Incentives, Mandates, and Operational Realities: A Civilian Perspective
Preparedness on the “outside”: The assumption for T & E needs?

- Disaster or attack
- Casualties
- Federal support
- EMS or Hospital/ER
- Local/regional support
- Peripheral role for other clinicians
Preparedness on the “outside”: The reality for T & E needs?

disaster or attack

casualties

Prim. Care, School RNs, Specialists

Retail based clinics

Federal support

EMS or Hospital/ ER

Local/regional support
What is needed?

- Two layers of capabilities
- Very similar to the rest of medicine
- Universal workforce competency in certain areas, regardless of clinical specialty, such as:
  - Recognition of a disaster or attack
  - Self protection
  - Initial treatment/stabilization
  - Understanding when to call for help
  - Adequate training for any “supportive role” activities (e.g. H1N1 ER coverage, etc.)
- Advanced capabilities in certain, but not all, providers and sites
Where can this be addressed?

• **Early on:**
  – Medical, Nursing, Dental, Public Health school curricula
    • PRO: captive, universal audience, validated process
    • CON: extinguishment of skills

• **Later:**
  – Residency or Fellowship Training
  – Practicing Staff
    • PRO: timely information
    • CON: very difficult to get staff to participate
What is needed?
Example: residency experience

<table>
<thead>
<tr>
<th>TABLE 2</th>
<th>Respondents by Program Type Reporting No or Minimal Training in the Clinical Recognition and Management of Either General Victims or Child Victims for Each Type of Terrorist Event</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Event</strong></td>
<td><strong>Pediatrics, %</strong></td>
</tr>
<tr>
<td></td>
<td><strong>General</strong></td>
</tr>
<tr>
<td>Thermomechanical</td>
<td>80</td>
</tr>
<tr>
<td>Chemical</td>
<td>72</td>
</tr>
<tr>
<td>Biological</td>
<td>67</td>
</tr>
<tr>
<td>Radiation</td>
<td>85</td>
</tr>
</tbody>
</table>

<sup>a</sup> Significant difference exists between program types (p < .05).
What is needed?
Example: differences in setting

<table>
<thead>
<tr>
<th>TABLE 3</th>
<th>Percentage Reporting No/Minimal Training by Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affiliation</td>
<td>University or Medical School Associated (N = 91), %</td>
</tr>
<tr>
<td>Type of Event</td>
<td></td>
</tr>
<tr>
<td>Thermomechanical</td>
<td>70</td>
</tr>
<tr>
<td>Chemical</td>
<td>65</td>
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<tr>
<td>Biological</td>
<td>57</td>
</tr>
<tr>
<td>Radiation</td>
<td>77</td>
</tr>
</tbody>
</table>

<sup>a</sup> Significant difference between groups (P < .05).

Shelly D. Martin, Anneke C. Bush and Julia A. Lynch
*Pediatrics* 2006;118;620-626
“encouragement” options in the non-military world...

**INCENTIVES**
- Certificate programs
- Statements of Support
- Elective opportunities
- Non-mandatory training

- All depending upon TIME and FUNDING and individual BUY-IN to be successful
  - Issues around grant support of this type of work

**MANDATES**
- Joint Commission expectations
- Residency training requirements (RRC)
- Topic covered on professional exams
- Continuing Medical Education requirement
- Licensure requirement

- Very difficult to INITIATE-resistance to change...
The boundaries blur quickly as to “federal” vs. “non-federal…”

disaster or attack

casualties

Prim. Care, School RNs, Specialists

Retail based clinics

EMS or Hospital/ER

Federal support

DMAT, MRC

Local/regional support

Medical Volunt.

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