CSOC: Indicators & Triggers
A coordinated response across the continuum of healthcare that meets the health and medical needs of the community during an emergency

NWHRN Vision
Background

- Formally organized in 2005
- Merged with another Coalition in 2012
- Governed by an Executive Council
- Voluntary participation
- Sponsorship program exists
- Moving towards a non-profit model
- Over 300 “participants”
Executive Council

Building Capabilities through Planning, Training, and Exercise

Committees/Workgroups
- Disaster Clinical Advisory Committee
- Hospital Committee
- Pediatric Workgroups

Annual Meetings
- Ambulatory Care
- In-Home Services
- Long-Term Care
- Behavioral Health

King County Trainings, Exercises, Workgroups and Projects

Pierce County Trainings, Exercises, Workgroups and Projects

Healthcare Organizations

Law Enforcement

Emergency Management

Public Health

Fire/EM

Community Organizations

Critical Infrastructure

Private Sector

Elected Officials
Disaster Clinical Advisory Committee

**DCAC Snapshot**
- 37 members
- 22 organizations
- 30 DCAC roles

**Example Roles**
- Ambulatory Care MD
- Clinical Operations Nurse
- Emergency Medicine MD
- Infection Control Specialist
- Mental Health Clinician
- Pediatrician

- **Response role** advising HMAC
- **Preparedness role** informing plans, starting with regional medical surge guidelines

- Develop based on input from 2011 Crisis Standards of Care Workshop and IOM
Situation Awareness Strategy

**Input**
- Surveys
- Case reports/syndromic surveillance
- Conference Calls
- Chat rooms
- Bed availability/status updates
- Public inquiries (contact center)
- Social Media

**Output**
- Healthcare Impact Reports
- Situation Reports
- Conference Calls
- Public messaging
Example Data Collection Elements

- Bed availability and boarders (e.g. ICU, acute care)
- # of visits or admits (disaster or disease related)
- Call volumes and info topics of concern (includes EMS)
- Staff absenteeism
- Resource shortages (e.g. PPE, pharmaceuticals, blood) & whether vendors are limiting supplies
- Types of surge strategies implemented
- Mental health triage #s (forthcoming)
Strengths

- Executive level engagement structure
- Clinical engagement structure
- Dedicated staff (8-10)
- Productive preparedness structure
- Strong relationship with local health departments
- Situational Awareness – evolving!
- WATrac
Challenges

- Lack of State Leadership – no strategy
- Cumbersome data collection
- Poor analytical models
- Lack of real experience
- Competing priorities
- Reliant on national expertise
How To....

• best translate the value to orgs on data collection?
• pare down to essential indicators to feed decision making?
• communicate 3C’s status when resource levels may vary?
• create efficient facility monitoring once crisis state is implemented