

Mass Casualty Preparation

The Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) are looking for ideas, advice, and input on possible low- or no-cost steps that could be taken to use private payer incentives, market forces, changes in CMS and other legal and regulatory requirements, current grant programs, and other means to provide incentives or remove barriers to enhance private sector health care facility preparedness for large scale disasters that may create mass casualties.

A mass casualty disaster is an event that generates many more patients at one time than locally or regionally available resources can manage using routine emergency procedures. It requires exceptional emergency arrangements and additional or extraordinary assistance. It can also be defined as any event resulting in a number of victims large enough to disrupt the normal course of both emergency and routine health care services. For purposes of our inquiry, it may be useful to think of a mass casualty disaster as one that generates a large number of deaths at its epicenter (or at many epicenters), and a large number of persons, both harmed and unharmed, who flee the epicenter(s).

For example, the disaster might be caused by a massive levee failure, a “dirty bomb,” an influenza pandemic, a biological warfare attack, or a massive earthquake. The resulting effects on the health care sector could include the need to triage patients, to treat persons in numbers far exceeding normal routine or emergency care capabilities, to provide health care in innovative ways, to deal with secondary waves of casualties (e.g., from destruction or abandonment of clean water sources and sewage treatment), and to deal with situations in which normal law and order functions are also overwhelmed.

This inquiry is aimed at facility-based or agency providers and suppliers of health care services, and the health care professionals who work at those entities, including but not limited to hospitals (including critical access hospitals), emergency medical services, nursing facilities, health care clinics, hospices, home health agencies, end-stage renal disease facilities, ambulatory surgical care facilities, and pharmacies. It is also aimed at health plans and state or local health agencies that, while not operating “facilities” as such, provide coordination or direction to health care facilities and agencies.

While the particular cause of a mass casualty will lead to different health care treatment problems and options in clinical dimensions, there are many commonalities likely to exist across potential scenarios. These include destruction of health care facilities at or near the epicenter, large numbers of potential patients from the primary cause fleeing the epicenter, large numbers of patients suffering from secondary causes (accidents, crime, breakdown of sanitation, exhaustion of food supplies, etc.) fleeing the epicenter, early exhaustion of stocks of medical supplies and drugs, breakdown of law and order, and other extreme disruptions. As an example, such an event would likely lead to large numbers of otherwise healthy persons exhausting their supply of life- or health-sustaining prescription medicines.

Such an event would likely require major changes in the operation of those health care facilities that remain able to function.

Our inquiry includes the following issues:

1. What steps can and should be planned or undertaken now by health care facilities, at own expense and self-interest, in anticipation of low-probability but potentially high casualty emergency events?.
2. What budget neutral steps are necessary or desirable by HHS and CMS to improve private sector healthcare facility preparation for such events?
3. What other financial or non-financial incentives might be created, or barriers removed, or legislative changes enacted, that would facilitate emergency preparedness and response?
4. What existing US government grant programs might usefully be targeted and modified, in part, to assist health care facilities, through state and local health officials/departments, to improve preparedness for these mass casualty events?
5. Are there innovative economic ideas, not considered, that could be proposed from individuals on the call that would improve private healthcare facility emergency preparedness, while NOT increasing health care costs?