

Medical Society's Blueprint for a Successful Community Response to Emergency Preparedness

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Abbreviations:

EMS = emergency medical services
HEICS = Hospital Emergency Incident Command System
SNF = Skilled Nursing Facility

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Abstract

It is clear from disaster evaluations that communities must be prepared to act independently before government agencies can cope with the early ramifications of disasters. In response to devastation to the borough of Staten Island, New York in the wake of 11 September 2001, the Richmond County Medical Society established a structure to incorporate community needs and institutions to work together for the common good. A program that brings together two hospital systems, nursing homes, emergency medical services, and the Office of Emergency Management physician leadership in a meaningful way now is in place. This approach has improved the disaster preparedness of Staten Island and demonstrated how the Medical Society can provide leadership in disaster preparedness and serve as a conduit for communication amongst entities that normally do not communicate.

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Introduction

Staten Island is one of the five boroughs of New York City. The only way to or from the island is by bridge or ferry. During the events of 11 September 2001, Staten Island was confronted with the stark reality of being on its own as the city coped with the tragic events in Manhattan. The island truly was isolated, as all emergency services were diverted to Manhattan. It was clear that neither New York City nor Staten Island was prepared for a disaster of any magnitude. Residents needed to overcome the malaise that it would never happen in their community.

In response to this situation, the Richmond County Medical Society developed its own Disaster Preparedness Committee to address the isolation after 9-11. This was demonstrated again during the events that occurred after Hurricane Katrina. Communities must be prepared to be self-sufficient for several days before government agencies can be expected to help. The goal of this committee was to coordinate the efforts of the two local hospital systems with the efforts of police, fire, and emergency medical services (EMS), identify the needs of the community, and coordinate the response of all providers, nursing homes, and physicians. The Medical Society's goal was to develop a community network that would enable first responders to have reliable communication without relying on just telephone and Internet communication. The low-cost, reliable technology of a HAM radio network was chosen to facilitate this objective. A series of meetings were conducted to break down old competitive barriers and develop a new spirit of cooperation and trust.

The process was first to establish good communication between the two hospitals. Therefore, an exchange of working telephone numbers and fax numbers was imperative. The goal of any reliable emergency preparedness plan is to develop a good communication program so that the correct staff members can be dispatched to the right place at the right time. The plan called for meetings between both hospital systems, using the Medical Society

as neutral ground. The Medical Society coordinated the standardization of communication and helped with the Hospital Emergency Incident Command System (HEICS) education and implementation.

After bringing the hospital systems together, the two organizations performed a tabletop exercise so they could get to know one another and break down the barrier of competition that previously had plagued their ability to cooperate. This proved to be a successful method to bring the two parties together to learn of each other's strengths and weaknesses. Once these were identified, meetings were structured around these issues. A drill to move patients from one hospital facility to another so that ambulance crews could become familiar with each location also was conducted.

The local HAM radio club became a member of the subcommittee, and they trained hospital personnel on the use of HAM radios. Physicians and hospital and nursing home personnel were trained. The goal was to guarantee communication during a crisis. The HAM radio technology was selected because it can be used during emergencies when telephone or computer communication may not be available. The use of HAM radios would allow for communication across the topography of the island.

Once the hospital committee was established and working, the skilled nursing facilities (SNFs) were incorporated. This was important because during a disaster, hospitals may need to empty beds so that injured victims can be treated. This may require that patients be transferred to a SNF earlier than expected. The transfer of critically ill patients may overwhelm the SNF, so a plan must be in place for these traditional rivals to communicate amongst themselves and the hospitals. They must communicate their equipment needs and bed availability. Equipment and personnel may be needed and sent to the SNF from the acute facility in order to adequately care for the patients. The nursing homes must communicate if patients must be transferred from one facility to another.

Once the nursing home members were incorporated into the subcommittee, a tabletop drill to include all active facilities was performed. Each facility participated in the drill at their location. The event was a category-II hurricane that challenged the strengths and weaknesses of all participants. The issues identified were used as future agenda items and to direct future training. Nursing homes were less familiar with HEICS than were the hospitals. Throughout these tabletop exercises, EMS, law enforcement, fire personnel, and the Office of Emergency Management were involved. Once the hospitals and nursing homes were integrated into the design preparation, a large-scale community drill was planned. The communication was passed from facility to facility in a disaster scenario. The communication drill tested e-mail, telephone, fax, cellular telephone, text

messaging, and HAM radio capabilities. Issues were identified such as wrong or outdated telephone numbers and a lack of operational equipment, such as fax machines without paper or ink. A plan was developed to be used in case personnel had to be exchanged between hospitals or nursing homes, each facility would know what that physician was credentialed and privileged to perform. The physicians also were involved, identifying what personnel were available, and how they could be used. The goal of physician involvement was to sustain enough personnel to cope with a long-term disaster and to use them efficiently, based on skill and office location. Sometimes, the walking wounded can be triaged to an appropriate physician office. In other cases, physicians could be directed to where they are needed most, and at the appropriate time and shift. After the events on 9-11, many physicians came to the hospital at the same time. If personnel were needed for a sustained recovery effort, it would not have been possible. Only through appropriate planning and triage can a disaster be dealt with appropriately. It also is important to educate the community-based physicians to ensure they are prepared to cope with a disaster. They must be confident that their offices are secure. Offices must be equipped correctly and staff must have the appropriate skills and training to cope with a disaster. The healthcare community is integrated into the disaster preparedness plan. The next stage will be to integrate local civilian groups and develop a plan for evaluating the home bound and mentally disabled patients.

This community approach to disaster response has been helpful for the community to identify its needs, improve communication, and provide community members some sense of security that all providers are working together. The Medical Society has proven to be a good vehicle for this process because it has a community-centered focus. It assures a minimum level of standardized communication, equipment, and staff. The Richmond County Medical Society shared resources among providers that do not have the appropriate resources to cope with a disaster. The need to share medications between institutions was recognized. This is true, especially for the SNFs that usually do not stockpile large quantities of medication. It enlisted communication between entities that normally did not communicate, such as hospitals and nursing homes. This approach has improved the disaster preparedness of Staten Island, and has illustrated how the Medical Society can serve as a conduit for communication among entities and provides leadership in disaster preparedness.

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