Institutional Networks: Regional Response to Disasters

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I'd like to present California's experience and the approach that we're taking in working to develop regional and statewide response networks to disasters, particularly in regard to cooperative strategies with hospitals. I ask you to set it within the framework of the overall disaster medical and public health, and environmental health planning, response, and recovery system. That system, I think, is important in that it's an all-hazard system. What we're talking about today, bioterrorism and pandemic influenza, are unique portions of a particular kind of disaster or hazard that we must face where the public health community comes into the fore, and we need to learn how to work better to integrate them into that overall system.

The system begins at the local level: hospitals, physicians, the public and environmental health, emergency medical system (EMS), fire, law enforcement, and emergency management. I'd like to focus, again, specifically on the hospital perspective.

VISION

All California hospitals will internally manage disaster, will have preestablished linkages with other hospitals and government emergency managers, and will exchange critical information and seek additional resources as required. This is my vision and that of our office.

GOAL

Our goal is to assist the California hospital industry to improve emergency plans and forge regional and statewide planning and response partnerships. To get there, we believe it's our role to promote disaster medical preparedness and response planning—and exercising, as well as training and development—within the state of California with the industry, so we can forge better regional, statewide, and community-wide partnerships.

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I now discuss the provider side of the coin, from the hospitals' and physicians' perspective, as well as the fact that on the government side we have to understand what they're going through. If we do not, we're doomed to failure. It proves that we as bureaucrats can actually learn over time.

TODAY'S SITUATION

- Hospital (health care) industry in flux.
- Denial: "It won't happen here."
- Minimum emergency preparedness (EP) regulatory/accreditation requirements being met.
- Limited coordination with government emergency management system.
- Confusion and consternation regarding hospitals' role in preparing for weapons of mass destruction (bioterrorism).

HOW DID WE GET HERE?

- Hospitals are private businesses that tend to focus on business needs.
- EP is not a priority.
- EP is a cost center without offsetting revenue.
- Government has not done a good job in reaching out to hospital industry and "selling" its priorities.

I think the last point here is that we really haven't done a good job in reaching out to hospitals and selling our idea of the importance of preparing for a terrorism event here in the United States. We really haven't done a good job in selling emergency preparedness to hospitals and the health care industry, and I think we have a lot to learn and a lot of work ahead—with our partners in the health care industry—to make strides in this area.

RESULTS: LESS THAN OPTIMAL

- 1989 Loma Prieta earthquake: hospitals were not prepared for simultaneous internal and external events.
- 1994 Northridge earthquake: hospitals not using Hospital Emergency Incident Command System (HEICS) had more difficulties managing response.
- 1997 statewide flooding: hospitals refused to follow government direction while the rest of community evacuated.

The results have not always been optimal, and I can use our state as an example, but I know unfortunately there are others around the country. In the 1989 Loma Prieta earthquake, we had a hospital rise up in the air a couple of inches and sit back down again. That caused simultaneous internal and external disasters. They had written plans to deal with a disaster but not one on how to manage that kind of a response. So in the intervening years before the Northridge earthquake, we helped the hospital community by working with a group of hospitals and county governments to develop an incident command system for hospitals to help manage a disaster response.

In the Northridge earthquake, our seismic safety commission documented that those hospitals that did use the HEICS had an easier time and did a better job of managing the response. Unfortunately, some hospitals weren't using it, and they experienced more difficulties.

We had hoped that we had really worked out many of the issues in planning and response for the hospitals in an emergency. However, a couple of years later when 165,000 people were evacuated because of flooding, we found that two hospitals refused to leave. As a matter of fact, they took in extra patients and moved them all up to a higher floor. If the levies had broken, I have no idea how we would have gotten them out of there. A year later we had the influenza season, and again essentially the hospitals did not work within the system that we had all tried to put together. They were calling the National Guard asking for nurses. They were asking county governments to declare local emergencies. So obviously we have a long way to go.

AVAILABLE OPTIONS, FUNDING, MANDATES, AND SHARED GOALS

There are three different approaches: throw money at the issue or mandate it (again, the carrot and stick) or look at shared goals that we buy into collaboratively. Our approach in California was "all of the above." In California, being "Left Coasters" and all-inclusive, we have to take a holistic approach. Let me call it that. We do believe there is some need for additional funding, whether it's in planning and preparedness or in response.

Funding for Emergency Preparedness Activities

- Pursuing monies for model EP activities.
- Advocating inclusion of hospitals in federal WMD funding stream.

We cut a deal with the Federal Emergency Management Agency after the Northridge earthquake to reimburse hospitals and clinics for some of the extra services, supplies, and associated staff that they brought in. Unfortunately, the hospitals were never reimbursed. We can't continue to do that. We must figure out a way to reimburse them for the activities and the services they provide. We need to determine what the proper role is of this weapons-of-mass-destruction arena, how hospitals relate to it, and how we can use some of that money to better prepare them.

Mandates for Greater Level of Hospital EP

- Investigating update of California licensing and certification requirements for health care facilities.
- SB 1953—Hospital Seismic Safety Act.
- New JCAHO "Environment of Care" guidelines.

There is a role for mandates. Because of our experience in past disasters, we are working with our Department of Health Services, which licenses health care facilities, to upgrade our requirements for health care facility disaster plans. We also have the Hospital Seismic Safety Act. It's just been extended as far as implementation date to build better, stronger, and safer buildings.

Finally, we think the new Joint Commission on Accreditation of Healthcare Organizations guidelines are absolutely critical because, for the first time, they move the hospital industry and health care industry closer to the emergency management industry, and we will talk the same language, which I think is very important.

SHARED GOALS FOR EP: PUBLIC/PRIVATE PARTNERSHIPS

- Annual medical and health disaster conferences.
- Annual hospital and ambulance exercise.
- Hospital and Health System Disaster Interest Group (CHA subcommittee).
  - Model HAZMAT protocols.
  - Model bioterrorism annex for hospital EP plans.
- Promote HEICS.

I think we're going to see much better results if we have shared goals. We've tried in California over the last couple of years to hold annual medical and health disaster conferences focusing on hospitals in the northern and southern parts of the state. They had almost 500 people attending. Last year, the first year we did our annual statewide exercise, 400-plus hospitals, 56 of 58 counties, and 100 ambulance providers participated. We just finished the exercise a week ago and we're still counting up the numbers, but it looks like it will be pretty close again. This activity brings the hospitals into concert with the government's need to plan for and train for disaster response.

We're very proud of a subcommittee we have developed with the California Health Care Association, our state hospital association. It is working on developing model HAZMAT protocols and a model bioterrorism plan for hospitals. They're developing it. We don't mandate it. There's an ownership there. There are three or four major hospital systems representing almost 200 hospitals on this group, and we believe that if it comes out of the industry itself we have a much better chance of selling it within the rest of the health care industry and the state. We're also continuing to promote the HEICS. We believe it has a lot of benefits. It's available for free from our Web site (www.emsa.ca.gov). We'll also send you a free video.

SHARED GOALS: PARTNERSHIP

- Regional/community cooperative agreements:
  - Pooling resource (supplies, personnel);
  - Common staff training.
- Shared communication:
  - Communication model in California: ReddiNet;
  - Model for standardization: healthcare facility emergency codes.

We believe that regional, community-wide, cooperative agreements are important. In Portland, Oregon, Reno, Nevada, and the Washington, DC, area, they've made these kinds of approaches to dealing with how the hospitals can work together to share resources in time of need, and I think that's absolutely critical.

In a typical hospital in Sacramento, you may find a nurse who works in three different and separate health care systems. We need to train the staff in a common way because they could be in different places at the time of a disaster. We have to have shared communications systems. We have a system we're using in eight counties serving 18 million people: the ReddiNet system. It comes from the Health Care Association of Southern California. It's used daily for EMS diversion, multicasualty incident, hospital status, and emergency department availability. They used it during the Democratic National Convention for surveillance. I think this is a step in the right direction. Also, the Health Care Association has developed a model for standard-

ization of hospital emergency codes. Again, because of nurses and staff working in different facilities, we need to have standardization wherever possible.

RESULTS: IF THINGS GO AS PROPOSED

- Awareness and buy-in by hospitals for EP.
- Improved planning:
  - Internal;
  - External.
- Better staff preparedness:
  - Training;
  - Exercises (drills).

We think if some of these efforts pay off we're going to be better prepared. There will be better and more widespread awareness, improved planning, improved training, and staff preparedness, which will benefit all of us. Cooperatively, we will succeed; individually, we will fail. We firmly believe this cannot be done by an individual, an individual organization, an individual health care provider, or a government entity. We have to work together. We don't have all the answers. We're not even sure if we have some of the answers, but we have some thoughts on it based on our experiences, and we'd be very glad to share them with you in detail.