The Role of Hospitals in Planning

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for materials used in this presentation
Background: THEORY (Myth?)

• Hospitals have built in surge capacity
  (aka “disaster plans”)

• Traditional focus on the hospital’s ability to expand capabilities
  - Facility
  - Staff
  - Resources

• THEN CAME SEPTEMBER 11, 2001
• Unknown threats exist

• Healthcare institutions remain underprepared

• Contamination or destruction of TC/EDs remains a major concern

• Existing urban trauma centers/emergency departments often at capacity
  ➢ Hospital Diversion = surge capacity is gone!
Let’s agree on one thing first:

A community-based medical/surgical surge capacity program is the ONLY way that we are going to provide care in a mass casualty disaster setting.
KEY ISSUES

• Role of hospitals in CMSC
• Role of the community in CMSC
• Impact on hospital function
• What is the “standard of care” in a remote location?
• Liability
  - Hospitals
  - Staff
  - Locality
  - State
Determinants of Surge Capacity

Pre-hospital management

Event

Surge arrivals

Hospital or network capacity

Staff

Medical supplies

 Beds

Surge Discharge

Home

Out-of-region facility

SNF

Treated

Died

Medical supplies
Bulwark for a CMSC: Statewide Trauma System

- Connecticut DPH regulation - 1995
  - citizens from across the state have access to trauma care
- The goal of the State Trauma System Plan
  - inclusive and dynamic trauma system
  - appropriately funded
  - well staffed
  - resources needed to respond to the needs of the injured patient in the State of Connecticut
The Bottom Line...

- Infrastructure is already in place
  - American College of Surgeons verifies trauma centers as Level I-III
  - State Trauma Regulations designate trauma centers
  - Hospitals accustomed to working as a network
- ~ 90% of Connecticut citizens are within 20 minutes of a Trauma Center
- Essential to involve the hospitals and the trauma system in planning and preparation for disasters of any sort
Key Principles in (Community) Disaster Response Planning Issues

- Preparation
- Training
- Practice
- Detection and surveillance
- Triage and Access
  - Patients
  - Staff
- Communication
  - Intra-facility
  - Inter-facility
  - Family members
  - Media relations
  - Rumor control
  - Education
Conceptual Model of Education As A Modulating Factor


MINIMAL KNOWLEDGE
INACTION
FEAR
CONFUSION
MINIMAL PANIC

MAXIMAL KNOWLEDGE
ACTION
CONFIDENCE
UNDERSTANDING
MAXIMAL PANIC

ACTION
CONFIDENCE
UNDERSTANDING
MAXIMAL KNOWLEDGE

MINIMAL KNOWLEDGE
INACTION
FEAR
CONFUSION
MINIMAL PANIC
Additional Considerations for Effective Response

*Minimal Acceptable Care*

*NOT Standard of Care!*

Keep intervention to a MINIMUM (if at ALL) during acute casualty influx. Reassess needs once influx subsides.
Management of the Bird Flu Pandemic
Connecticut’s Assumptions About “the Surge”

- Resources of the US Department of Homeland Security’s National Disaster Medical System (NDMS) are not immediately available following a mass casualty occurrence.
- NDMS is a secondary resource for transportation of patients to definitive care outside of Connecticut during the first hours of a mass casualty
Connecticut’s Assumptions About “the Surge”

• For the first 24-96 hours of an incident, the Connecticut system of response relies on
  - existing transportation resources
  - mutual aid agreements
  - five designated emergency preparedness regions
    • established in 2005 by the CT Department of Emergency Management and Homeland Security (DEMHS).
Connecticut’s Assumptions About “the Surge”

- Sophisticated resources for the expert management of (medical/trauma/burn) patients typically are found in (medical/trauma/burn centers).
We are used to........
We can, & we will

have to
do this differently!