PubMed

U.S. National Library of Medicine
National Institutes of Health

Filter your results: All (31)
Manage Filters

Display Settings: Abstract, 50 per page, Sorted by Recently Added

7 items were deleted from the Clipboard.

Clipboard: 31 Remove all items

1. Am J Public Health. 2009 Oct;99 Suppl 2:S365-71.

Pandemic influenza and community preparedness.

Marshall H, Ryan P, Roberton D, Street J, Watson M.

Paediatric Trials Unit, Women's and Children's Hospital, 72 King William Rd, North Adelaide, South Australia. helen.marshall@adelaide.edu.au

OBJECTIVES: We aimed to examine community knowledge about and attitudes toward the threat of pandemic influenza and assess the community acceptability of strategies to reduce its effect. METHODS: We conducted computer-aided telephone interviews in 2007 with a cross-sectional sample of rural and metropolitan residents of South Australia. RESULTS: Of 1975 households interviewed, half (50.2%) had never heard of pandemic influenza or were unaware of its meaning. Only 10% of respondents were extremely concerned about the threat of pandemic influenza. Respondents identified children as the highest priority for vaccination, if supplies were limited; they ranked politicians and teachers as the lowest priority. Although only 61.7% of respondents agreed with a policy of home isolation, 98.2% agreed if it was part of a national strategy. Respondents considered television to be the best means of educating the community. CONCLUSION: s. Community knowledge about pandemic influenza is poor despite widespread concern. Public education about pandemic influenza is essential if strategies to reduce the impact of the disease are to be effective.

PMID: 19797751 [PubMed - indexed for MEDLINE]

Remove from clipboard

Publication Types, MeSH Terms

2. Am J Public Health. 2009 Oct;99 Suppl 2:S287-93.

Pandemic influenza preparedness and response among public-housing residents, single-parent families, and low-income populations.

Bouye K, Truman BI, Hutchins S, Richard R, Brown C, Guillory JA, Rashid J.

Office of Minority Health and Health Disparities, Office of the Chief of Public Health Practice, Office of the Director, Centers for Disease Control and Prevention, 1600 Clifton Road, NE, Mail Stop E-67, Atlanta, GA 30333, USA. keh2@cdc.gov

During the early stages of an influenza pandemic, a pandemic vaccine likely will not be available. Therefore, interventions to mitigate pandemic influenza transmission in communities will be an important component of the response to a pandemic. Public-housing residents, single-parent families, and low-income populations may have difficulty complying with community-wide interventions. To enable compliance with community interventions, stakeholders recommended the following: (1) community mobilization and partnerships, (2) culturally specific emergency communications planning, (3) culturally specific education and training programs, (4) evidence-based measurement and evaluation efforts, (5) strategic planning policies, (6) inclusion of community members as partners, and (7) policy and program changes to minimize morbidity and mortality.

PMID: 19797740 [PubMed - indexed for MEDLINE]

Remove from clipboard

MeSH Terms

3. Am J Public Health. 2009 Oct;99 Suppl 2:S261-70.

Protection of racial/ethnic minority populations during an influenza pandemic.

Hutchins SS, Fiscella K, Levine RS, Ompad DC, McDonald M.

Office of Minority Health and Health Disparities, Office of the Chief of Public Health Practice, Office of the Director, Centers for Disease Control and Prevention, 1600 Clifton Rd, Mailstop E-67, Atlanta, GA 30333, USA. ssh1@cdc.gov

Racial/ethnic minority populations experience worse health outcomes than do other groups during and after disasters. Evidence for a differential impact from pandemic influenza includes both higher rates of underlying health conditions in minority populations, increasing their risk of influenza-related complications, and larger socioeconomic (e.g., access to health care), cultural, educational, and linguistic barriers to adoption of pandemic interventions. Implementation of pandemic interventions could be optimized by (1) culturally competent preparedness and response that address specific needs of racial/ethnic minority populations, (2) improvements in public health and community health safety net systems, (3) social policies that minimize economic burdens and improve compliance with isolation and quarantine, and (4) relevant, practical, and culturally and linguistically tailored communications.

PMID: 19797739 [PubMed - indexed for MEDLINE]

Publication Types, MeSH Terms, Substances

4. Public Health Rep. 2009 Mar-Apr;124(2):338-43.

Emergency preparedness for vulnerable populations: people with special health-care needs.

Nick GA, Savoia E, Elqura L, Crowther MS, Cohen B, Leary M, Wright T, Auerbach J, Koh HK.

Center for Public Health Preparedness, Division of Public Health Practice, Harvard School of Public Health, Boston, MA 02115, USA. gnick@hsph.harvard.edu

PMID: 19320378 [PubMed - indexed for MEDLINE]

Publication Types, MeSH Terms, Grant Support

5. Public Health Rep. 2009 Mar-Apr;124(2):295-303.

Resource allocation on the frontlines of public health preparedness and response: report of a summit on legal and ethical issues.

Barnett DJ, Taylor HA, Hodge JG Jr, Links JM.

Johns Hopkins Center for Public Health Preparedness, Department of Environmental Health Sciences, Johns Hopkins Bloomberg School of Public Health, 615 N. Wolfe St., Room E7035, Baltimore, MD 21208, USA. dbarnett@jhsph.edu

OBJECTIVES: In the face of all-hazards preparedness challenges, local and state health department personnel have to date lacked a discrete set of legally and ethically informed public health principles to guide the distribution of scarce resources in crisis settings. To help address this gap, we convened a Summit of academic and practice experts to develop a set of principles for legally and ethically sound public health resource triage decision-making in emergencies. METHODS: The invitation-only Summit, held in Washington, D.C., on June 29, 2006, assembled 20 experts from a combination of academic institutions and nonacademic leadership, policy, and practice settings. The Summit featured a tabletop exercise designed to highlight resource scarcity challenges in a public health infectious disease emergency. This exercise served as a springboard for Summit participants' subsequent identification of 10 public health emergency resource allocation principles through an iterative process. RESULTS: The final product of the Summit was a set of 10 principles to guide allocation decisions involving scarce resources in public health emergencies. The principles are grouped into three categories: obligations to community; balancing personal autonomy and community well-

being/benefit; and good preparedness practice. CONCLUSIONS: The 10 Summit-derived principles represent an attempt to link law, ethics, and real-world public health emergency resource allocation practices, and can serve as a useful starting framework to guide further systematic approaches and future research on addressing public health resource scarcity in an all-hazards context.

PMID: 19320372 [PubMed - indexed for MEDLINE]

Remove from clipboard

Publication Types, MeSH Terms, Grant Support

6. Ann Emerg Med. 2009 Apr;53(4):505-14. Epub 2009 Jan 10.

Houston's medical disaster response to Hurricane Katrina: part 1: the initial medical response from Trauma Service Area Q.

Hamilton DR, Gavagan TF, Smart KT, Upton LA, Havron DA, Weller NF, Shah UA, Fishkind A, Persse D, Shank P, Mattox K.

Department of Family and Community Medicine, Baylor College of Medicine, Houston, TX 77098, USA. douglash@bcm.tmo.edu

After Hurricane Katrina hit the Gulf Coast on August 29, 2005, thousands of ill and injured evacuees were transported to Houston, TX. Houston's regional disaster plan was quickly implemented, leading to the activation of the Regional Hospital Preparedness Council's Catastrophic Medical Operations Center and the rapid construction of a 65-examination-room medical facility within the Reliant Center. A plan for triage of arriving evacuees was quickly developed and the Astrodome/Reliant Center Complex mega-shelter was created. Herein, we discuss major elements of the regional disaster response, including regional coordination, triage and emergency medical service transfers into the region's medical centers, medical care in population shelters, and community health challenges.

PMID: 19135760 [PubMed - indexed for MEDLINE]

Remove from clipboard

MeSH Terms

7. Ann Emerg Med. 2009 Apr;53(4):515-27. Epub 2009 Jan 10.

Houston's medical disaster response to Hurricane Katrina: part 2: transitioning from emergency evacuee care to community health care.

Hamilton DR, Gavagan T, Smart K, Weller N, Upton LA, Havron DA, Fishkind A, Persse D, Shank P, Shah UA, Mattox K.

Baylor College of Medicine, Department of Family and Community Medicine, Houston, TX 77098, USA. douglash@bcm.tcm.edu

After Hurricane Katrina hit the Gulf Coast on August 29, 2005, thousands of ill and injured evacuees were transported to Houston, TX. Houston's regional disaster plan was quickly implemented, leading to the activation of the Regional Hospital Preparedness Council's Catastrophic Medical Operations Center and the rapid construction of a 65-examination-room medical facility within the Reliant Center. A plan for triage of arriving evacuees was quickly developed and the Astrodome/Reliant Center Complex mega-shelter was created. Herein, we discuss major elements of the regional disaster response, including regional coordination, triage and emergency medical service transfers into the region's medical centers, medical care in population shelters, and community health challenges.

PMID: 19135759 [PubMed - indexed for MEDLINE]

Remove from clipboard

MeSH Terms

8.

Pediatrics. 2008 Oct;122(4):895-901.

Disaster planning for schools.

Council on School Health.

Collaborators (18)

Community awareness of the school district's disaster plan will optimize a community's capacity to maintain the safety of its school-aged population in the event of a school-based or greater community crisis. This statement is intended to stimulate awareness of the disaster-preparedness process in schools as a part of a global, community-wide preparedness plan. Pediatricians, other health care professionals, first responders, public health officials, the media, school nurses, school staff, and parents all need to be unified in their efforts to support schools in the prevention of, preparedness for, response to, and recovery from a disaster.

PMID: 18829818 [PubMed - indexed for MEDLINE]

9.

Public Health Rep. 2008 Jul-Aug;123(4):441-9.

Regionalization in local public health systems: variation in rationale, implementation, and impact on public health preparedness.

Stoto MA.

Georgetown University School of Nursing & Health Studies, Washington, DC 20057-1107, USA. stotom@georgetown.edu

Comparative case studies found that regionalization originated from a crisis or perceived need for a coordinated response, a need to build local public health capacity, or an effort to use federal preparedness funds more efficiently. Regions vary in terms of their congruence with regional structures for partner agencies, such as emergency management agencies, as well as hospital and health services markets and organizational structure. Some focus on building formal organizational relationships to coordinate and sometimes standardize preparedness and response activities or build regional capacity, while others focus on building informal professional networks. Whatever the approach, strong leadership and trust are required for effective planning, emergency response, and sustainability. This article suggests that regionalization improves emergency preparedness by allowing for more efficient use of resources and better coordination and demonstrated progress in terms of planning and coordination; regional capacity-building, training, and exercises; and development of professional networks.

PMID: 18763406 [PubMed - indexed for MEDLINE]

10.

Am J Public Health. 2008 Jul;98(7):1288-93. Epub 2008 Jan 2.

Providing shelter to nursing home evacuees in disasters: lessons from Hurricane Katrina.

Laditka SB, Laditka JN, Xirasagar S, Cornman CB, Davis CB, Richter JV.

Department of Health Services Policy and Management, Arnold School of Public Health, University of South Carolina, 800 Sumter St, Columbia, SC 29208, USA. sladitka@gwm.sc.edu

OBJECTIVES: We examined nursing home preparedness needs by studying the experiences of nursing homes that sheltered evacuees from Hurricane Katrina. METHODS: Five weeks after Hurricane Katrina, and again 15 weeks later, we conducted interviews with administrators of 14 nursing homes that sheltered 458 evacuees in 4 states. Nine weeks after Katrina, we conducted site visits to 4 nursing homes and interviewed 4 administrators and 38 staff members. We used grounded theory analysis to identify major themes and thematic analysis to organize content. RESULTS: Although most sheltering facilities were well prepared for emergency triage and treatment, we identified some major

preparedness shortcomings. Nursing homes were not included in community planning or recognized as community health care resources. Supplies and medications were inadequate, and there was insufficient communication and information about evacuees provided by evacuating nursing homes to sheltering nursing homes. Residents and staff had notable mental health-related needs after 5 months, and maintaining adequate staffing was a challenge. CONCLUSIONS: Nursing homes should develop and practice procedures to shelter and provide long-term access to mental health services following a disaster. Nursing homes should be integrated into community disaster planning and be classified in an emergency priority category similar to hospitals.

PMID: 18172147 [PubMed - indexed for MEDLINE]

Remove from clipboard

Publication Types, MeSH Terms

11. Public Health Nurs. 2010 Jan-Feb;27(1):41-8.

Self-assessed emergency readiness and training needs of nurses in rural Texas.

Jacobson HE, Soto Mas F, Hsu CE, Turley JP, Miller J, Kim M.

University of Texas at El Paso, El Paso, Texas 79968-0531, USA. hejacobson@utep.edu

OBJECTIVE: Nurses, particularly public health nurses, play a key role in emergency preparedness and response in rural areas. To prepare rural jurisdictions for unforeseen disastrous events it is imperative to assess the public health emergency readiness and training needs of nurses. The objective of this study was to assess the self-reported terrorism preparedness and training needs of a nurse workforce. DESIGN AND SAMPLE: Cross-sectional prevalence of practicing nurses in regions of North Texas. 3,508 rural nurses practicing in North Texas participated in the study. MEASUREMENTS: Data were collected through a mailed survey; analyses included multinominal logistic regression and descriptive statistics. RESULTS: A total of 941 (27%) nurses completed the survey. The majority of respondents reported limited bioterrorism-related training. Fewer than 10% were confident in their ability to diagnose or treat bioterrorism-related conditions. Although only 30% expressed a willingness to collaborate with state and local authorities during a bioterrorism event, more than 69% indicated interest in future training opportunities. Preferred training modalities included small group workshops with instructor-led training, and Internet-based training. CONCLUSIONS: Licensing agencies, professional organizations, and community constituencies may need to play a stronger role in improving the bioterrorism-related emergency preparedness of rural nurses.

PMID: 20055967 [PubMed - in process]

Remove from clipboard

Publication Types

12. Telemed J E Health. 2009 Dec 31. [Epub ahead of print]

Telehealth Tools for Public Health, Emergency, or Disaster Preparedness and Response: A Summary Report.

Alverson DC, Edison K, Flournoy L, Korte B, Magruder C, Miller C.

1 Center for Telehealth and Cybermedicine Research, University of New Mexico Health Sciences Center , Albuquerque, New Mexico .

Abstract Rapid advances in telehealth development and adoption are increasing the spectrum of information and communication technologies that can be applied not only to individual patient care but more broadly to population health as well. Participants in this breakout session were asked to address, from their diverse perspectives, a series of questions relating to the current and potential uses of telehealth applications and networks for public health and emergency/disaster preparedness and response systems. Participants identified several gaps in current understanding and research emphasis. There is a clear need for more and larger outcome studies to assess the impact and cost benefit of telehealth applications in terms of improving public health at the population and community levels. In addition, more research is needed to demonstrate the ability of telehealth tools and technologies to facilitate and extend the reach of major national clinical and public health research initiatives. Perhaps most importantly, the National Institutes

of Health should develop and/or strengthen strategic partnerships with other funding agencies with overlapping or complementary interests to accelerate interdisciplinary research in this rapidly evolving but relatively understudied and complex field.

PMID: 20043703 [PubMed - as supplied by publisher]

Remove from clipboard

13. Am J Disaster Med. 2009 Sep-Oct;4(5):279-86.

Disaster preparedness: are retired physicians willing to help?

Shephard EM, Klein EJ, Koelemay KG, Thompson J.

Department of Pediatrics, University of Washington School of Medicine, Seattle, Washington, USA.

OBJECTIVE: To identify the proportion of retired physicians belonging to a state-wide professional association who would be willing to volunteer in the event of a disaster. METHODS: A paper-based, self-administered questionnaire sent to all physicians listed as retired members of the Washington State Medical Association (WSMA). The main questions included whether subjects would be willing to volunteer during a disaster, which tasks they would be most willing to perform, and whether they would be willing to participate in disaster preparedness training. RESULTS: A total of 2,443 surveys were mailed, 2,274 arrived at their destination (169 were undeliverable), and 1,447 were returned (response rate 64 percent). Fifty-four percent of respondents reported they would be willing to perform healthcare tasks during a disaster and 24 percent of respondents said they would possibly be willing to help. Tasks retired physicians were most willing to assist with included minor wound care (85 percent), vaccine administration (74 percent), and starting intravenous lines (71 percent). Fewer respondents indicated willingness to assist with community education (60 percent) or staffing ambulatory clinics (48 percent). Seventy-eight percent indicated they would attend disaster preparedness training. CONCLUSIONS: Healthcare facilities must be prepared to cope with staffing shortages in the event of a disaster and volunteers such as retired physicians could fill crucial roles in a medical response plan. The majority of retired physicians surveyed would be willing to participate. They would be most willing to perform well-defined tasks directly related to patient care. Most would be willing to participate in preparatory training.

PMID: 20014545 [PubMed - in process]

Remove from clipboard

Publication Types

14. Disaster Med Public Health Prep. 2009 Dec;3 Suppl 2:S172-5.

Implications of the Emergency Medical Treatment and Labor Act (EMTALA) during public health emergencies and on alternate sites of care.

Roszak AR, Jensen FR, Wild RE, Yeskey K, Handrigan MT.

US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, Senior Public Health Advisor, Emergency CareCoordination Center, Switzer Bldg Room 5217, 200 Independence Ave SW, Washington, DC 20201, USA. andrew.roszak@hhs.gov

Hospitals throughout the country are using innovative strategies to accommodate the surge of patients brought on by the novel H1N1 virus. One strategy has been to help decompress the amount of patients seeking care within emergency departments by using alternate sites of care, such as tents, parking lots, and community centers as triage, staging, and screening areas. As at any other time an individual presents on hospital property, hospitals and providers must be mindful of the requirements of the Emergency Medical Treatment and Labor Act. In this article we review the act and its implications during public health emergencies, with a particular focus on its implications on alternative sites of care.

PMID: 19952887 [PubMed - in process]

Remove from clipboard

15. Disasters. 2009 Oct 28. [Epub ahead of print]

Communication, neighbourhood belonging and household hurricane preparedness.

Kim YC, Kang J.

Assistant Professor, Department of Community and Behavioral Health, College of Public Health, University of Iowa, United States.

This paper reports on an examination of data on how local residents in Tuscaloosa, a mid-sized city in the state of Alabama, United States, responded to Hurricane Ivan of September 2004. The evaluation revealed that an integrated connection to community-level communication resources-comprising local media, community organisations and interpersonal networks-has a direct impact on the likelihood of engaging in pre-hurricane preparedness activities and an indirect effect on during-hurricane preparedness activities. Neighbourhood belonging mediated the relation between an integrated connection to community-level communication resources and during-hurricane preparedness activities. Neighbourhood belonging was determined to increase the likelihood of taking preparedness actions during Hurricane Ivan, but not prior to it. In addition, we discovered an interesting pattern for two different types of risk perceptions: social and personal risk perceptions. Social risk perceptions increase the likelihood of taking preventative steps before a hurricane while personal risk perceptions are positively related to engaging in preventative action during a hurricane.

PMID: 19878261 [PubMed - as supplied by publisher]

16. Health Phys. 2009 Nov;97(5 Suppl):S155-60.

Surge capacity volunteer perspectives on a field training exercise specifically designed to emphasize likely roles during a disaster response.

Emery RJ, Sprau DD, Morecook RC, Herbold J.

The University of Texas School of Public Health, Center for Biosecurity and Public Health Preparedness, Houston, 77030, USA. Robert.J.Emery@uth.tmc.edu

Experience gained from involvement in a number of emergency response activities since September 2001 in Texas indicated that the likely roles of statewide medical reserve corps units typically included aspects such as crowd control, registration and tracking, and information management. The need for training specifically focused on these likely roles became apparent. A novel field training exercise was developed that specifically focused on these likely roles. The exercise centered on a scenario involving the surreptitious placement of radioactivity in high traffic areas across the country, resulting in the contamination of large numbers of individuals. Because the source of the contamination was unknown, surge capacity contamination screening and data collection centers became necessary. Feedback collected from drill participants was measured to be overwhelmingly positive, with the vast majority of participants indicating a marked improvement in their understanding of their likely roles in a disaster of this type. The approach used in this training effort may be of use to other disaster surge capacity organizations as part of their strategic planning efforts as a means of ensuring that individuals involved in response activities possess familiarity with their likely roles during a wide scale public health disaster event.

PMID: 19820470 [PubMed - indexed for MEDLINE]

MeSH Terms

17. Disaster Med Public Health Prep. 2009 Jun;3(2 Suppl):S68-73.

Major influences on hospital emergency management and disaster preparedness.

Sauer LM, McCarthy ML, Knebel A, Brewster P.

Department of Emergency Medicine, Johns Hopkins University School of Medicine, Baltimore, MD 21209, USA. Lsauer2@jhmi.edu

The role of hospitals in the community response to disasters has received increased attention, particularly since the terrorist attacks of September 11, 2001. Hospitals must be prepared to respond to and recover from all-hazards

emergencies and disasters. There have been several initiatives to guide hospitals' role in these events and to assist hospitals in their effort to prepare for them. This article focuses on the efforts of 4 distinct groups: The Joint Commission (TJC), the executive branch of the US government, the US Congress, and the Department of Health and Human Services (DHHS). Despite the different approach each group uses to assist hospitals to improve their emergency management capabilities, the initiatives reinforce one another and have resulted in increased efforts by hospitals to improve their disaster preparedness and response capabilities and community integration. The continued progress of our medical response system in all-hazard emergencies and disasters depends in large part on the future guidance and support of these 4 key institutions.

PMID: 19491590 [PubMed - indexed for MEDLINE]

MeSH Terms

18. Influenza Other Respi Viruses. 2009 Mar;3(2):75-9.

Managing public health crises: the role of models in pandemic preparedness.

Moghadas SM, Pizzi NJ, Wu J, Yan P.

Institute for Biodiagnostics, National Research Council Canada, Manitoba, Canada. seyed.moghadas@nrc-cnrc.gc.ca

BACKGROUND: Given the enormity of challenges involved in pandemic preparedness, design and implementation of effective and cost-effective public health policies is a major task that requires an integrated approach through engagement of scientific, administrative, and political communities across disciplines. There is ample evidence to suggest that modeling may be a viable approach to accomplish this task. METHODS: To demonstrate the importance of synergism between modelers, public health experts, and policymakers, the University of Winnipeg organized an interdisciplinary workshop on the role of models in pandemic preparedness in September 2008. The workshop provided an excellent opportunity to present outcomes of recent scientific investigations that thoroughly evaluate the merits of preventive, therapeutic, and social distancing mechanisms, where community structures, priority groups, healthcare providers, and responders to emergency situations are given specific consideration. RESULTS: This interactive workshop was clearly successful in strengthening ties between various disciplines and creating venues for modelers to effectively communicate with policymakers. The importance of modeling in pandemic planning was highlighted, and key parameters that affect policy decision-making were identified. Core assumptions and important activities in Canadian pandemic plans at the provincial and national levels were also discussed. CONCLUSIONS: There will be little time for thoughtful and rapid reflection once an influenza pandemic strikes, and therefore preparedness is an unavoidable priority. Modeling and simulations are key resources in pandemic planning to map out interdependencies and support complex decision-making. Models are most effective in formulating strategies for managing public health crises when there are synergies between modelers, planners, and policymakers.

PMID: 19496845 [PubMed - indexed for MEDLINE]

Publication Types, MeSH Terms

19. Disaster Med Public Health Prep. 2009 Mar;3(1):33-41.

Variations in disaster preparedness by mental health, perceived general health, and disability status.

Eisenman DP, Zhou Q, Ong M, Asch S, Glik D, Long A.

Division of General Internal Medicine and Health Services Research, Department of Medicine, David Geffen School of Medicine, University of California, Los Angeles, CA 90095-1736, USA. deisenman@mednet.ucla.edu

OBJECTIVES: Chronic medical and mental illness and disability increase vulnerability to disasters. National efforts have focused on preparing people with disabilities, and studies find them to be increasingly prepared, but less is known about people with chronic mental and medical illnesses. We examined the relation between health status (mental health, perceived general health, and disability) and disaster preparedness (home disaster supplies and family communication plan). METHODS: A random-digit-dial telephone survey of the Los Angeles County population was conducted October 2004 to January 2005 in 6 languages. Separate multivariate regressions modeled determinants of disaster preparedness, adjusting for sociodemographic covariates then sociodemographic variables and health status variables. RESULTS: Only 40.7% of people who rated their health as fair/poor have disaster supplies compared with

53.1% of those who rate their health as excellent (P < 0.001). Only 34.8% of people who rated their health as fair/poor have an emergency plan compared with 44.8% of those who rate their health as excellent (P < 0.01). Only 29.5% of people who have a serious mental illness have disaster supplies compared with 49.2% of those who do not have a serious mental illness (P < 0.001). People with fair/poor health remained less likely to have disaster supplies (adjusted odds ratio [AOR] 0.69, 95% confidence interval [CI] 0.50-0.96) and less likely to have an emergency plan (AOR 0.68, 95% CI 0.51-0.92) compared with those who rate their health as excellent, after adjusting for the sociodemographic covariates. People with serious mental illness remained less likely to have disaster supplies after adjusting for the sociodemographic covariates (AOR 0.67, 95% CI 0.48-0.93). Disability status was not associated with lower rates of disaster supplies or emergency communication plans in bivariate or multivariate analyses. Finally, adjusting for the sociodemographic and other health variables, people with fair/poor health remained less likely to have an emergency plan (AOR 0.66, 95% CI 0.48-0.92) and people with serious mental illness remained less likely to have disaster supplies (AOR 0.67, 95% CI 0.47-0.95). CONCLUSIONS: People who report fair/poor general health and probable serious mental illness are less likely to report household disaster preparedness and an emergency communication plan. Our results could add to our understanding of why people with preexisting health problems suffer disproportionately from disasters. Public health may consider collaborating with community partners and health services providers to improve preparedness among people with chronic illness and people who are mentally ill.

PMID: 19293742 [PubMed - indexed for MEDLINE]

Remove from clipboard

Publication Types, MeSH Terms, Grant Support

20. J Public Health Manag Pract. 2009 Mar;15(2 Suppl):S13-9.

South Carolina Area Health Education Consortium Disaster Preparedness and Response Training Network: an emerging partner in preparedness training.

Kennedy B, Carson DS, Garr D.

South Carolina Area Health Education Consortium, Charleston, SC, USA.

The South Carolina Area Health Education Consortium (SC AHEC) was funded in 2003 to train healthcare professionals in disaster preparedness and response. During the 5 years of funding, its Disaster Preparedness and Response Training Network evolved from disaster awareness training to competency-based instruction and performance assessment. With funding from the assistant secretary for preparedness and response (ASPR), a project with implications for national dissemination was developed to evaluate 2 aspects of preparedness training for community-based healthcare professionals. The SC AHEC designed disaster preparedness curricula and lesson plans, using a consensus-building technique, and then (1) distributed sample curricula and resources through the national Area Health Education Center system to assess an approach for providing preparedness training and (2) delivered a standardized preparedness curriculum to key influential thought leaders from 4 states to evaluate the effectiveness and acceptability of the curriculum. As a result of this project, the SC AHEC recommends that preparedness training for community-based practitioners needs to be concise and professionally relevant. It should be integrated into existing healthcare professions education programs and continuing education offerings. The project also demonstrated that although AHECs may be interested and well suited to incorporate preparedness training as part of their mission, more work needs to be done if they are to assume a prominent role in disaster preparedness training.

PMID: 19202395 [PubMed - indexed for MEDLINE]

Remove from clipboard

MeSH Terms

21. J Public Health Manag Pract. 2009 Mar;15(2 Suppl):S1-2.

Emergency preparedness continuing education for community-based providers: the National Training Strategy.

Ablah E.

PMID: 19202394 [PubMed - indexed for MEDLINE]

Remove from clipboard

Wolters Kluwer | Lippincott Williams & Wilkins

Publication Types, MeSH Terms

22. Prehosp Disaster Med. 2008 Sep-Oct;23(5):385-90.

Fostering disaster resilient communities across the globe through the incorporation of safe and resilient hospitals for community-integrated disaster responses.

Albanese J, Birnbaum M, Cannon C, Cappiello J, Chapman E, Paturas J, Smith S.

Yale New Haven Center for Emergency Preparedness and Disaster Response, New Haven, Connecticut, USA.

The impact of catastrophic events on hospitals and communities is huge and continues to hinder progress in developing nations and industrialized countries alike. Over the last 10 years, the UN/ISDR has sponsored a series of global conferences to increase awareness of the importance of risk and vulnerability reduction and the need to build disaster resilient communities. In recognition that hospitals contribute to the health and resiliency of a community, ISDR has adopted the PAHO and WHO "Safe and Resilient Hospital" initiative. The primary focus of the initiative is to ensure the physical and functional integrity of hospitals during a disaster. Hospital resiliency also must encompass the ability to fully integrate hospital facilities and their services into an overall community response to prevent hospitals from becoming isolated from other responding organizations. In order to help promote the "safe and resilient hospital" initiative, during the 15WCDEM, three strategic objectives were identified for hospitals that meet SEARO Benchmark #5. These are: (1) establish tiers of standards (criteria) that define "safe and resilient" hospitals in diverse regions of the world; (2) develop a tool to assess the extent to which hospitals, meet the criteria for "safe and resilient" hospitals; and (3) apply the evidence derived from use of this tool to promote the concept of "safe and resilient" hospitals as an integral part of emergency preparedness, responses, and recovery, and maximize the political commitment from decision-makers within and outside the healthcare sector to support, protect, and integrate the initiative into a community-wide disaster response. Ultimately, attaining these objectives will protect the lives of patients and healthcare workers, ensure that hospitals are able to provide urgently needed and everyday medical care to the community they serve and minimize risk and vulnerabilities of patients, healthcare workers and other individuals within the community.

PMID: 19189606 [PubMed - indexed for MEDLINE]

Remove from clipboard

MeSH Terms

23. Health Promot Pract. 2008 Dec 30. [Epub ahead of print]

Promoting Community Preparedness: Lessons Learned From the Implementation of a Chemical Disaster Tabletop Exercise.

High EH, Lovelace KA, Gansneder BM, Strack RW, Callahan B, Benson P.

Health educators are frequently called on to facilitate community preparedness planning. One planning tool is community-wide tabletop exercises. Tabletop exercises can improve the preparedness of public health system agencies to address disaster by bringing together individuals representing organizations with different roles and perspectives in specific disasters. Thus, they have the opportunity to identify each other's roles, capabilities, and limitations and to problem-solve about how to address the gaps and overlaps in a low-threat collaborative setting. In 2005, the North Carolina Office of Public Health Preparedness and Response developed a series of exercises to test the preparedness for chemical disasters in a metropolitan region in the southeastern United States. A tabletop exercise allowed agency heads to meet in an environment promoting inter- and intraagency public-private coordination and cooperation. The evaluation results reported here suggest ways in which any tabletop exercise can be enhanced through recruitment, planning, and implementation.

PMID: 19116424 [PubMed - as supplied by publisher]

Remove from clipboard

View Full-Text Article at SAGE Publications

24. J Am Med Dir Assoc. 2008 Oct;9(8):599-604. Epub 2008 Sep 7.

The controversy inherent in managing frail nursing home residents during complex hurricane emergencies.

Dosa DM, Hyer K, Brown LM, Artenstein AW, Polivka-West L, Mor V.

Veteran's Administration Hospital, Providence, RI, USA. David_Dosa@brown.edu

Emergency planning for vulnerable populations constitutes a major element of community disaster preparedness and is an area in which guidance is particularly sparse. As evidenced by the well-publicized deaths of nursing home residents following Hurricanes Katrina and Rita, the need to improve nursing home emergency preparedness is self-evident. Nevertheless, as efforts to improve preparedness develop, a central controversy remains. Aside from mandatory complete evacuations, is it better to evacuate or not to evacuate frail elderly nursing home residents in the setting of hurricane emergencies? This paper reviews the historical evidence on both sides of the argument and suggests a policy and research agenda.

PMID: 19083295 [PubMed - indexed for MEDLINE]

25. Disaster Med Public Health Prep. 2008 Dec;2(4):251-7.

Community planning for pandemic influenza: lessons from the VA health care system.

Lurie N, Dausey DJ, Knighton T, Moore M, Zakowski S, Deyton L.

RAND Corporation, Arlington, VA 22202, USA. lurie@rand.org

BACKGROUND: Coordination and communication among community partners-including health departments, emergency management agencies, and hospitals-are essential for effective pandemic influenza planning and response. As the nation's largest integrated health care system, the US Department of Veterans Affairs (VA) could be a key component of community planning. PURPOSE: To identify issues relevant to VA-community pandemic influenza preparedness. METHODS: As part of a VA-community planning process, we developed and pilot-tested a series of tabletop exercises for use throughout the VA system. These included exercises for facilities, regions (Veterans Integrated Service Networks), and the VA Central Office. In each, VA and community participants, including representatives from local health care facilities and public health agencies, were presented with a 3-step scenario about an unfolding pandemic and were required to discuss issues and make decisions about how the situation would be handled. We report the lessons learned from these pilot tests. RESULTS: Existing communication and coordination for pandemic influenza between VA health care system representatives and local and regional emergency planners are limited. Areas identified that would benefit from better collaborative planning include response coordination, resource sharing, uneven resource distribution, surge capacity, standards of care, workforce policies, and communication with the public. CONCLUSIONS: The VA health system and communities throughout the United States have limited understanding of one another's plans and needs in the event of a pandemic. Proactive joint VA-community planning and coordination-including exercises, followed by deliberate actions to address the issues that arise-will likely improve pandemic influenza preparedness and will be mutually beneficial. Most of the issues identified are not unique to VA, but are applicable to all integrated care systems.

PMID: 18824920 [PubMed - indexed for MEDLINE]

26. J Gerontol Nurs. 2008 Aug;34(8):9-16.

Surviving the storms: Emergency preparedness in Texas nursing facilities and assisted living facilities.

Castro C, Persson D, Bergstrom N, Cron S.

Center on Aging, School of Nursing, The University of Texas Health Science Center at Houston, SON-628, 6901 Bertner Avenue, Houston, TX 77030, USA. Carmen.Castro@uth.tmc.edu

This study assesses the preparedness of long-term care facilities in Texas responding to Hurricanes Katrina and Rita. A 41-item questionnaire was mailed to facilities; the response rate was 42%. Among responding facilities, 4513 residents were evacuated, and 6% of respondents reported resident death. Financial losses were reported by 8% of nursing facilities and 45% of assisted living facilities due to transportation and staff overtime. Respondents indicated the need for improved disaster preparednesstraining, better coordination, and transportation. Changes in policy and practice will lead to better trained staff who will provide the care residents need for improved health outcomes during future public health disasters.

PMID: 18714601 [PubMed - indexed for MEDLINE]

Remove from clipboard

Publication Types, MeSH Terms

27. BMC Res Notes. 2008 Mar 7;1:6.

Risk-communication capability for public health emergencies varies by community diversity.

Savoia E, Stoto MA, Biddinger PD, Campbell P, Viswanath K, Koh H.

Center for Public Health Preparedness, Division of Public Health Practice, Harvard School of Public Health, 677 Huntington Avenue, Boston, MA 02115, USA. esavoia@hsph.harvard.edu

BACKGROUND: Public health emergencies heighten several challenges in risk-communication: providing trustworthy sources of information, reaching marginalized populations, and minimizing fear and public confusion. In emergencies, however, information may not diffuse equally among all social groups, and gaps in knowledge may increase. Such knowledge gaps vary by social structure and the size, socioeconomic status, and diversity of the population. This study explores the relationship between risk-communication capabilities, as perceived by public officials participating in emergency tabletop exercises, and community size and diversity. FINDINGS: For each of the three communication functions tested, risk-communication capabilities are perceived to be greater in communities with fewer then 10% of the population speaking a language other than English at home, decreasing as the percentage grows to 20% (ANOVA P </= 0.02). With respect to community size, however, we found an N-shaped relationship between perceived risk communication capabilities and population size. Capabilities are perceived highest in the largest communities and lowest in the smallest, but lower in communities with 20,000-49,999 inhabitants compared to those with 2,500-19,999. CONCLUSION: The results of this study suggest the need to factor population diversity into risk communication plans and the need for improved state or regional risk-communication capabilities, especially for communities with limited local capacity.

PMCID: PMC2518279

PMID: 18710541 [PubMed - in process]

Free article Remove from clipboard

28. J Public Health Manag Pract. 2008 Sep-Oct;14(5):E15-22.

Assessing regional public health preparedness: a new tool for considering cross-border issues.

Jones M, O'Carroll P, Thompson J, D'Ambrosio L.

Center for Community Health and Evaluation, Group Health Center for Health Studies, Seattle, Washington 98101, USA. jones.margaret@ghc.org

OBJECTIVE: To provide regional, state, and local public health officials a conceptual framework and checklist for assessing regional public health emergency preparedness, specifically in regard to cross-border public health preparedness needs. METHODS: The project had four phases that are as follows: defining the scope, conducting a literature review, soliciting expert opinion, and creating the assessment framework and checklist. A conceptual framework was developed to define the scope of the project on the basis of the kinds of resources likely to be shared across borders in a public health response (eg, data, supplies, staff), in support of the public health functions likely to be important in a health emergency (eg, epidemiology, laboratory). A literature review was then conducted to identify key articles and tools addressing regional preparedness. Key informant interviews (n = 23) were conducted with public health and emergency management professionals in the Pacific Northwest to identify a set of systems, agreements, and protocols that should be systematically considered in assessing regional public health preparedness. Using the literature review and themes from interviews, a checklist was developed. RESULTS: A checklist was developed for use

by public health leaders, which recommends 24 specific agreements, protocols, systems, and management structures that should be considered to foster cross-border public health preparedness. CONCLUSIONS: Regional public health preparedness represents not only the sum of state-level preparedness of the states in a region but also the capacity of those states to collaborate across state and international borders during a public health emergency. This checklist provides a tool to systematically consider cross-border preparedness issues.

PMID: 18708880 [PubMed - indexed for MEDLINE]

Remove from clipboard

MeSH Terms

29. J Rural Health. 2008 Summer;24(3):321-5.

Promoting regional disaster preparedness among rural hospitals.

Edwards JC, Kang J, Silenas R.

Rural and Community Health Institute, Department of Humanities in Medicine, Texas A&M University, Bryan, Texas 77802, USA. EDWARDS@tamhsc.edu

CONTEXT AND PURPOSE: Rural communities face substantial risks of natural disasters but rural hospitals face multiple obstacles to preparedness. The objective was to create and implement a simple and effective training and planning exercise to assist individual rural hospitals to improve disaster preparedness, as well as to enhance regional collaboration among these hospitals. METHODS: The exercise was offered to rural hospitals enrolled with the Rural and Community Health Institute of the Texas A&M University System Health Science Center, and 17 participated. A 3-hour tabletop exercise emphasizing regional issues in a pandemic avian influenza scenario followed by a 1-hour debriefing was implemented in 3 geographic clusters of hospitals. Trained emergency preparedness evaluators documented observations of the exercise on a standard form. Participants were debriefed after the exercise and provided written feedback. RESULTS: Observations included having insufficient staff for incident command, facility constraints, the need to further develop regional cooperation, and operational and ethical challenges in a pandemic. CONCLUSIONS: The tabletop exercise gave evidence of being a simple and acceptable tool for rural medical planners. It lends itself well to improving medical preparedness, analysis of weak spots, development of regional teamwork, and rapid response.

PMID: 18643812 [PubMed - indexed for MEDLINE]

Remove from clipboard

Publication Types, MeSH Terms, Grant Support

30. Prehosp Disaster Med. 2008 Mar-Apr;23(2):103-12.

Ability of regional hospitals to meet projected avian flu pandemic surge capacity requirements.

Ten Eyck RP.

Center for Global Health Systems, Management, and Policy, Department of Community Medicine, Wright State University Boonshoft School of Medicine, Kettering, Ohio 45420, USA. Raymond.Teneyck@wright.edu

INTRODUCTION: Hospital surge capacity is a crucial part of community disaster preparedness planning, which focuses on the requirements for additional beds, equipment, personnel, and special capabilities. The scope and urgency of these requirements must be balanced with a practical approach addressing cost and space concerns. Renewed concerns for infectious disease threats, particularly from a potential avian flu pandemic perspective, have emphasized the need to be prepared for a prolonged surge that could last six to eight weeks. NULL HYPOTHESIS: The surge capacity that realistically would be generated by the cumulative Greater Dayton Area Hospital Association (GDAHA) plan is sufficient to meet the demands of an avian influenza pandemic as predicted by the [US] Centers for Disease Control and Prevention (CDC) models. METHODS: Using a standardized data form, surge response plans for each hospital in the GDAHA were assessed. The cumulative results were compared to the demand projected for an avian influenza pandemic using the CDC's FluAid and FluSurge models. RESULTS: The cumulative GDAHA capacity is sufficient to meet the projected demand for bed space, intensive care unit beds, ventilators, morgue space, and initial

personal protective equipment (PPE) use. There is a shortage of negative pressure rooms, some basic equipment, and neuraminidase inhibitors. Many facilities lack a complete set of written surge policies, including screening plans to segregate contaminated patients and staff prior to entering the hospital. Few hospitals have agreements with nursing homes or home healthcare agencies to provide care for patients discharged in order to clear surge beds. If some of the assumptions in the CDC's models are changed to match the morbidity and mortality rates reported from the 1918 pandemic, the surge capacity of GDAHA facilities would not meet the projected demand. CONCLUSIONS: The GDAHA hospitals should test their regional distributors' ability to resupply PPE for multiple facilities simultaneously. Facilities should retrofit current air exchange systems to increase the number of potential negative pressure rooms and include such designs in all future construction. Neuraminidase inhibitor supplies should be increased to provide treatment for healthcare workers exposed in the course of their duties. Each hospital should have a complete set of policies to address the special considerations for a prolonged surge. Additional capacity is required to meet the predicted demands of a threat similar to the 1918 pandemic.

PMID: 18557289 [PubMed - indexed for MEDLINE]

MeSH Terms

31. J Community Health. 2008 Aug;33(4):241-7.

Community health centers and emergency preparedness: an assessment of competencies and training needs.

Ablah E, Tinius AM, Horn L, Williams C, Gebbie KM.

Department of Preventive Medicine and Public Health, University of Kansas School of Medicine-Wichita, 1010 N. Kansas, Wichita, KS 67214, USA. eablah@kumc.edu

Community health centers (CHCs) provide care to a large number of medically underserved Americans. As primary care providers and trusted members of their communities, CHCs need to be prepared to respond to emergency and disaster situations, as they may be relied upon for medical care and other support services. Focus groups were conducted with CHC medical directors and administrators from New York City. Participants discussed previous emergency preparedness training, future training needs, applicability of competencies, and usefulness of two training programs. Participants indicated that they had more experience with preparedness training than many of their colleagues, although participants still reported further training needs. In particular, emergency roles and responsibilities, decontamination and containment, and personal preparedness were given as needed training topics for staff. The training resources were reported to be useful and beneficial. Participants also reported that most of the competencies were appropriate for CHC clinicians. During an emergency, people want to receive care from their normal provider, and for many, that provider is a CHC. This and other research suggests that the emergency preparedness needs facing CHCs are significant and should be addressed.

PMID: 18379863 [PubMed - indexed for MEDLINE]

MeSH Terms