

DOWNLOAD PDF SPECIAL COMMITTEE ON DISASTER PREPAREDNESS PLANNING

Chapter 1 : PPT - Hospital Disaster Preparedness PowerPoint Presentation - ID

The Standing Committee on Disaster Response and Preparedness is committed to educating lawyers, bar associations and the justice system to prepare for and respond to disasters. ABA Policy In recent years, the Standing Committee has adopted numerous policies related to disaster preparedness and response in the areas listed below.

EDs are better prepared than they used to be, but still fall short of where they should be Schur et al. A survey conducted by CDC in gives a comprehensive picture of hospital preparedness in the years following September 11 Niska and Burt, Hospitals vary widely in the degree to which they have prepared for the range of possible threats. At the time of the survey, almost all hospitals More than 80 percent of hospitals had plans for chemical The remainder of this section reviews the current status of and recommended actions for enhancing hospital preparedness across five critical hospital roles during disasters: Surge Capacity Hospitals in most large population centers are operating at or near full capacity. In many cities, hospitals and trauma centers have problems dealing with a multiple-car highway crash, much less the volume of patients likely to result from a large-scale disaster. During emergencies, hospitals can do a number of things to free up capacity and extend their resources, but there are serious physical limitations on this expansion of their capabilities. Surveys indicate that the numbers of available beds, ventilators, isolation rooms, and pharmaceuticals may be insufficient to care for victims of a large-scale disaster Kaji and Lewis, The Rhode Island nightclub fire discussed further below demonstrated that even medium-sized incidents can overwhelm local hospital capacities Hick et al. The frequent ambulance diversions and ED boarding discussed earlier in this report also signal limitations on hospital surge capacity. The issue of capacity is an immediate problem because many hospitals and their EDs are already maximizing their existing capacity after years of capacity shedding designed to reduce costs. At the Breaking Point. The National Academies Press. Many hospitals have already opened up additional beds in an effort to alleviate overcrowding, but continue to face nursing shortages and staffing issues in supporting the existing beds Derlet and Richards, ; Asplin and Knopp, The limiting factor in the ability to respond to a disaster will vary by hospital and by type of disaster. An important limiting factor is the availability of specialists who can treat the types of cases resulting from a disaster event. For an event involving a rare biological or chemical agent, there may be limited expertise in the community. For more common types of events, such as blast injuries, the limitation will likely be an inadequate supply of surgical specialists including neurosurgeons, orthopedic surgeons, and burn surgeons to treat the volume of cases requiring their specialized services. While other staff, such as emergency physicians, critical care specialists, and nurses, are important, they are less likely to represent a major constraint on the ability to treat additional patients. One way in which hospitals can alleviate staff shortages is to use emergency medical services EMS personnel as physician extenders. In many disaster scenarios, the prehospital component is over in 1â€”2 hours, making a large number of EMS personnel available just as hospital activity is peaking. Physical space is an important consideration, but probably not the most critical factor. Hospitals can add to available capacity on short notice by halting elective admissions and discharging noncritical patients. In addition, they can sometimes use ED hallways, inpatient hallways, and nonclinical areas to house victims in an emergency. According to the CDC survey, however, only 61 percent of hospitals had developed plans for the use of nonclinical space in such cases Niska and Burt, In some instances, particularly a more circumscribed disaster, hospitals can make room for patients by transferring existing inpatients to more distant facilities. But the CDC study revealed that only 46 percent of hospitals had agreements with other hospitals to accept patients in the case of a disaster Niska and Burt, Intensive care unit ICU beds are much more difficult to empty on short notice than other beds and are probably the key limiting factor in terms of physical capacity, as they often are in day-to-day crowding GAO, a. Another physical limitation is the number of negative pressure rooms needed to prevent the spread of airborne pathogens. Limitations in available equipment, such as mechanical ventilators and decontamination showers, are also important. The committee concludes that the lack of

adequate hospital surge capacity is a serious and neglected element of current disaster preparedness efforts. Page Share Cite Suggested Citation: Depending on the type of event, some of the nonroutine things that can happen include the following Ackermann et al. Casualties are likely to bypass on-site triage, first aid, and decontamination stations. EMS responders will often self-dispatch. Providers from other jurisdictions may appear at the scene and transport patients, sometimes without coordination or communication with local officials. In some cases, local facilities are not aware of the event until or just before patients start arriving. Hospitals may receive no advance notice of the extent of the event or the numbers and types of patients they can expect. There may be little or no communication among regional hospitals, incident commanders, public safety, and EMS responders to coordinate the response regionwide. Consider the regional response needed after the Rhode Island nightclub fire in February During a concert, a fire broke out on the stage in the small venue and quickly spread throughout the nightclub before many patrons could escape. The fire consumed the building in 3 minutes, and 96 people were killed. It took firefighters from 15 communities to put out the flames; 65 ambulances also responded Gutman et al. The first patients began to arrive at local hospitals minutes after the fire broke out. Most hospitals received notification from EMS before patients began to arrive, but several others said they received no notification, or there was limited or incorrect information regarding the number of patients to expect. A total of victims sought care at hospitals. It received 82 patients, 25 percent of whom were admitted and 25 percent of whom were transferred to other hospitals. A level I trauma center located 12 miles away from the nightclub received 68 patients; approximately 63 percent were admitted Gutman et al. It was only the second time that Shriners had opened its doors to adult patients Ginaitt, As a result, 10 transfers by helicopter occurred from four different hospitals within the first few hours. All air medical resources available in New England were used that evening Gutman et al. The amount of regional resources needed to respond to this medium-sized emergency incident is striking. It demonstrates the need for hospitals to coordinate planning with each other as well as other responders, including prehospital providers and air medical personnel. This often means working and planning with groups across state lines to decide on and implement the surge capacity, workforce training, protective equipment, and surveillance and communications systems appropriate for the region. Coordination among Local, Regional, State, and Federal Entities The underlying philosophy of disaster management is that every event is handled at the lowest possible geographic, organizational, and jurisdictional level DHS, When a disaster event becomes larger than can be handled adequately by local response capabilities, the state usually gets involved, enabling the allocation of statewide resources to the affected area. The state government has ultimate responsibility for the health and wellbeing of its citizens, and can allocate funding and statewide emergency resources, utilize National Guard troops, and draw on state supplies of drugs and vaccines. Most agree that for disaster response to be effective, incident control must be clear, communications good, and providers at the local level involved in the process. In the event of a disaster, local emergency providers must respond as additional resources are mobilized at state or federal levels. The medical care component of most disasters is usually over after a few hours, so even if these additional resources can be assembled, they may arrive too late to be of much help Waeckerle, Further, only regional and local planning can adequately anticipate and address local utilization patterns that will impact the execution of disaster plans. Therefore, all hospitals must be prepared to receive patients suffering from any type of illness, injury, or exposure. To respond effectively, hospitals must interface with incident command at multiple levels and be prepared to deal with transitions between levels, for Page Share Cite Suggested Citation: Each hospital should be familiar with the local office of emergency preparedness and know how hospitals are represented at the emergency operations center during an event, whether through the hospital association, the health department, the EMS system, or some other mechanism. HEICS is a standardized approach to disaster management—essentially an internal hospital application of NIMS—that was developed and has been used nationwide for a decade. Regionalization Current federal preparedness funding has been geared toward preparing all hospitals to respond at some level to all hazards. Because the range of possible threats is so broad, the feasibility of meaningfully preparing all hospitals is

unrealistic. Regionalization of certain aspects of preparedness may facilitate a more timely and effective response Bravata et al. The benefits of regionalizing disaster response include consolidation of inventories of drugs and vaccines; surveillance to identify outbreaks of disease; efficiency of concentrating certain types of medical response at fewer hospitals; and improved communications, command, and control associated with regionwide events GAO, a. Regionalization is also likely to benefit triage, medical care, outbreak investigations, security management, emergency management, and training. Regional trauma systems are critical to planning for the care of severely injured patients during a disaster. While 47 states have developed or are developing a statewide trauma system plan and 38 states now designate trauma systems, there is wide variation across states in the level of development of these systems and in the degree of coordination with disaster planning. In one example of a regional approach to disaster planning, Connecticut developed a statewide system for hospital preparedness for bioterrorism that was built on the trauma system Jacobs et al. The Connecticut Department of Public Health contracted with two level I trauma centers, which were designated as regional centers of excellence for bioterrorism preparedness. The existing trauma system and communications network provide the basic infrastructure for the system, which links to the Metropolitan Medical Response System centered in Hartford. The two centers of excellence serve to coordinate all aspects of medical disaster response activities within their regions, including surveillance, training, planning, facilities, equipment, and supplies. This model is based on the realization that resources are too scarce for a haphazard approach—disaster funding should be targeted to those regions and hospitals where it will do the most good for the community Page Share Cite Suggested Citation: Ideally, all assets required for a community or a state to mount an effective response should be developed within the regional context described in Chapter 3. Federal funding for the development of such approaches is currently limited. This program was also recently defunded. Communications Good communications among the many community services involved in disaster response are essential to an effective response—to ensuring that patients will be directed to the most appropriate facilities, that hospitals will not be overwhelmed with patients, that hospitals will be alerted sufficiently in advance of the arrival of patients to be able to mount the appropriate response, and that resources will be allocated effectively throughout the community. Unfortunately, communication is a significant weakness of the current system, reflecting the existing fragmentation of emergency care. According to the CDC survey, surprisingly few hospitals had provisions in their bioterrorism response plans for contacting outside entities such as EMS 72 percent , fire departments 66 percent , or other hospitals 51 percent. Hospital collaboration in mass casualty drills with outside organizations followed a similar pattern—only 71 percent collaborated with EMS, 67 percent with fire departments, and 46 percent with other hospitals Niska and Burt, In addition to coordinated communications, investments should be made in enhanced communications equipment. Hospitals should have reliable and redundant digital and voice communications with the regional and state public safety, emergency management, and public health agencies. The loss of hospital communications capabilities during Hurricane Katrina turned out to be a major obstacle to coordinating the evacuation and care of victims. Hospitals should have some satellite telecommunications capability in preparation for a catastrophic event. The VHA currently deploys personnel to all presidentially declared disasters, including Hurricane Andrew, the Northridge earthquake, and the September 11 terrorist attacks. VHA staff also support such events as the Super Bowl, presidential inaugurations, and papal visits. Training and Disaster Drills The unique aspects of disaster response require specialized training, both in the clinical management of disaster victims and in institutional procedures that may be quite different from those under normal operating conditions HRSA, ; Treat et al. There are strong indications that training is inadequate in both areas. Hospital Training and Drills Results of the CDC survey indicate that progress has been made since September 11 in training hospital staff to deal with emergencies, but deficiencies remain. Training in response to terrorism-related threats varied widely among staff: This nevertheless represents an improvement over training prior to September Treat and colleagues , for example, found that fewer than 25 percent of hospitals in and around Washington, D.

Chapter 2 : Hospital Disaster Preparedness for Obstetricians and Facilities Providing Maternity Care - ACC

The special committee is directed to study and make recommendations in the area of public and private cooperation in preparedness planning for emergency responses to natural and man-made disasters, including pandemics.

This information is designed as an educational resource to aid clinicians in providing obstetric and gynecologic care, and use of this information is voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations in practice may be warranted when, in the reasonable judgment of the treating clinician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology. The American College of Obstetricians and Gynecologists reviews its publications regularly; however, its publications may not reflect the most recent evidence. Any updates to this document can be found on www.acog.org. ACOG does not guarantee, warrant, or endorse the products or services of any firm, organization, or person. Neither ACOG nor its officers, directors, members, employees, or agents will be liable for any loss, damage, or claim with respect to any liabilities, including direct, special, indirect, or consequential damages, incurred in connection with this publication or reliance on the information presented. Large-scale catastrophic events and infectious disease outbreaks highlight the need for disaster planning at all community levels. Features unique to the obstetric population including antepartum, intrapartum, postpartum and neonatal care warrant special consideration in the event of a disaster. Pregnancy increases the risks of untoward outcomes from various infectious diseases. Trauma during pregnancy presents anatomic and physiologic considerations that often can require increased use of resources such as higher rates of cesarean delivery. Recent evidence suggests that floods and human-influenced environmental disasters increase the risks of spontaneous miscarriages, preterm births, and low-birth-weight infants among pregnant women. The potential surge in maternal and neonatal patient volume due to mass-casualty events, transfer of high-acuity patients, or redirection of patients because of geographic barriers presents unique challenges for obstetric care facilities. These circumstances require that facilities plan for additional increases in necessary resources and staffing. Although emergencies may be unexpected, hospitals and obstetric delivery units can prepare to implement plans that will best serve maternal and pediatric care needs when disasters occur. Clear designation of levels of maternal and neonatal care facilities, along with establishment of a regional network incorporating hospitals that provide maternity services and those that do not, will enable rapid transport of obstetric patients to the appropriate facilities, ensuring the right care at the right time. Using common terminology for triage and transfer and advanced knowledge of regionalization and levels of care will facilitate disaster preparedness. Hospitals that provide maternity services should implement a standing perinatal subcommittee likely to include obstetrics, pediatrics, and anesthesia in charge of disaster preparedness, which can be mobilized quickly in the event of an emergency. Hospitals with maternity services should develop specific strategies for stabilizing and transporting obstetric patients, managing surge capacity and the need for consultative services, sheltering-in-place, and incorporating regional facilities that do not provide maternity services. Hospitals providing care for maternal and neonatal patients should communicate using a common terminology, such as OB-TRAIN Obstetric Triage by Resource Allocation for Inpatient, to facilitate and prioritize transport based on acuity of care. Disaster preparedness may include a designated obstetric team that can be called upon in an emergency setting or implemented as part of a planned evacuation. Communication strategies should include back-up broadcast systems in the event of loss of telephone communication that take advantage of new technology, such as telemedicine, that can function over the internet and still may be accessible when other lines of communication have been cut off. Obstetric units should have a designated safe location for laboring patients who cannot be transported because of imminent delivery. This plan should include an identified alternative site for delivery if the labor and delivery unit is damaged and a system to ensure the necessary

equipment can be transported quickly to the alternative site. Ensuring that the woman and her infant are transported together is a vital element of disaster planning. This situation may require additional coordination in the event that the woman or her infant needs care at a specialized facility and may be initially transported separately. Hospitals should prepare for power outages and lack of access to electronic medical records. Obstetricians and other obstetric care providers should consider the option of altering obstetric services to function with less resource use. Examples include early hospital discharge after delivery and enhanced use of telephone and telemedicine triage, with attention to documentation requirements. Background Large-scale catastrophic events and infectious disease outbreaks—including the terrorist attacks of September 11, , the bombing at the Boston Marathon, the H1N1 influenza pandemic, and the Ebola outbreak—highlight the need for disaster planning at all community levels. Furthermore, the increased frequency of environmental natural disasters, such as Hurricane Katrina ; Hurricane Sandy ; and the hurricanes Harvey, Irma, and Maria; and the increase in incidence of earthquakes, floods, heat waves, and severe wildfires that have direct consequences on human health, demonstrate the important role for health care providers in disaster preparedness 1. Because disasters are unpredictable in nature, attention has focused on measures that can be taken to minimize their effects and prepare citizens, businesses, health care facilities, and nations to manage the damage caused by disasters. In recent years, new publications by ACOG and SMFM have defined specific levels of maternity care that provide important direction for managing obstetric disaster preparedness. Additionally, new disaster response protocols specific to obstetric triage have been published that help create uniform language for coordinating complex maternal and neonatal levels of acuity 4. This document integrates these updates to provide enhanced guidance for obstetric disaster preparedness. This Committee Opinion does not specifically address security breaches, such as an active shooter in the hospital, or events of bioterrorism. The Role of Health Care Institutions in Disaster Preparedness Given that health care institutions play an important role in responding to disasters, the discipline of hospital preparedness now occupies a central role in effective disaster mitigation planning 5 , 6. Currently, many of the documents that offer guidance on hospital preparedness are relevant to most types of medical facilities. Every state has a disaster preparedness team directed by the Federal Emergency Management Agency and the Department of Homeland Security. The obstetrician-gynecologist leadership should review hospital disaster plans to ensure optimal coordination and staffing specific to the labor and delivery and postpartum units. In some instances of disaster, the National Guard, or the Department of Homeland Security, or both, may assume the administration of an existing hospital or set up satellite medical facilities. Hospital administration should recognize the potential for such emergency activities. Considerations for Obstetric Care Facilities Features unique to the obstetric population—including antepartum, intrapartum, postpartum and neonatal care—warrant special consideration in the event of a disaster. Birth is difficult to predict and obstetric units are vulnerable to a patient volume surge and unpredictable resource use. Recommendations for hospital disaster preparedness are summarized in Box 1. Additional obstetric-specific considerations and recommendations for disaster preparedness are summarized in Box 2. Pregnancy increases the risks of untoward outcomes from various infectious diseases such as influenza 7 Trauma during pregnancy presents anatomic and physiologic considerations that often can require increased use of resources such as higher rates of cesarean delivery Recent evidence suggests that floods and human-influenced environmental disasters such as the World Trade Center collapse increase the risks of spontaneous miscarriages, preterm births, and low-birth-weight infants among pregnant women Obstetricians and other health care providers may not be aware of or routinely consider these risks. Planning for Obstetric Surge Capacity The potential surge in maternal and neonatal patient volume due to mass-casualty events, transfer of high-acuity patients, or redirection of patients because of geographic barriers presents unique challenges for obstetric care facilities. There are three subsets of surge capacity: Consideration also should be given to shared needs during disaster management. The important and challenging issue of ethical resource allocation when demand exceeds supply has been addressed in the general medical literature 15 , Much of the focus has been on the distribution of limited numbers of

ventilators among large surges of critically ill patients who require respiratory support. These principles also apply to other potentially limited resources eg, cardiovascular support medications, antimicrobials, and intravenous supplies. To optimize outcomes, hospital committees charged with disaster planning need to review the availability and organization of these important resources before real-time disaster management is necessary. In addition, much of the planning for general hospital preparedness centers on the ability to control elective procedures and visits, thereby reducing patient volume and allowing for more intensive focus on the surge of resource-intensive patients and others affected by the disaster. One strategy to mitigate the increase in patient volume involves preemptive management of scheduled procedures, when medically appropriate eg, full-term induction of labor or cesarean delivery. This strategy has been employed successfully in preparation for nondisaster scenarios in which the probable strain on resources is known in advance eg, city events with large-scale road closures and could be applied in instances of disaster preparedness in which the event has a projected window of vulnerability eg, hurricanes. For each level the capabilities, types of health care providers, and required services are delineated. The regionalized, collaborative network also could facilitate the management of surge capacity during a disaster. The established relationships and enhanced lines of communication would enable the rapid and creative response required in unexpected disasters. In such circumstances, a level III or level IV center may be forced to stop accepting new patients or create additional capacity for critical patients by transporting or directing those requiring less specialized care to lower-level centers. Plans should be in place to have consultants available to provide their expertise remotely to assist lower-level facilities or to facilitate obstetric care at institutions that would not otherwise provide maternity services. In principle, hospitals without maternity services would not be designated to receive obstetric patients even during a crisis because pregnant, laboring, and postpartum patients are best served by a hospital with a maternity care designation 14. All hospitals should be familiar with the ACOG and SMFM levels of maternal care designations and should have integrated regional referral networks based on these levels. However, in the event of a disaster, even hospitals that do not provide obstetric services need to prepare for such patients by coordinating with a maternity hospital and preparing a plan to stabilize and transfer patients when appropriate. Triage of the Obstetric Patient in Disaster Response Once a hospital has determined its capacity to provide adequate maternity services, the next step is efficient and appropriate triage of obstetric patients. Health care facilities need to consider the woman and her fetus or neonate in terms of resource allocation and surge capacity. Despite these considerations, recent research has shown that few national obstetric/gynecologic societies offer specific guidance for triage of obstetric patients in the crisis setting To approach the triage of patients in an obstetric unit, health care providers must consider antepartum, intrapartum, and postpartum care along with care plans for the newborn nursery and neonatal intensive care unit. Given the wide range of acuity among each of these groups of patients, common terminology and collaborative networks are crucial Hospitals providing care for maternal and neonatal patients should communicate using a common terminology, such as OB-TRAIN, to facilitate and prioritize transport based on acuity of care. As such, the OB-TRAIN model builds upon a previously existing neonatal TRAIN system that organizes pediatric patients according to their medical needs and the type of transport required if evacuation becomes necessary This plan should include an identified alternative site for delivery if the labor and delivery unit is damaged and a system to ensure the necessary equipment can be transported quickly to an alternative site. Postpartum triage for the neonate is another important consideration. Special Considerations for Infectious Disease Outbreaks Few obstetricians are trained in critical care, yet obstetric patients can be affected severely by some infectious disease outbreaks and may require disproportionate critical care resource allocation 7 In many facilities, adult intensive care units are distant from labor and delivery units. Physical separation may pose logistic barriers to the delivery of optimal intensive care for critically ill pregnant women. These barriers may be exacerbated during times of overwhelming patient volume. These trends warrant thoughtful consideration and extra coordination with critical care clinicians before and during disaster mitigation. These considerations may be true especially when focusing specifically on influenza pandemics.

Data from influenza pandemics demonstrate heightened rates of hospitalization and preterm birth associated with maternal influenza infection [11]. The increased number of newborns born at preterm gestations during an influenza epidemic has clear implications for neonatal intensive care capacity and resource allocation that parallels increased maternal resource needs. Two special considerations presented by the obstetric population related to infection control practices are 1 the desire for familial involvement in the birthing process, and 2 the importance of lactation and early parental bonding with the neonate. Infectious disease outbreaks often require tight restrictions on visitation procedures while the nature of the epidemic is being investigated. Isolation often is a difficult hospital practice to implement in general and is especially challenging to enforce in the obstetric population given the need women have for support during labor, delivery, and the postpartum period. Likewise, the importance of lactation and early parent-newborn bonding introduces infection control considerations that are not relevant to other patient populations and, therefore, warrant additional advance planning. Maternity services should coordinate with infectious disease specialists for guidance in this challenging clinical scenario. Temporary Modifications in Standard of Care Obstetricians and other obstetric care providers should consider the option of altering obstetric services to function with less resource use. Such alterations often are necessary and beneficial when the volume of patients in a health care facility is unusually high. This concept has received considerable legal and medical attention [20]. The goal of these efforts is to give facilities and health care providers guidance on temporary flexibility in care standards as well as who is permitted to provide care. Equally important is planning by the hospital leadership for the potential need to rapidly credential temporary obstetric care providers in the face of a health care provider shortage that can occur with a variety of disaster scenarios. Facility preparedness committees are encouraged to consult with their local legal colleagues to assist in interpreting state and federal guidance on this issue. Remote and Distance Care With Telemedicine In the case of an environmental disaster, pregnant and postpartum women in need of care may be cut off from a hospital facility, medical records, and health care providers. The Health and Medicine Division of the National Academy of Sciences, Engineering, and Medicine formerly the Institute of Medicine has recently considered remote and distance care [22] and has reported on one example of the successful use of telephone triage in obstetric care

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Chapter 3 : Dept of Health - Carroll County Health Department

Special Committee on Disaster Response and Preparedness The mission of the Committee is to promote and assist lawyers, law firms, bar associations and the justice system prepare for and respond to disasters; to assist.

Sacramento, CA Overview Unprecedented. From hurricanes and wildfires to floods and mass shootings, the nation saw no shortage of disasters in But with every disaster we confront, more knowledge is gained and wisdom gathered. And we carry those experiences forward into the future, strengthening our planning and fortifying our readiness. Lessons from the Atlantic hurricane season Cyberattack “ how one hospital survived a ransomware attack Mass casualty incident planning and no-notice drills California Wildfires: Conference Meeting Locations The conference and exhibit show will be held at the Sacramento Convention Center, located just across the street from the Hyatt Regency Sacramento, the host hotel. The pre-conference workshop on Monday, Sept. A staggering 9, wildfires ravaged 1. Fiery infernos raged throughout the state, spawning five of the most calamitous fires in state history, and spurring the call for mandatory evacuations and deployment of numerous disaster response teams to provide critical emergency assistance. Hear from fellow hospital and state agency representatives who will share their firsthand accounts of the fallout from the firestorms, the heroic response activities and the invaluable lessons learned. The complete pre-conference workshop agenda will be available soon. Lessons from the Atlantic Hurricane Season Concurrent Breakout Sessions Beyond the Survey: Emergency Management Fundamentals 4: Concurrent Breakout Sessions Responding as One: Hospital representatives should be available during exhibit and poster viewing sessions to discuss their best practices with attendees. Click here to submit your best practices poster entry form. Submissions must be received by July Tuition Register by August 24 and save! Education programs and publications are a membership benefit and are not available to eligible non-member California hospitals. Tuition includes continental breakfasts, lunches, education sessions, exhibit show and reception, and continuing education. Confirmations A confirmation will be emailed to all registrants. Cancellations must be made in writing seven or more days prior to the scheduled event and faxed to No refunds will be given after these dates. Cancellation and substitution notification may be emailed to education calhospital. In the unlikely event that the program is cancelled, refunds will be issued to paid registrants within 30 days. Photo Release CHA will photograph this event. If you prefer not to be photographed, please email CHA at education calhospital. Continuing Education Full attendance at the educational sessions is a prerequisite for receiving continuing education. Attendees must sign in at each session at the conference and include their professional license number, if required. Participants in this program who wish to have the continuing education hours applied toward ACHE Qualified Education credit must self-report their participation. Hotel The Hyatt Regency Sacramento is the host hotel for the conference. Located in the heart of downtown Sacramento and directly across the street from the State Capitol, the Hyatt is close to numerous dining options, shopping and parks.

Chapter 4 : About the Wildfire Preparedness and Response Legislative Conference Committee | Focus

For the purposes of this Committee, "disaster preparedness" is defined as prevention of, preparation for, response to, and recovery from large-scale unexpected disasters (fire, flood, earthquake, mold and mildew, pests, etc.) which threaten the Library's staff, patrons, collections, equipment, and facilities.

Chapter 5 : About Us | Caring for Children in a Disaster | CDC

REMARKS TO The Special Committee on Disaster Preparedness Planning December 13, ¼ Good Morning. My name is Ben Peirce. I am the Central.

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Chapter 6 : Disaster Planning Conference - Emergency Preparedness

Hospital Disaster Preparedness. Special Committee on Disaster Preparedness Planning December 13, What We Are Preparing For: All Hazards. Bioterrorism, Other Infectious Disease Outbreaks, and Other Public Health Threats and Emergencies.

Chapter 7 : Ready Iowa - IDHRC

Support pediatricians and families that include a child/youth with special needs to "start the conversation" and improve preparedness planning. Identify and disseminate ways for pediatricians to incorporate emergency/disaster planning into anticipatory guidance.

Chapter 8 : Disaster Preparedness and Emergency Planning Committee

The Disaster Management and Emergency Preparedness (DMEP) course teaches planning methods, preparedness, and medical management of trauma patients in mass casualty disaster situations.