended. ■

Dr. Ernest Yeh currently serves as an Associate Professor in Clinical Emergency Medicine, and is Chief of the Division of Emergency Medical Services (EMS) at Temple University Hospital and Program Medical Director for the Temple Transport Team.

John L. Hick serves as ASPR TRACIE's Lead Editor on detail from HHS/ASPR. He is an Emergency Physician and Deputy Chief EMS Medical Director at Hennepin County Medical Center in Minneapolis, MN, and a Professor of Emergency Medicine at the University of Minnesota.

Temple University Hospital staff triage patients in the covered ambulance bay. Photo courtesy of Dr. Ernest Yeh.

Commentary

The excellent response by Temple University Hospital highlights a number of issues common to mass casualty incidents:

***1. Casualty distribution** across multiple facilities is often challenged by spontaneous arrivals or, in this case (as well as Aurora, CO), multiple transports by police. All transporting agencies need to be aware of the potential to overwhelm the closest facility and consider alternate destinations particularly for patients with minor injuries. Hospitals close to the incident should always expect spontaneous arrivals.*

***2. Patient arrival processes** seldom live up to expectations – rarely used barcode and other special systems are often misused, standard processes are too slow, and "disaster numbers" may not track or integrate with the electronic health record systems (including radiology images). Lots of planning and testing of the patient arrivals process is necessary.*

***3. Large trauma centers** can bring a vast amount of clinical resources to bear in a hurry that makes the clinical care seem fairly smooth. It is often the family reunification, patient information, and media-related issues that are the key reasons to activate the command center. And yet, for a smaller facility, planning for 54 victims may seem monumental. Therefore, careful planning for the initial clinical management and prioritization for referral to other facilities is very important.*

***4. Daily practice = disaster practice.** Unless you have trained your personnel VERY well, they will default to what they do every day (e.g., registration personnel may carry out the entire registration process rather than abbreviating it to process more patients). Under stress, cognitive abilities suffer, so we tend to "fall to the level of our training" rather than "rise to the occasion." Plan to keep response processes similar to daily operations and where you cannot (e.g., crisis care situation) make sure to do adequate pre-event and just-in-time education.*

Strong incident management practices, supported by clinical and emergency management experts at your facility, are also critical to adjusting to situations that don't fit with usual practices.

***5. Consider** whether your personnel sufficiently understand the tiers of response if you use a response system with several levels of response. During an incident, staff often become confused about what level is highest (this happened during the Rhode Island nightclub fire in 2003 among others) or are not sure of their role at the different levels. Since it is rare to activate these plans, consider having a single activation level for the front line personnel that triggers a uniform response and then allow the command center to modify it based on evolving needs (e.g., send a page out that no more resources are needed).*

***6. In a mass casualty event** in an urban area, if patient distribution is optimal, they will be transported by EMS to multiple facilities. Having a means to generate master lists of patients as rapidly as possible that can be accessed by the hospitals, EMS, and emergency management/public health (ideally through a hotline or other central mechanism) for purposes of family reunification is critical to reducing stress for the families, patients, and can reduce the volume of calls to the hospitals and to 911. This information can change rapidly in the initial hours; therefore, a secure electronic system is optimal. Pennsylvania has such a system; it's not perfect, but no system ever is.*

> "Daily practice = disaster practice."

Photo courtesy of HHS ASPR.

Crisis Standards of Care: The Illinois Initiative

Contributed by Suzet McKinney, DrPH, MPH

Experiences such as Hurricane Katrina and the 2009 H1N1 pandemic are sobering reminders that we need to have plans in place to make ethical, informed patient care decisions during crisis situations. The Institute of Medicine (IOM) updated their initial 2009 Crisis Standards of Care (CSC) report with a comprehensive report in 2012 and an additional report on CSC Indicators and Triggers in 2013. This information is comprehensive, but can be daunting when deciding where and how to start the planning process. In this article, I present the approach taken by officials in Chicago and the state of Illinois to advance CSC planning across the state.

Public health officials in Chicago began working to develop an approach to CSC planning in late 2012, in order to meet requirements within the Medical Surge capability of both the Public Health Emergency Preparedness (PHEP) and Hospital Preparedness Program (HPP) grants. One member of the staff had studied CSC planning extensively and was well versed in both IOM reports. *Early discussions quickly revealed both the complexity of CSC planning and the need for close coordination with state health officials.* This led to coordination meetings between the Chicago and Illinois Departments of Public Health and the Metropolitan Chicago Healthcare Council (MCHC), the local hospital membership organization. From there, city and state health officials began to lay the foundation for a statewide, integrated approach to CSC planning. A multi-disciplinary core planning committee was developed, with representation from city and state public health, clinical emergency response, rural and urban healthcare, mid-size city/town healthcare, critical care, EMS, medical ethics, poison control, and healthcare coalitions; members were carefully selected from across the state with consideration for their leadership and expertise within their disciplines.

The core planning committee began its work by ensuring that each member had a clear definition of CSC and an understanding of how extreme healthcare emergencies requiring the implementation of CSC plans might affect their discipline during an integrated healthcare response. Required readings (e.g., sections of the IOM reports) were established to ensure that all core committee members approached the process from the same level of understanding. Multiple discussions were held to further comprehension of the material, which highlighted the need for full stakeholder engagement. The committee quickly recognized that the planning process would be long-term, and could be

continued on page 7

continued from page 6

highly political, and socially and culturally sensitive if not properly managed. We developed a plan for conducting stakeholder and public engagement meetings and a statewide CSC stakeholder's conference. We also developed a list of subcommittees that would be formed to address specific disciplines or population sub-groups. *The core planning committee also decided to identify an independent, non-government facilitator to guide the planning process. This was done in an effort to prevent social, cultural, and political differences between the City of Chicago and other parts of the state from hindering progress.* Once the independent facilitator was hired, ethical and legal subcommittees were immediately formed to lay the foundation for planning. The legal subcommittee reviewed Illinois case law that could apply to CSC planning, and conducted literature reviews to develop an appropriate framework that could be used to help define the Illinois process. The ethics subcommittee outlined key ethical commitments that should be used to help govern decision-making under crisis conditions, a document which will be turned into a "white paper" for wider dissemination and discussion.

Since the initial subcommittees were developed, we have conducted stakeholder engagement meetings in multiple regions of the state among public health, healthcare, emergency management, and public safety communities. The goals of these meetings were to gather general information/data from various sectors and determine sector-specific values and beliefs regarding CSC planning.We note that reactions from the responder community and acceptance of the process varies greatly depending on specific areas of the state. Conducting stakeholder engagement meetings in multiple areas of the state was critical in gaining *statewide* support and buy-in. With that in mind, we used Q-sort methodology to identify correlations between participants across a sample of variables and reduce many individual viewpoints down to a few factors.

The Illinois process is still over a year away from completion (estimated June 2017); however, we have learned a number of key lessons thus far. In any jurisdiction conducting CSC planning, widespread provider engagement is critical, given it will be their responsibility to implement the plans. Similarly, communities and members of the general public who will be most impacted by the plan also need to be fully engaged in the process. CSC planning is complex and therefore requires a structured and integrated approach. The Chicago/Illinois

In an initial analysis of input from more than 300 providers from public health, public safety, and healthcare delivery across the state of Illinois, concordance around a few key themes has been identified. Fairness related to being able to save large numbers of patients while stewarding scarce resources was one unifying theme. Another theme was related to the prioritization of care of the healthcare workforce that may be at greatest risk of exposure and illness – the very same workforce required to ensure continuity and functionality of the healthcare system. In 2016, we will continue to use Q-sort methodology as we conduct public engagement meetings to gain input from those who will be most impacted by the implementation of CSC plans.

continued on page 8

continued from page 7

planning began with a defined structure that was organized and inclusive. As planning progresses, modifications to the approach will need to be made, but having a basic structure will help guide the process and keep it on track.

Ensuring that the legal and ethical characteristics of your state are considered in the process and used as the foundation for planning is key. Failing to properly plan for these foundational components can derail your process if they are not addressed in the beginning.

Start with medical ethicists from key hospitals, academic ethicists from universities in your jurisdiction, attorneys from public health, emergency management, and the attorney general's office. Most importantly, be patient. Do not rush the process, and remember that the subject matter may cause disagreements among the best of colleagues. This is hard work, but it is important work.

While we do not know where the next large-scale disaster will occur, a structured, integrated, and comprehensive CSC plan can make the difference in how readily your emergency response system will be able to meet the surge capacity and capability needs of the event, and at its conclusion, how resilient your community will be following the disaster. ■

Suzet McKinney, DrPH, MPH, is the Executive Director of the Illinois Medical District Commission, and the former Deputy Commissioner of the Bureau of Public Health Preparedness and Emergency Response at the Chicago Department of Public Health.

Critical Planning Factors in the Illinois Experience

- Must have widespread provider engagement
- Must involve the community and general public in the process
- Structured and integrated approach with project management
- Jurisdiction specific legal and ethical characteristics must be evaluated and serve as a foundational component of planning
- Do not rush the process – it will take time.
- Consider a third party/ outside mediator or facilitator to support engagement.

The Illinois Initiative Timeline

2009
- IOM publishes initial CSC report

2012
- IOM updates CSC report
- Chicago public health officials meet to develop approach to CSC planning

2013
- Multi-disciplinary core planning committee developed
- Developed plan for engagement meetings and statewide CSC stakeholder's conference
- IOM publishes CSC Indicators and Triggers report

2014
- Ethical and legal subcommittees developed

2015
- Stakeholder engagement meetings conducted
- Statewide CSC Stakeholder conference held

2016
- Ethics subcommittee to produce white paper on decision-making under crisis conditions
- Legal subcommittee to present draft overview of legal considerations
- Conduct public engagement meetings

"You Can't Always Get What You Want"

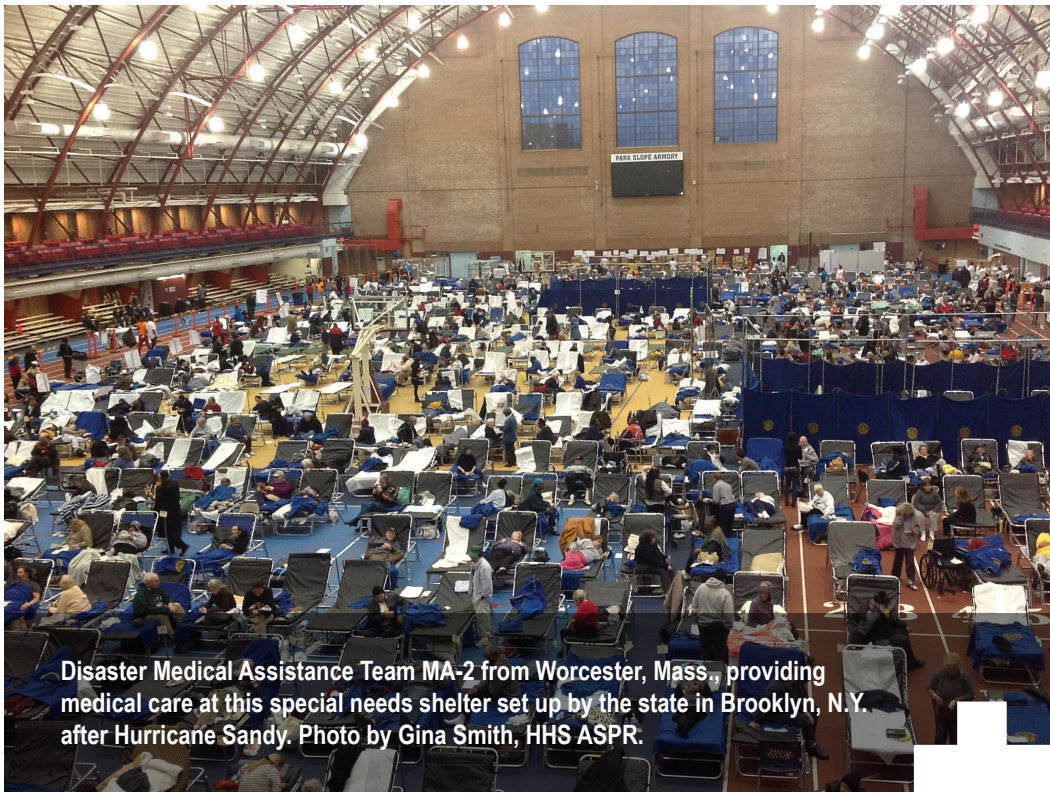
Contributed by John Hick, MD and Dan Hanfling, MD

With every area of the United States at risk for at least some type of catastrophic disaster and with healthcare systems running more and more on "just-in-time" supply and staffing strategies, it is critical to plan for situations when healthcare demand exceeds supply.

Crisis standards of care (CSC) planning, initially conceived during the H1N1 pandemic, has matured to become an extension of surge capacity planning. CSC planning can help healthcare providers "do the greatest good for the greatest number" when conventional and contingency strategies have failed, and remaining strategies must prioritize the potential health benefits of the entire community over those of the individual patient.

One of the primary goals of CSC planning is to stay out of crisis by using incident management to move to a proactive (rather than a reactive) approach as early as possible during an event.

Emphasis should be placed on leveraging the resources available across healthcare coalitions and/or health systems in order to try to balance demand by moving patients where they can be cared for, adapting care, and bringing in resources, among other tactics and techniques.



Disaster Medical Assistance Team MA-2 from Worcester, Mass., providing medical care at this special needs shelter set up by the state in Brooklyn, N.Y. after Hurricane Sandy. Photo by Gina Smith, HHS ASPR.

As many states and healthcare entities grapple with these issues, and states are in the process of completing or writing state plans in order to meet the ASPR National Healthcare Preparedness Program (NHPP) grant requirements, several common issues have emerged which are worth drawing attention to:

"Paper Plans" – Since an integrated approach between medical care, public health, emergency management, and emergency medical services (EMS) is critical to the success of crisis care planning, it is unfortunate that in many states and healthcare coalitions the writing of the plan remains the end goal and involving clinicians, residents, and political officials in the process of planning for CSC receives less attention. CSC requires not a single government-level plan, but the integration of crisis planning principles into existing response plans (e.g., a crisis annex) at the facility, coalition, regional, state,

continued on page 10

continued from page 9

and federal levels. Stakeholders at each level must understand their role, and the inter-dependent nature of the actions taken (for example, implementing triage protocols at a 911 dispatch center and changing transport criteria may require multiple actions by the EMS medical director, jurisdictional government, and state government /EMS board involvement to adjust protocols and regulations in order to facilitate the EMS strategies).

Proportionality – Plans should assure flexibility so that access to care is not limited more than required by the situation. Operating under "crisis conditions" represents a dynamic process, and limits placed today may not be relevant tomorrow.

The responses and response structures should be able to adapt based upon good situational awareness with regards to the availability and access to specific resources. For example, prioritizing certain groups and individuals for resources in short supply (e.g., prioritizing high-risk patients for limited influenza vaccine) may be appropriate at certain times, but not others. Excluding individuals from receiving care when resources are currently available to them, however, is not appropriate. Being able to differentiate when such plans need to be implemented is an important part of this planning effort.

Prognosis – In 2014, the American College of Chest Physicians published the Consensus Statement Care of the Critically Ill and Injured During Disasters and Pandemics, which is required reading for most hospital providers and planners. The suggestions therein modify critical care triage based on experiences from the 2009 pandemic that demonstrated the fallibility of existing ventilator triage decision support tools. None of the tools used to predict death or other outcomes were intended to predict how an individual patient will do. Therefore, though the Sequential Organ Failure Assessment (SOFA) score and other prognostic indicators may have value when comparing patients who need a resource, they should generally not be used to exclude a patient based on a set threshold. Clinical tools (such as the Minnesota Department of Health Strategies for Scarce Resource Situations) can still be very helpful, but they should always be modified as needed to reflect the specific event.

Process – While many of the resource shortfalls that may occur in a disaster can be anticipated, the successful implementation of strategies depends on having the process for decision making (who, what, where, when, how) described in the emergency plan. The plan should describe the role of the facility/agency, how crisis decisions will be made, which subject matter experts will be involved (and how and when), policy development, integration with healthcare coalition and health system activities, and how the transitions from conventional, to contingency, and to crisis (and back) will be managed. Although triage decision-making processes are a part of this, planners and providers should remember that the need to triage specific critical care resources will be a rare situation. Overwhelming outpatient volumes, and increased demand for specific

continued on page 11

continued from page 10

pharmaceuticals, personal protective equipment, or staff are far more likely to occur and should be the focus of the majority of planning and discussions.

Practice – CSC plans are developed through both "bottom-up" (facility) and "top-down" (state public health) efforts to document process. These plans, like all others, must be tested. Though it is very difficult to conduct full-scale exercises of CSC plans, they must be subject to robust discussions, workshops, and table-top exercises at all levels to assure that the healthcare administrators and providers are comfortable with the facility plans, and that, in concert with their coalition partners, they understand how those plans interact with agency plans and community expectations. The interaction between the facilities and the state is critical to providing the policy, logistical, and legal support to the clinical efforts, allowing providers to deliver the "greatest good." Application of CSC processes to day-to-day shortages (e.g., in pharmaceutical supplies) can highlight the importance of integration of clinical experts into the incident management process and of the tiered approach to managing a scarce resource situation. The approach to CSC planning is generic and well-outlined in documents such as the 2012 and 2013 Institute of Medicine guidance, but the resources and roadblocks vary dramatically depending on local factors. Though many times the focus of CSC planning efforts is on controversial areas, the core of CSC planning does not involve triage of life-saving resources. Its emphasis should be on the integration of well-described incident management and decision approaches needed when "usual" surge plans are inadequate. Augmenting our emergency plans to account for these situations are the bread and butter of basic disaster planning and the foundation upon which CSC planning activities should be based. ■

John L. Hick serves as ASPR TRACIE's Lead Editor on detail from HHS/ASPR. He is an Emergency Physician and Deputy Chief EMS Medical Director at Hennepin County Medical Center in Minneapolis, MN and a Professor of Emergency Medicine at the University of Minnesota.

Dan Hanfling, MD, Contributing Scholar, UPMC Center for Health Security; Member, InterAgency Board, Health and Medical Responder Safety; Attending Physician, BestPractices, Inc. (a division of EmCare);Clinical Professor of Emergency Medicine, George Washington University; Strategic Adviser, HHS/ASPR, Hospital Preparedness Program.

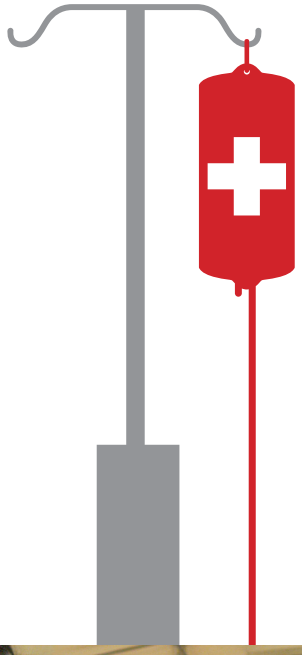
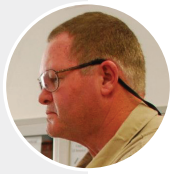


Photo courtesy of HHS ASPR.

RECOMMENDED RESOURCES

TECHNICAL RESOURCES



Crisis Standards of Care Topic Collection

The resources in this Topic Collection can help users develop plans for providing medical care under catastrophic disaster conditions.

Hospital Surge Capacity and Immediate Bed Availability

This Topic Collection highlights recent case studies, lessons learned, tools, and promising practices for planning and improving capabilities for a surge event.

ASSISTANCE CENTER

Regional Definition for Crisis Standards of Care

Log in to the Information Exchange to access a redacted ASPR TRACIE TA Request Response that provides a general overview and analysis of the current HPP CSC grant requirements, implementation guidance, Healthcare Preparedness Capabilities, and other available resources. (Not a member yet? See below for registration directions.)

INFORMATION EXCHANGE

Register for the Information Exchange!

Register for the ASPR TRACIE Information Exchange, where you can click on the Crisis Standards of Care thread and share your opinion about this issue. Already have an account? Log in and share your feedback!

Need help registering for the Information Exchange? Access our quick tutorial!

OTHER RESOURCES

Communities of Interest for Crisis Standards of Care and Allocation of Scarce Resources.

This site provides a clearinghouse of resources and information; and encourages users to submit their jurisdiction's/facility's CSC plan.

Publications by the Institute of Medicine of the National Academies

These resources serve as foundational documents and provide practical CSC templates and toolkits.

UPCOMING 2016 EVENTS

March

March 18-19; Louisville, KY
First Defense Expo 2016

First Defense Expo is an event centered around a strong educational program covering a broad array of issues, challenges and opportunities important to everyone involved in disaster planning and response.

March 22-24; Orlando, FL
Preparedness, Emergency Response, and Recovery Consortium and Expo

ASPR TRACIE will be presenting at the "PERRC" Consortium where healthcare, medical, public health, and volunteer emergency management personnel involved in disaster recovery and response efforts will share ideas and best practices.

April

April 19-22; Dallas, TX
Preparedness Summit

Look for ASPR TRACIE at the Preparedness Summit, which focuses on public health and healthcare preparedness and provides attendees with a unique cross-disciplinary learning opportunity to address issues such as global health security.

May

May 3-4; New Orleans, LA
Joint Commission Emergency Preparedness Conference

Speakers will share real-world experiences and tools and resources that support compliance with The Joint Commissions' Emergency Management Standards.

May 3-6; Las Vegas, NV
American Burn Association 48th Annual Meeting

Attendees will learn about recent advances in burn care research and treatment.

June

June 16-19; Baltimore, MD
IAFC Hazmat Response Teams Conference

This event offers hands-on training across topics such as biothreat response and sample collection, incident management best practices, and chemical and physical properties of hazardous materials.

July

July 17-19; San Diego, CA
Health Forum and the American Hospital Association Leadership Summit

This event offers leaders in healthcare the opportunity to discuss the issues facing their organizations and network to learn more about the promising practices.

July 19-21; Phoenix, AZ
NACCHO Annual 2016

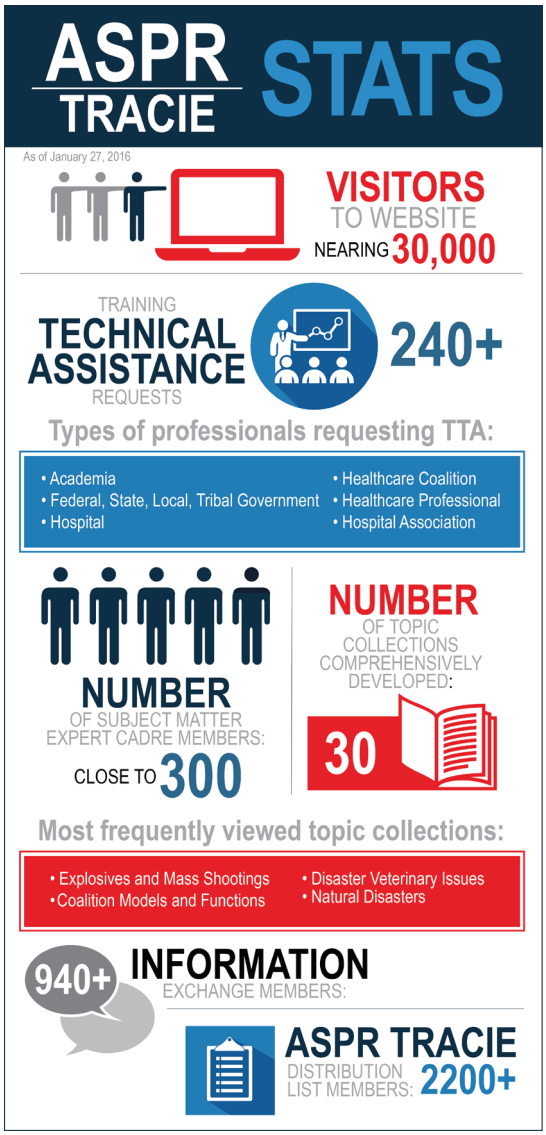
This conference offers local health department staff, partners, funders, and individuals interested in local public health the chance to share information around the theme "Cultivating a Culture of Health Equity."

ASPR TRACIE:

Your Healthcare Emergency Preparedness Information Gateway

The Exchange is produced by the Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE). Through the pages of *The Exchange*, emergency health professionals share firsthand experiences, information, and resources while examining the disaster medicine, healthcare system preparedness, and public health emergency preparedness issues that are important to the field. To receive *The Exchange*, please go to ASPR TRACIE's homepage (**https://asprtracie.hhs.gov/**), and enter your email address in the "Subscribe to the ASPR TRACIE Listserv" box on the bottom right.

ASPR TRACIE was created to meet the information and technical assistance needs of ASPR staff, healthcare coalitions, healthcare entities, healthcare providers, emergency managers, public health practitioners, and others working in disaster medicine, healthcare system preparedness, and public health emergency preparedness. The infographic illustrates ASPR TRACIE's reach since launching in September 2015.



ASPR
ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

CONTACT US

ASPR TRACIE

Toll-Free: 1-844-587-2243

askASPRtracie@.hhs.gov

https://asprtracie.hhs.gov