

DMOC After Action Review for Hurricanes Gustav and Ike

September 25, 2008

Sustains:

- 1) Resource Request Chain – Improved understanding of what was being requested and by who will hopefully lead to better reimbursement.
- 2) DMOC concept – The idea of a health and medical operation center to help consolidate all the activities that are occurring was useful.
- 3) DFW wide radio channel – The use of the shared radio channel to coordinate the NDMS arrivals was useful and more use of the shared radio channel would be helpful.
- 4) Evaluation for placement issues – The jurisdictions found the centralized evaluation and placement capacity of the DMOC to be helpful.

Quick Fixes

- 1) Modified IAPs / SitRep produced daily at established times – A suggested regularly scheduled report in a fixed format would improve information flow.
- 2) List of services available through DMOC including community resources – Having a list of functions that the DMOC can accomplish will help outsiders understand the possibilities.
- 3) Special Knowledge Expertise – A document listing special expertise available through the DMOC will help others decide when to contact the DMOC.
- 4) Briefing sheet – A description of how the local community handles health and medical issues for outside agencies.
- 5) Federal Medical Station (FMS) inventory and needed services document – A simple fact sheet of what comes with and what services will need to be provided when using an FMS.

Improvements

- 1) National Medical Disaster System – Many issues of communication and federal / local relationships were discussed. A meeting with the local FCC and HHS will need to be arranged.
- 2) Communications Policy – Issues of vetting information so there is an official communication of important information needs to be established. Will consider getting together some people to build this policy and bring to the DMOC meeting.
- 3) Clinic hours and function – Establishing a written description of the shelter clinic and the level of care provided will help all jurisdictions and shelters understand better what the clinic can be accomplished. Will sit with the clinic management team and try to build this document.
- 4) Non-emergent transportation – Discussion of dialysis transport and return to the shelter from emergency departments was brought up. Feeling the

- emergency management owns some of this issue. Will work with the emergency management community to create a solution to this problem.
- 5) Nurse staffing – Using paid staff versus volunteers was brought up. The difficulty of getting volunteers when the local community is not impacted was discussed. The fact that many hospitals are short staffed was brought up. A connection to nurse staffing agencies and better use of Parkland resources to meet this issue was suggested. Will try to gather a group to work on this issue prior to next DMOC meeting.
 - 6) Tracking – Better tracking of all the evacuees being placed into higher level of care facilities (NH, LTACs, and hospitals) for repatriation needs to be established. Will work with EMOC and HSR 2/3 on how better to do this.
 - 7) DMOC staffing – The staffing of the DMOC was variable and not consistent. We need to establish staffing levels with specific functions and rotation schedules. This will most likely require a task force of the DMOC to accomplish. Plan to establish the task force at the next DMOC meeting.
 - 8) Continued improvement of regional collaboration – Discussion of NDMS patient notification in other counties was raised specifically and better use of WebEOC product in the region. Will continue to work on EMOC concept.