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3. Risk Management And Insurance, Partners HealthCare, Somerville/MA/United States of America
4. Emergency Preparedness, Partners HealthCare System, Boston/MA/United States of America

Study/Objective: We designed a climate risk-assessment project that demonstrates value to leadership and expert stakeholders, and ultimately creates understanding of climate threats facing our health system, in order to implement effective interventions.
Background: Climate change is influencing weather intensity and patterns creating new, increased threats for health care facilities. Historical data are no longer sufficient in determining risk, as evidenced by the 2016 Louisiana floods where one-third of flooding occurred outside of the 100-year flood zones. Health care organizations must consider the surrounding built environment and community networks, which could influence the impact of an extreme-weather event upon their operations. Conducting the detailed, forward-looking analysis required to make informed decisions requires broad leadership and subject matter, expert collaboration internal and external to the organization.
Methods: A multidisciplinary project team was formed comprised of senior leaders in real-estate, emergency preparedness, risk management, insurance, and external climate experts. Together, these representatives could address structural, operational and fiscal challenges and opportunities related to climate threats based in science. Three data collection tools were chosen: (1) detailed, multi-scenario climate modeling; (2) completion of a climate-resilient health care facilities checklist; and (3) stakeholder meetings with insurers, public utilities, and public transportation agencies to understand external vulnerabilities and opportunities. Finally, analysis was conducted with near and long-term horizons, allowing two-points of intervention: operational changes in the near-term, and facility construction changes addressing long-term threats.
Results: Phase I of the project was completed for 30 sites across the health system. Results were shared with key leaders at the enterprise and institution level. Key findings include a system-wide threat from extreme heat events and vulnerabilities to critical infrastructure which may place an indirect burden on our facilities.
Conclusion: Building climate resiliency requires a multi-disciplinary approach. Assessed at multiple time horizons, facilities upgrades, operational enhancements, and improved coordination with interdependent agencies and institutions can occur.

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A Proposed Disaster Casualty Classification Framework

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Study/Objective: To design a disaster-casualty classification framework.
Background: "Casualty" is a key term in the discipline of disaster medicine. Searching and rescuing disaster casualties is the main work of a health care task force in a disaster zone. However, the term is often erroneously used for the seriously injured and dead. Until the term "casualty" had been clearly defined and classified, we couldn't get a full picture of casualty flow in disasters. There is a difference in managing patients with treatable traumas and diseases versus those who struggle resulting in death.
Methods: Multiple web searching tools (Pubmed, Wikipedia, Yahoo search, etc.) were used for relevant articles, abstracts, and grey literatures covering the period January 2000-December 2015. A qualitative survey questionnaire was designed based on search results. An informal, multi-disciplinary, expert working group was established, including 18 individuals representing the discipline of emergency management, public health, clinical medicine, and military medicine. The experts were invited to write comments on the questionnaire separately. The comments of the experts were synthesized into a comprehensive report. In July of 2016, an expert meeting was held on our campus to discuss the report and reach a consensus about the disaster-casualty classification framework.
Results: Eleven documents were considered highly relevant. The experts believed that before giving a definition to "casualty," "disaster scene" and "health care facility in the disaster zone" should be defined. We then define "casualty" as "anyone incurring a trauma or illness, or dying as a direct result of disaster." Disaster casualty must include the deceased and can be classified into two parts: casualties with trauma and casualties with illness. Each part has three sub-groups: death on the scene, casualty coming to a health care facility for treatment, and casualty who needs medical treatment but didn't come to any health care facility. For casualty coming to a health care facility for treatment, it can be classified into three portions: death in the health care facility, the inpatient, and the outpatient. Each associated term must be defined carefully and explicitly. Disaster casualty has its unique classification method; each part and sub-group need different public health and medical interventions and treatments.
Conclusion: This is a tentative study to draw a picture of disaster casualty. Disaster exerts tremendous influence on disaster casualty and the process of casualty production is complex and complicated. Our disaster-casualty classification framework is proposed to be tested and improved.

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The Challenges on Implementation of Pre-Disaster Efforts of Health Crisis Center (PPKK), Indonesia Ministry of Health (MoH) in 2014

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