Targeted Agenda Program: An Innovative Approach to Facilitate Progress in Disaster Health

Joost J.L.M. Bierens, MD, PhD, MCDM;[1] Brigitte Nooij, MA;[2] Ferd Sturmans, MD, PhD[3]

1. Chair, Local Organizing Committee, 15th World Congress on Disaster and Emergency Medicine; Professor in Emergency Medicine, Department of Anesthesiology, VU University Medical Centre, Amsterdam, The Netherlands
2. Coordinator, Targeted Agenda Program, VU University Medical Centre, Amsterdam, The Netherlands
3. Chair, Scientific Committee, 15th World Congress on Disaster and Emergency Medicine

Correspondence:
Joost J.L.M. Bierens
Department of Anesthesiology
VU University Medical Centre
De Boelelaan 1117
1007 MB, Amsterdam, The Netherlands
E-mail jbierens@vumc.nl

Keywords: disaster health; disaster medicine; network; preparedness; science; targeted agenda program; training; World Congress on Disaster and Emergency Medicine

Abbreviations:
15WCDEM = 15th World Congress on Disaster and Emergency Medicine
PDM = *Prehospital and Disaster Medicine*
TAP = targeted agenda program
WADEM = World Association for Disaster and Emergency Medicine

Web publication: 27 August 2008

Abstract

The Targeted Agenda Program (TAP) has been introduced for the first time during the 15th World Congress on Disaster and Emergency Medicine (15WCDEM) in Amsterdam in 2007 to stimulate interaction between the participants before, during and after the congress. A TAP process consists of 11 steps, starting with defining a relevant issue and ending with the publication of a TAP report based on expert opinions. Seven TAP groups participated during the 15WCDEM. The TAP issues referred to: (1) the need for health impact assessment of disasters; (2) the golden standard for preparedness for a chemical, biological, radiological and nuclear disasters; (3) the role of acute psychosocial first aid; (4) the 10 most important issues for policymakers to minimize health effects of floods; (5) the search for a golden standard in the treatment of wounded combatants; (6) the preparedness of health organizations for consequences of extreme weather conditions; and (7) the health problems of high-vulnerability groups during disasters. This article describes the motivation and operational aspects of the TAP and advocates that this concept can play an important facilitating role in focus, networking and enhancement of knowledge in the field of disaster health.

Bierens JJLM, Nooij B, Sturmans F: Targeted agenda program: An innovative approach to facilitate progress in disaster medicine. ***Prehospital Disast Med*** **2008;23(4):s43–s47.**

Introduction

In 2001, the World Association of Disaster and Emergency Medicine (WADEM) elected to convene its 15th World Congress on Disaster and Emergency Medicine (15WCDEM) in Amsterdam on 13–16 May 2007. It was the intent of the organizers that this 15WCDEM would become an unprecedented, interactive event. This objective was based on observations that relatively little research has been conducted in disaster health. Many experts are self-appointed, and base their expertise on experience with only one disaster: the "n = 1 expert". However, many experts with the same or higher level of expertise are present in the audience of each Congress on disaster medicine. Also, it was anticipated that during the 15WCDEM, a great wealth of expertise would be present among the delegates, and that these experts should be given the opportunity to become active participants.

In an effort to promote interaction between the participants, an innovative concept of Targeted Agenda Programs (TAPs) was developed. The aim of the TAP concept was to catalyze knowledge accumulation by actively involving participants, and in this manner, facilitate progress in the knowledge and understanding of disaster health. Also, the TAP concept could improve the focus in the myriad of issues related to disaster health. In addition, initiating a TAP during 15WCDEM could enable the establishment or extension of existing expert networks and help to identify, confirm, and/or strengthen leadership and profiles among the participants. Using TAPs, some current strategic or operational issues within individual organizations could be placed within a broader multi-disciplinary and international context. The outcomes from the

1. Define a relevant TAP issue
2. Identify subject experts
3. Draft abstract on relevant TAP issue
4. Abstract approval by Scientific Committee
5. Abstract posted on Congress Website
6. Start discussions using Website
7. Presentations (oral), first day of 15WCDEM
8. Open discussions sessions second day of 15WCDEM
9. Invitation-only session, third day of 15WCDEM
10. Summarize results during Closing Ceremony
11. TAP Report

Table 1—The 11-step TAP process

TAP sessions would be expertise-based as the best alternative for evidence-based.

It also was anticipated that the TAP sessions would help to make the Congress an interesting venue necessary to attract experts and organizations from outside the WADEM networks. The presence of new experts and organizations and opening of potential opportunities for cooperation, could strengthen the position of WADEM in the international arena of disaster and emergency health.

However, it was realized that implementation of the TAP concept could place a large organizational and financial burden on the Congress. For this reason, it was decided to limit the number of potential TAP topics to eight to be executed by TAP-groups consisting at most, of only eight experts. The additional costs for each TAP group was calculated to be an average of €12,500, mainly to cover the costs of the TAP Coordinator, the TAP portion of the Congress Website, and the extra facilities that would be required at the RAI Congress Centre, such as room rental and equipment.

It was decided that these additional expenses had to be auto-financed by each participating (sponsoring) TAP organization. The registration fee of the participating experts was to be set at an all-inclusive, cost break-even level. Travel and hotel costs were to be arranged between the participating TAP organization and the participating TAP expert. Although the costs involved seemed considerable, the TAP organizations received much in return. Essentially each would have its own, interactive, international, agenda-driven, three-day conference within the framework of 15WCDEM. The revenue generated also included access to international bodies in disaster health and to establish profiles, leadership, and answers to current questions.

In this issue of *Prehospital and Disaster Medicine,* six reports are published of the seven TAPs that occurred within the framework of WCDEM2007. The missing report, on the aftercare of vulnerable groups in disasters, is from the Dutch Safety Board. As a result of a recent investigation of a fire at the detention centre at Schiphol-Oost airport in 2006, they were interested to know the existence of minimum requirements for vulnerable groups in disaster situations.[1] The Dutch Safety Board has a policy to publish uniquely in formal reports and not in journals.

Six reports by the TAPs that were conducted before and during 15WCDEM are published in this issue of *Prehospital and Disaster Medicine* (PDM). The topic issues and the final results of these seven TAP groups are summarized in Table 1 and the Appendix. As can be concluded from examination of these summaries, the TAP groups covered many essential aspects of disaster health before and during 15WCDEM. Many people were involved in the deliberations, and those involved were very enthusiastic about the concept and its opportunities. The implementation of the TAP concept has resulted in new knowledge, networks, and ideas for research. Available knowledge has been extended to a larger audience. Communication and collaboration between experts and organizations, including the WADEM, has been intensified. Several TAP groups have expressed their intent to continue the process during the 16WCDEM, which will take place in Vancouver, British Columbia, Canada in May 2009.

The TAP process, results, and suggestions for improvements follow.

The TAP Process

To better understand the TAP process and to provide insight into the opportunities and problems associated with implementation of the concept, the preparations and the 11 steps to achieve results from use of a TAP are described (Table 1).

Before the TAP concept commences, it was imperative that stakeholder organizations agreed to participate. For this reason, personal contacts were established during international congresses in the six years before the 15WCDEM was convened. Personalized letters and e-mails were sent to stakeholders and telephone conferences between them and the Local Organizing Committee were organized. But, it seemed to be difficult for some people to understand what a TAP would entail. More than 80 international experts, industries, and representatives of organizations were identified and contacted to identify if they had a potential interest in organizing a TAP. The new concept of agenda-setting before a congress, and having people actively involved in developing a body of knowledge on a well-defined issue, appeared to be difficult to understand by many. Some individuals had the impression that they were being asked to contribute to one or more sessions during the Congress. Some other persons had difficulties in understanding that the concept should lead to a well-defined target. Many who understood the concept and were enthusiastic, were unable to participate due to lack of time or the financial means. The commercial or legal implications of an expert advice appeared to be a problem for some industries. Many organizations that initially were contacted to organize a TAP, contributed to the Congress by organizing a single scientific session or by becoming a sponsoring organization. Initially, of the more than 30 potentially interested organizations or participants directly contacted, only nine were prepared to take the lead in organizing, conducting, and supporting a TAP. At a later stage, two of the nine organizations had to withdraw. The reason for withdrawal was that they were unable to define the targeted issue or could not establish the participation of an international network within the organization. All of the remaining organizations were based in the Netherlands, the host country of 15WCDEM. The 11 steps of the TAP process were coordinated by a specially designated TAP Coordinator who worked for three days a week during 14 months.

The organizations that remained were required to follow the 11 steps of the TAP process. These 11 steps are listed in Table 1 and are described below.

1. Define a Relevant TAP Issue
As a first action, a well-defined, leading issue of interest was described: what do we want to learn before and during 15WCDEM? The issue had to be relevant for the development of emergency and disaster health. Most organizations found it difficult to exactly define the issue. As a consequence of simply writing down the questions, fundamental and essential issues were discussed that previously had been taken for granted. Most of the participating organizations required several meetings to finalize Step 1. One organization finally withdrew due to large discrepancies within the organization on the interpretation of the underlying issue.

2. Identify Subject Experts
When the participating organization had defined the issue, experts had to be contacted by the organizers. The number of experts selected was limited to eight. If possible, each TAP group was to include one representative of the WADEM and one representative of the Dutch Medical Emergency and Planning Office (Geneeskundige Hulpverlening bij Ongevallen en Rampen: GHOR). It was advised that not only persons from the "we–know-each-other-for-decades" networks should be invited but "to-invite-your-enemy" to be included. Selection of international experts was relatively easy for organizations and/or TAP leaders who already had participated in international networks. However, for some organizations, the lack of participation in an international network was one reason to start a TAP. For these organizations, locating subject experts was laborious. Some TAP groups were able to get their teams constituted only a few months before the opening of the Congress. One organization finally withdrew because they were unable to establish an international team of experts.

3. Draft Abstract on Relevant TAP Issue
As a result of the feedback provided by the invited experts, it often was necessary to reformulate the definition of the TAP issue or TAP questions that were established in Step 1. For example, most organizations initially addressed their topic from a national or mono-disciplinary point of view, instead of an international or multi-disciplinary, point of view. A 500–750 word document was produced that included a preamble, the problem to be addressed, and the aim of the TAP. Some of the TAP groups discovered that the awareness or basic understanding of the issue being addressed was minimal. For this reason, in addition to the abstract, it was helpful to write an extensive article that provided essential background information. In most TAP groups, close cooperation between the TAP coordinator and the Chair of the Local Organizing Committee was needed in order to draft the abstract.

4. Abstract Approval by Scientific Committee
When the draft was finalized, the Local Scientific Committee had to approve the abstract to be relevant for 15WCDEM. In some cases minor revisions were suggested.

5. Abstract Posted on the Congress Website
By posting the abstract on the Website, all TAP members and other visitors to the Website could be informed about the issues and members of the TAP groups. The construction of the interactive Website was more time-consuming than anticipated, and the first two abstracts were approved before the interactive part of the Website had been completed.

6. Start Discussions Using Website
This step was vital in the pre-Congress exchange of ideas between the TAP members and between the TAP members and other potential participants of the Congress. However, participation in the discussion was not self-evident. Success factors for a lively Website discussion mentioned by the TAP leaders included:

a. Timely implementation of the discussion (it takes time to get the discussions moving);
b. Participants and the TAP-leader should have met each other at least once in person;
c. A structured schedule of well-defined questions with a limited scope was mandated; and
d. Wrapping-up answers and identifying new questions with another limited scope should have been mandated on a regular time basis. Most important was the permanent attention of the TAP leader to keep all participants involved.

In hindsight, the request to non-TAP members to participate in discussions on the issues was inadequately stressed; another factor that could have been improved was the design and the interactive mode of the Website. It also was learned at a late stage, that participation in the discussions was promoted by actively informing each individual Website visitor and each Congress participant that registered, about the possibility for participation in the TAP discussions. All together, the Web pages of the TAP received several thousands of hits.

The first six steps were taken prior to the beginning of the actual Congress. In hindsight, these six initiating steps were time consuming and the input and for some TAP groups, the output of information was lower than was expected.

7. Oral Presentations (Day 1)
Oral presentations that defined the progress achieved during the Web-phase of the TAP were provided during a 90–120 minute session during the first day of the 15WCDEM. During the first day of the 15WCDEM, it became clear that the pre-Congress activities had helped in achieving a coherent mind-set of the speakers in each of the TAP groups. This was valuable in focusing the content of the presentations and in precisely defining the issues that were going to be discussed during the three meetings during 15WCDEM.

8. Open Discussions (Day 2)
During the discussion session on Day 2 (90–120 minutes), there was an opportunity to discuss the issue in an open forum. Some TAP groups also included information from oral and poster sessions in the Congress that related to their topic. This interaction was highly effective in helping to reach the targeted agenda. On the other hand, it also was observed that many experts who were present in the RAI Congress Centre during the 15WCDEM did not participate in TAP

sessions that dealt with topics in which they had a good reputation or expertise. This might have been due to unfamiliarity with the concept they were occupied by other obligations, or were unaware that their participation in the TAP was possible and that sharing of their experience would be helpful in the development of knowledge in their area of expertise in disaster health.

9. Invitation-Only Session (Day 3)

During the morning of the third day of the 15WCDEM, an invitation-only conference (120 minutes) was conducted for each of the TAP groups. Some TAP groups had identified additional experts before and during the 15WCDEM, and these experts were invited to participate. During this invitation-only meeting, the targeted issue reached a final stage and the answers to the final question of the targeted agenda were formulated.

10. Summary of Results

During the plenary Closing Ceremony in the afternoon of the third day of the 15WCDEM, each TAP leader presented the final results of the TAP. This helped the delegates to leave the Congress delegates a clear messages about the progress made by each of the TAPS.

11. Final Report

The final duty of each TAP Group was to prepare and submit a final report of the findings and progress made by the respective TAPs. Six of these Reports follow in this issue of PDM.

Conclusions

The Local Organizing Committee initiated the TAP concept because at a congress where so many "brains, visions, and experiences" meet, there should be a vehicle to enhance the understanding of disaster health. The TAP concept has been instrumental in stimulating and facilitating interaction. In addition, it is known from a didactical point of view, that interactive participation strongly increases knowledge retention and retrieval. Therefore, it can be assumed that those who participated in a TAP left the 15WCDEM with many lessons learned; and hopefully have remembered them long after returning home.

The recorded experiences obtained from the first TAPs demonstrate that they were productive and successful. Discussions within the TAP groups often were related to the essential values of the participants such as mission and responsibility. As is written in one of the reports: "The TAP was a very good opportunity to be able to discuss during three days issues of great interest to the key-issues facing the organization". Most reports clearly refer to continuation of the initiatives started during this process, and the participants are looking forward to continuing the process during future Congresses. The role that WADEM could play here seems apparent.

The recorded experiences obtained from the first TAPs demonstrate that several improvements in the process were predictive and successful. These relate to providing clear information and communication on the aim, methods, and target of a TAP, the availability of a user-friendly, Web-based interface, and the need to repeat and actively contact the Congress participants to stimulate their participation both before and during such congresses.

For the Local Organizing Committee of 15WCDEM, the TAP sessions were one of the most important components in a master plan to make the 15WCDEM interactive. This was made clear from the Opening Ceremony of the Congress with a first royal gesture by H.R.M. Princes Margriet, who initiated a painting on a blank, white canvas. During the remainder of the Congress, all participants could demonstrate their skills, by adding their touches. A photograph of the resulting painting is on the cover of this issue of PDM. The painting symbolizes the interactive collaboration between the participants of the 15WCDEM. The painting makes clear that there is much hidden talent in the WADEM community, and also, that some central themes and agendas are required to establish a coherent picture.[9]

References

1. The Dutch Safety Board. Fire at the detention centre Schiphol-Oost 2006. Available at http://www.safetyboard.nl. Accessed 10 July 2008.
2. van den Berg B, Grievink L, Gutschmidt K, Lang T, Palmer S, Ruijten M, Stumpel R, Yzermans J: The public health dimension of disasters—Health outcome assessment of disasters. *Prehospital Disast Med* 2008;23(4):s55–s59.
3. van der Woude I, Cock JS de, Bierens JJLM, Christiaanse JC: CBRN Preparedness: Knowledge, training and networks. *Prehospital Disaster Med* 2008;23(4):s65–s69.
4. Rooze M, Netten J, Ruyter A de, Vries M de, Helsloot I, Soir E de, Selwood P, Schenk H, Hustinx P, Olinder H: Prioritizing care during the acute phase: the prominent role of basic psychosocial life support. *Prehospital Disast Med* 2008;23(4):s49–s54.
5. Fundter DQP, Jonkman B, Beerman S, Goemans CLPM, Briggs R, Coumans F, Lahaye JW, Bierens JJLM: Health impacts of large scale floods: Governmental decision-making and resilience of the citizens. *Prehospital Disast Med* 2008;23(4):s70–s73.
6. Hoejenbos MJJ, McManus J, Hoggets T: Is there one optimal medical treatment and evacuation chain for all situations: "scoop and run" or "stay and play". *Prehospital Disast Med* 2008;23(4):s74–s78.
7. Hoejenbos MJJ: "Scoop and run" or "stay and play". Hoe bereiken we een optimale geneeskundige behandelings- en afvoerketen bij rampen. *Ned Mil Gen Tijdschr* 2007;60(6):218–226.
8. Ebi KL, Helmer M, Vainio J: The health impacts of climate change: Getting started on a new theme. *Prehospital Disast Med* 2008;23(4):s60–s64.
9. Bierens JJLM: World Congress on Disaster and Emergency Medicine belangrijke stap voor de inhoudelijke ontwikkeling van de GHOR. *Nieuwsbrief Crisisbeheersing* 2007;5(7-8):26–31.

Appendix—Overview of the Targeted Agenda Programs (TAPs) during the 15th World Congress on Disaster and Emergency Medicine 2007 in Amsterdam, the Netherlands, May 2007

TAP Organization (Website)	Summary of Target	Output and Recommendations
Center for Health Impact Assessment of Disaster (CGOR)[2] (http://www.cgor.nl)	What is the international appreciation of health impact assessment of disasters? When are health impact assessments of disasters considered to be necessary? Agenda setting of the role of health impact assessment of disasters for clinicians and aid workers.	The disaster has not ended when all acute care has been provided. Post-disaster care is mostly a public health issue. Health impact assessment of disasters is important to establish effective public health measures. International expertise in health impact assessment of disasters should be better bundled.
National Medical Emergency Preparedness and Planning Office (GHOR)[3] (http://www.ghor.nl, or http://www.ghor-rr.nl)	How is the international emergency medical system prepared for chemical, biological, radiological, or nuclear events? Has any country developed a golden standard? Should such a standard be developed, and is there a need for such a standard?	The emergency medical system in most countries is not prepared for chemical, biological, radiological, or nuclear events, but there is great need for this. Within Europe, the prehospital detection and treatment of all kinds of chemical, biological, radiological, or nuclear incidents should be uniform. Dedicated education and training is essential to acheive this.
Dutch Knowledge and Advice Center for Post-Disaster Psychological Care (Impact)[4] (http://www.impact-kenniscentrum.nl)	Is it worthwhile to introduce the new term, "acute psychosocial first aid" as the most important component of treatment during disasters, next to life-saving measures? What are the roles of resilience and risk communication in acute psychosocial first aid?	The term "acute psychosocial first aid" must become an integral part of disaster planning. Citizens and the common health organizations must play the most important role. Good risk communication by the right people makes a difference if acute psychosocial first aid reaches the desired results and offers citizens the opportunities to act adequately. Psychosocial care in the acure phase consists of practical, social, and emotional support.
Ministry of Interior and Kingdom Relations (Ministerie van Binnenlandse zaken en Koninkrijkrelaties)[5] (http://www.minbzk.nl)	What are the 10 most important issues for citizens and policy-makers to minimize the health effects of floods?	To mitigate and minimize the health effects caused by floods, improvements in each step of the safety chain are possible. Resilience of the population plays an important role, but the population must be supplied with correct information. There is a need for analyzing the effects of floods (or evacuations in case of a flood threat) on healthcare infrastructure, health care, and applicability of medical protocols and treatments.
Ministry of Defence (Ministerie van Defensie)[6,7] (http://www.mindef.nl)	Is it possible to develop a golden standard on the treatment of wounded combatants ("scoop and run" or "stay and play")? If not, which factors play a role in the decisions on how to treat wounded combatants?	It is impossible to develop just one golden standard. Dealing well with the time factor is not the only aspect. On the frontline, the highest possible level of care should be available. In the long run, optimal results can be acheived by a flexible and integrated organization.
Netherlands Red Cross and Red Cross Climate Centre[8] (http://www.climatecentre.org)	What is the current knowledge within health organizations with respect to the health consequences of extreme weather conditions? How can this knowledge become further enhanced?	There hardly is any knowledge with respect to the health consequences of extreme weather conditions within health organizations. Therefore, health organizations are not prepared. Recent examples, such as the extension of malaria-infested areas and heat waves, may trigger more attention for this issue.
Dutch Safety Board (Onderzoeksraad voor Veiligheid) (http://www.onderzoeksraad.nl)	Which problems occur during disasters in high-vulnerability groups and how can these problems be prevented?	The daily medical, psychological, and social problems of high-vulnerability groups are extended and more complex during disasters. However, fact-based knowledge is scarce and coordinated international studies are required to understand how to cope with this. Lack of knowledge on how to cope with those who are not resilient only is available on a basic level, and is dissipated over many different organizations. This knowledge should be collected and should serve as a starting point for further developments.

https://doi.org/10.1017/S1049023X00021233 Published online by Cambridge University Press

https://doi.org/10.1017/S1049023X00021233 Published online by Cambridge University Press