Methods: This presentation will be given by a panel of local community health experts in Connecticut.
Keywords: Connecticut; infrastructure; emergency readiness; emergency response; priorities; public health; terrorism
Prehosp Disast Med 2005;20(5):s168–s169.

Public Health Infrastructure Expansion: A Formula for Success

Leon F. Vinci

Health Promotion Consultants, Lincoln, Nebraska USA

Introduction: Until recently, Nebraska ranked 51st in per capita spending on public health in the United States. As a result, the public health system (and emergency health preparedness) in Nebraska was fragmented, and without leadership. Today, the Nebraska public health system has grown dramatically, from 27%, to nearly 100% coverage.
Objectives: This study describes the factors responsible for the recent public health infrastructure expansion in Nebraska.
Methods: In 2004, a survey of key informants in Nebraska was conducted regarding the factors responsible for the public health infrastructure expansion in the state. Key informants included public health leaders from statewide associations, government, local health agencies, academia, and advocacy groups.
Results: Survey participants reported that leadership, legislation, and funding were the most important factors in public health infrastructure enhancement. Another important factor was the need to for communities and government to develop an infrastructure for the response to public health emergencies.
Conclusion: Advocacy, legislation, funding, and the threat of an emergency or terrorism can facilitate the reformation of public health infrastructure.
Keywords: funding; leadership; legislation; public health; Nebraska; survey
Prehosp Disast Med 2005;20(5):s169.

Factors Impacting Public Health Emergency Preparedness in Local Communities: A Post-9/11 Survey

Leon F. Vinci

Health Promotion Consultants, Lincoln, Nebraska USA

Introduction: Connecticut's public health community experienced significant changes after the 2001 World Trade Center and Pentagon attacks and the 2001 US anthrax letter attacks.
Objectives: This presentation describes the new areas and services in Connecticut's public health emergency response system which have emerged since 11 September 2001, and the factors responsible for infrastructural change.
Methods: A retrospective analysis was performed of the steps, actions, and milestones in the governmental process as it related to the growth of public health preparedness in post-11 September 2001 Connecticut. Information was obtained from surveying state and local health departments regarding the factors important for public health preparedness.
Results: Leadership, legislation, and funding were the most important factors in public health infrastructure enhancement in Connecticut since 11 September.
Conclusion: Advocacy, legislation, funding, and the threat of an emergency or terrorism can propel community attention and priorities toward public health infrastructure enhancement.
Keywords: advocacy; Connecticut; emergency response system; funding; leadership; legislation; public health; terrorism
Prehosp Disast Med 2005;20(5):s169.

Pediatric Emergency Preparedness in General Hospital Emergency Departments in Connecticut

James F. Wiley II;[1] Asa Margolis;[2] Kim Reich[2]
1. University of Connecticut School of Medicine, Farmington, Connecticut USA
2. Department of Epidemiology and Public Health, Yale University School of Medicine, New Haven, Connecticut USA

Introduction: The atrocity in Beslan, Russia in 2004 underscored the importance of emergency preparedness for children in disasters.
Objective: This study determines the level of pediatric preparedness and identifies resources needed in general hospital emergency departments (EDs) in Connecticut.
Methods: This study was a retrospective survey of ED directors and nurse managers in 11 general hospitals in Connecticut. Data collected included: (1) demographic data; (2) content of hospital emergency operations plans (HEOPs); and (3) assessment of pediatric capability based on the Pediatric Preparedness for Disasters and Terrorism: National Consensus Conference in 2003, and the hospitals' rankings of the most needed pediatric resources.
Results: The average ED annual census was 40,954 ±21,939 visits with an average annual pediatric census of 6,533 ±5,168 visits. Sixty-four percent of hospitals were located in suburban areas, and 36% provided residency training. Thirty percent had HEOPs that included pediatric guidelines, 20% had HEOPs that took into account the differences among children; 30% had HEOPs that contained a pediatric care resource; and 10% had HEOPs that provided for guardianship care/reunification of children separated from their parents. Seventy percent of hospitals typically lacked supplies for a pediatric victim surge of 100 children greater than their usual daily census. The top three resources needed were: (1) a pediatric treatment guide; (2) a pediatric field and hospital triage guide; and (3) a comprehensive web-based resource for pediatric management.
Conclusion: The ED leaders identified significant gaps in pediatric emergency preparedness at their hospitals, including pediatric components within their HEOPs to guide the management of pediatric victims of terrorist events and adequate equipment and medications to handle a surge of pediatric victims.
Keywords: emergency department; hospital emergency operations plan; pediatric emergency; pediatrics; preparedness
Prehosp Disast Med 2005;20(5):s169.