Medical Surge

Resource	S/W	Comments
People	S	• Jurisdictional monitoring and surveillance for epidemiologists through ESSENCE: Electronic Surveillance System for the Early Notification of Community-based Epidemics are solid.
	W	• Having enough licensed providers is the limiting factor in surge response (4) • Need to connect surge plans and Medical Reserve Corp. volunteers who have medical training but are not integrated into planning (including credentialing, training, liability, IMS) (3) • Not enough qualified staff available to care for all special needs populations – particularly at their homes (3) • There is a severe and chronic shortage of healthcare professionals in the NCR (2) • Fire and EMS have a large role in dealing with medical surge (2) • Who is involved with a regional plan for responding to a jurisdictional event? • Virginia Medical Examiner's Office and hospital infection control/triage staff have limited ability to surge • Surge capacity depends on private sector response which may not be available • Need to provide for families of healthcare providers • Patient tracking and sustaining tracking systems like *Essence*
Equipment	S	• PPE has been obtained for employees through HRSA, but still need more (9) • Making headway in meaningful capability expansion (4) • CATI, ESSENCE, patient tracking in effect, but requires additional funding (4) • Equipment needed mainly for communication can occur through EOC/NIMS (3) • UASI grant funding of equipment and supplies. Have begun to scratch the surface to put those supplies in place. • Equipment to be able to track people in non-traditional environments • Huge need to connect with people who are isolated/quarantined. Are systems in place, but need to be maintained and grown.

		• Disease surveillance capability. Utilizing essence. Been in place since around 2004. • Hospitals have approximately 72 hours worth of supplies to sustain normal operations. • Have more major medical educational facilities than other regions. • There has been some increase in the number of hospital beds and labs • The adult detention center in FX is identified as a potential site for alternative care
	W	• Need additional funds to procure equipment to supply critical care medical beds (24) • Need additional storage capacity; must be able to survive on our own for 72 hours. (9) • Need to track patients and equipment. (9) • Regionally lack the physical space to handle large number of patients (6) • Transportation (5) • Need increased capacity for safe storage of remains. (3) • Need to harden hospital facilities to withstand environmental assault, e.g., flood (3) • In worse case scenario have to plan for assistance that comes. Need to identify how would expand beyond your physical space. (2) • We need specific scenario oriented equipment such as burn, chemical, and Mark I kits (2) • Need to in crease maintenance and testing of special HVAC equipment (2) • Have received some funding but only around a million dollars which has provided some equipment, but not enough to meet the need of the area. Have major shortcomings that need to be addressed. • Sustainment and replacement issues. • Medical gases are limiting factors. • Lab surge. • Physical space requirements for storage/triage/patient overflow for massive flow • Costs of preparedness are astronomical. • Need to keep in mind what constitutes a “bed.” • In a CBRNE event would need detection equipment at a hospitals. • Need a system that will allow the tracking of patients no matter where they are until they are released. • Need funding for evaluation and validation of this

		system to determine its efficiency/effectiveness. Will be useful for e.g., pandemic flu, etc. • Supplies are budgeted for 72 hours and for normal operations; unrealistic level of supplies for a crisis. Need to budget for surge and for longer period of time. • Plans do not have contingencies for communications failures. • Have limited if any surge capacity. • Shortage of healthcare personnel in this region. • Will not have capability to build surge capacity • Not aware whether or not medical personnel would be willing/able to assist in medical surge. • Cannot rely national resources to be available. • In national event can't expect federal help. • NDMS etc., need facility for federal resources to work. Will bring resources place., etc • Don't have appropriate infrastructure to mobilize. • Communication capacities for PIO need to be increased. • Need additional PPE equipment. (depending on what the CDC standard is) • DC 211, referral system. People need to be able to find out what to/not to do. Needs to be improved. • Need enhanced communications interoperability, e.g., CBDA, satellite, amateur radio, etc. • Hospital pharmaceutical supplies will expire • Equipment needs to be provided to other "non-hospital" organizations • Lack of NCR Plan/Resources to support decontamination at hospitals • No or limited capability for CBRNE detection at hospitals • Need to increase credentialing capabilities • Lack of logisticians to stockpile medical treatment equipment • Need real time or near real time alerting system (current is 48 hours) • Need technology to support *Essence* • Need to support Special needs population • Need to equip labs (agricultural etc.) to provide medical lab surge • Unaware as to whether equipment can handle constant use
Training	S	• Staff is adequately trained because of their license (5) • WHC has internet based educational system that could

		be increasingly helpful to all disciplines • Competency based training • Online resources • A lot of training curriculum available
	W	• A standardized training for scenario based training which involves live and web based training with trackable competency (18) • Staff may not handle mass casualty well because training size and nature is not on that scale (10) • Lack of PPE Training for community MDs and office (7) • Training for medical volunteers (6) • Disaster behavioral health (6) • Training on ESSENCE for public health/hospital personnel (5) • Support of Special Needs Citizens (5) • Training in management and systems for alternate care facilities (4) • Public education (4) • What is needed to support decontamination needs at hospitals (3) • Integration of roles between first responders and health (2) • Hospital/PH-HD/interface (2) • No training model for surge capacity (2) • Training for additional people (2) • Lack of rapid air monitoring for ID of CBRNE attacks and characterization of plans (2) • EMS role of assisting hospitals • What will fire department need to support quarantine plan • Training for non-medical volunteers • Need to practice NIMS-incident command • Epidemiological training/surveillance • Training on desired plan practices • No framework for JITT • Assigning local staff and training in roles • Lack of information exchange • Online resources have not been tapped effectively • Need blast fax/contact info • Backfilling staff while they are being trained • Need more creativity in training • Sustainability
Exercises/Evaluation	S	• Currently exercise regularly. (2)

		• Hospitals are required to train and exercise on an ongoing basis (JACHO). • Value of standardizations • IC is the same no matter the scenario. • Hospitals have twice yearly requirements need. • Northern Virginia military is beginning to consistently include behavioral healthcare. • Planning an exercise for 2006. • Have exercised decontaminations.
	W	• Need more regional, multi-ESF trainings that, among other things, exercises/tests mobilizations, procedures for handling hospital surge outside hospitals, handoff form hazmat to EMS, volunteers, behavioral healthcare abilities, capabilities regarding special needs populations, federal involvement in response, and surveillance systems. (51) • Need to centralize all evaluated weaknesses so that they can be prioritized and addressed. (4) • Hospitals and public health do not practice ICS and NIMS to the same extent as police and fire. (2) • Massive staffing required to conduct a real-time exercise since hospitals operate 24/7. • Need more creative or non-traditional exercise methodology. • Need to fill positions in order to train personnel. • Need a MRC exercise. • Never held a real surge exercise of a significant number of victims to stress the NCR, DOH, EMA, and hospital plans and systems. • Need to institutionalize new HSEEP exercise guidelines. • Exercises should reward identification of deficiencies instead of rewarding success. • Need public awareness campaign. • Need performance metrics related to requirements of electronic systems effectiveness.
Plans, Policies and Procedures	W	• Need to develop integrated plans to include: understanding of HIPAA as it applies to sharing information across agencies or jurisdictions, development of a coordinated public education campaign, coordinate mass transport, addressing legal and credentialing issues, development of mass fatality management plans, surge planning beyond hospitals, incorporation of insurance providers, develop detailed scenario specific plans, include medical examiners in

		planning. (18) • Family planning for health care providers so that they can come to work (2) • Standards of care decisions under different scenarios need to be developed (major shift for health professionals) • Need to develop plans to help with local implementation of federal orders as they apply to quarantine • Plan to communicate with public on what to expect • Need a gap analysis to identify issues like the need for alternative care facilities and staffing, special populations sheltering, medical care for people in quarantine