as we move forward in strengthening our response capabilities. These programs are sponsored by the HHS's Office of the Assistant Secretary for Preparedness and Response (ASPR), which provides Federal guidance and policy direction; the Agency for Healthcare Research and Quality (AHRQ), conducting research and evidence-based guidance for the US healthcare system; the leadership of the Office of the US Surgeon General (OSG) in supporting and encouraging volunteer medical and public health response teams to augment local healthcare; and US Department of Homeland Security (DHS) training for healthcare staff, leaders, and executives offered at its federal training facilities. This presentation also will summarize public health and medical preparedness synchronization in current and future Federal planning and funding initiatives. The most recent findings relating to integration of hospital and public health preparedness activities, in light of the recent H1N1 outbreak, also will be addressed. This critical update presents current efforts at the US national, state, and local level for hospital and healthcare preparedness activities and how these issues affect each healthcare leader.

Keywords: disaster; funding; government; health care; preparedness
Prehosp Disaster Med

Disaster Preparedness in America

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Introduction: After 11 September 2001, the threat of further attacks on America soil stimulated the recognition of the need for improved preparedness. Since that time, >100 organizations, Federal and private, were created to produce guidelines for disaster planning and response. About eight billion dollars have been spent in preparing the nation for disasters caused by manmade or natural hazards.
Objective: The goal of this study is to identify the most important lessons learned related to disasters preparedness over the past eight years.
Methods: This study consisted of a systematic literature and Internet review.
Results: The medical responses to the Minneapolis bridge collapse and to Hurricane Gustav showed improved population evacuation, prehospital response, and hospital deployment. Nevertheless, many areas are still of concern and require immediate attention. Hospital funding has decreased, there is no unified and standard approach for surge capacity planning, there are no standard hospitals plans to manage sudden mass-casualty events, and there is a lack of realistic drills at the prehospital- and hospital-level. In May 2008, a survey was presented to the US House of Representatives named "Hospital Emergency Surge Capacity: Not Ready for the Predictable Surprise". It concluded that neither the hospitals nor the trauma centers at seven major US cities would have been able to manage the number of victims during an incident similar in magnitude to the train bombing in Madrid.
Conclusions: After eight years of planning and preparedness and eight billion dollars in spending, there still are major gaps in disaster preparedness in America.

Keywords: guidelines; preparedness; response; standards; United States
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Control of Patient Flow during Wartime

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Introduction: Overcrowding of emergency departments (EDs) and increased patient volumes affect the ability to provide quality care. Optimization of patient flow can alleviate such overcrowding. During the 2nd Lebanon War, the MOH issued a directive ordering patients to go to specific EDs in a large metropolitan area. Admissions to all general hospitals were classified as: (1) medical; (2) childbirth; (3) civilian trauma; and (4) war-related trauma.
Objectives: To analyze the impact of the Ministry of Health (MOH) decision to control the patient flow to EDs during the 2nd Lebanon War.
Methods: Classified admissions to the various EDs during the 2nd Lebanon War were evaluated daily and graphs were created to help identify trends and determine the need for further intervention.
Results: Significant differences were found between the following ED admissions, before and after the notification: medical admissions in all hospitals; non-war trauma admissions, in all hospitals; births in one hospital; and war casualties admissions in one hospital.
Conclusions: It is possible to impact on the flow of patients to EDs and rationalize the use of resources, in order to direct patients to the ED best able to care for them. While this paper dealt with the patient flow during a period of armed conflict, the findings may be relevant to other situations in which control of patient flow in deemed necessary. Direct communication with the public is recommended in order to minimize delay between the issuance of a directive and its effective implementation.

Keywords: emergency department; hospital; patient flow; resources; war-time
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Who Responds to Emergency Preparedness Messages: The Story of Lions, Lambs, and Lone Wolves

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Despite a considerable investment of US federal funds directed at increasing individual preparedness since the 2001 terrorist attacks, overall population preparedness barely has increased. In trended US survey data collected between 2003 and 2008, the National Center for Disaster Preparedness (NCDP) has found that the proportion of