Anticipate. Plan. Deter.
Building Responder Resilience
Instructor Guide

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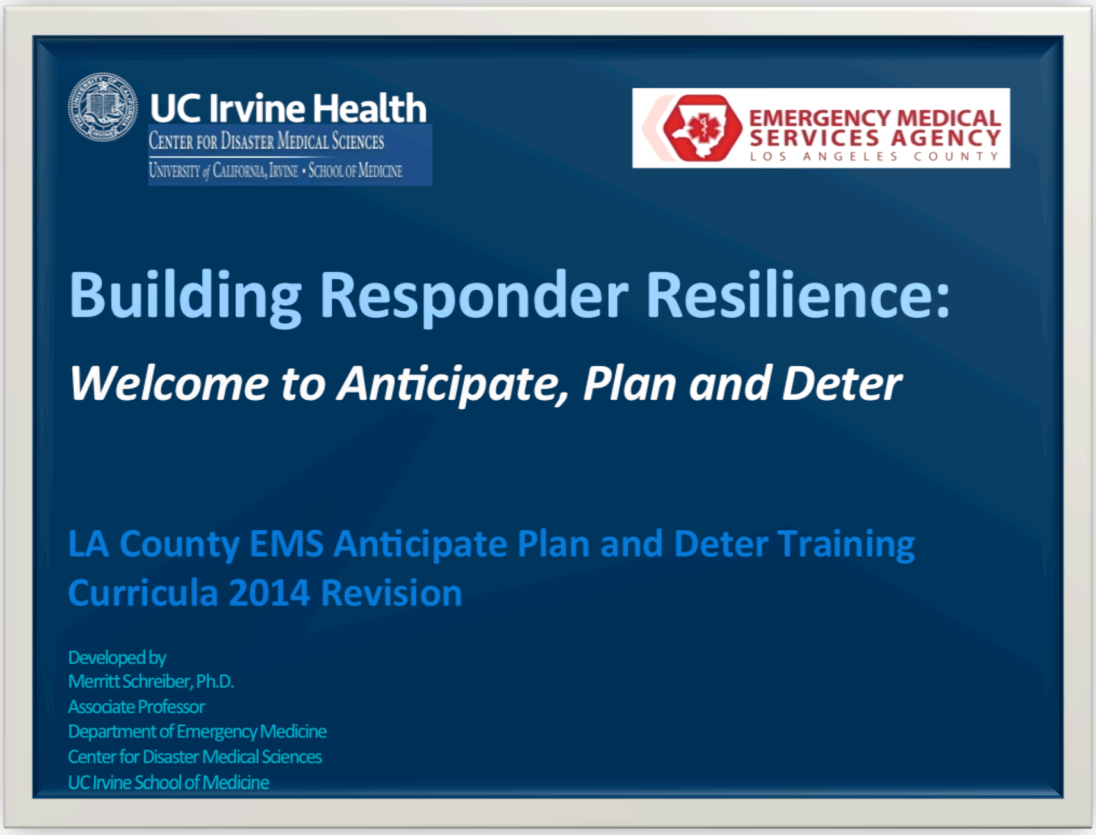

Welcome to "Anticipate Plan and Deter," a responder resilience program for disaster medical healthcare workers in Los Angeles county provided to you by the Los Angeles County Emergency Medical Services Agency and developed by Merritt Schreiber Ph.D. at the UC Irvine Center for Disaster Medical Sciences.

This is a 90-minute interactive training to help you learn about managing your stress. You will leave today with your own personalized plan to manage your coping risk and resilience in disaster, as well as other emergencies that we all face.

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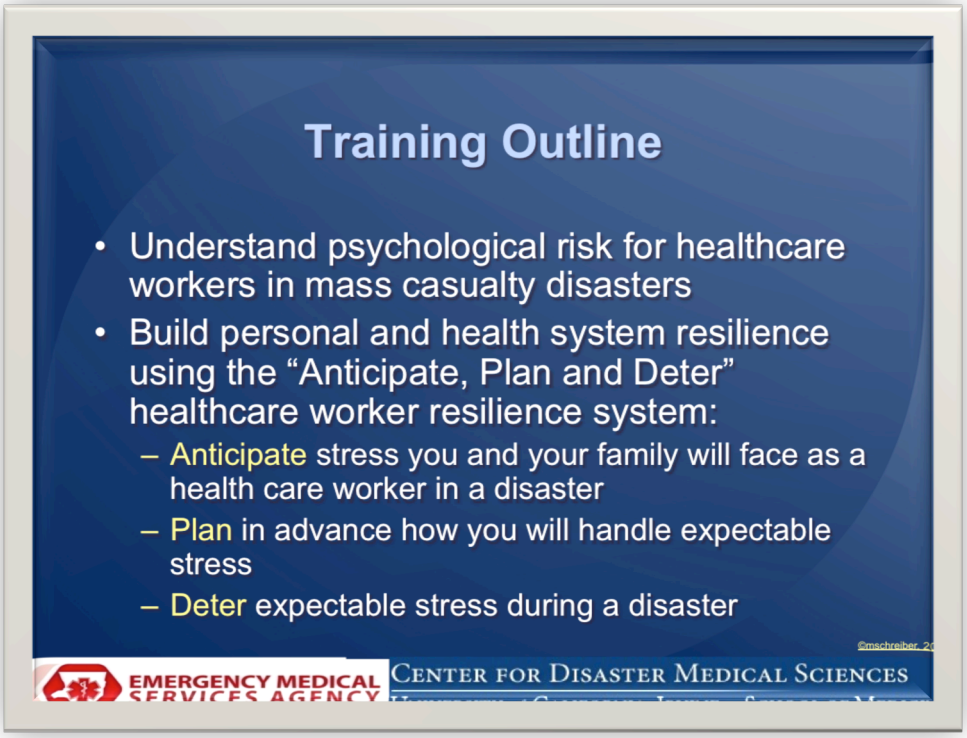

Start here:
This training will provide you with the Anticipate Plan Deter Personal Resilience skills to cope with disasters and perhaps every day stress you encounter as an emergency healthcare provider.

The course contains the following elements (Read the above bullets completely).

Anticipate Plan and Deter or "APD" as we call it, is a comprehensive approach to improving the resilience of healthcare workers in Los Angeles County. It involves three key elements: Anticipate, Plan and Deter.

APD is a resilience model that builds on your own considerable resilience resources. We know you are at a resilient group but disasters can challenge anyone. We want to enhance the resilience you already have with some additional tools and resources. We will review practical ideas that you can take home today and use anytime.

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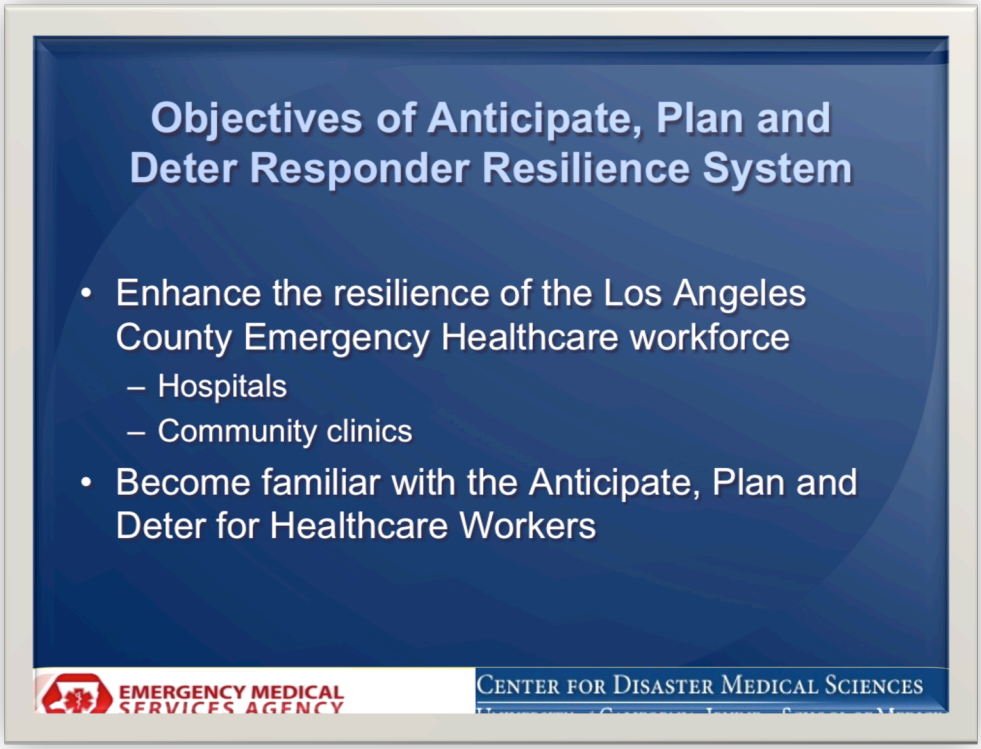

Here are the goals of this program:

- Read the above bullets and address any questions from the group.
- Key focus on pre-event preparedness, which is the purpose of this training element.

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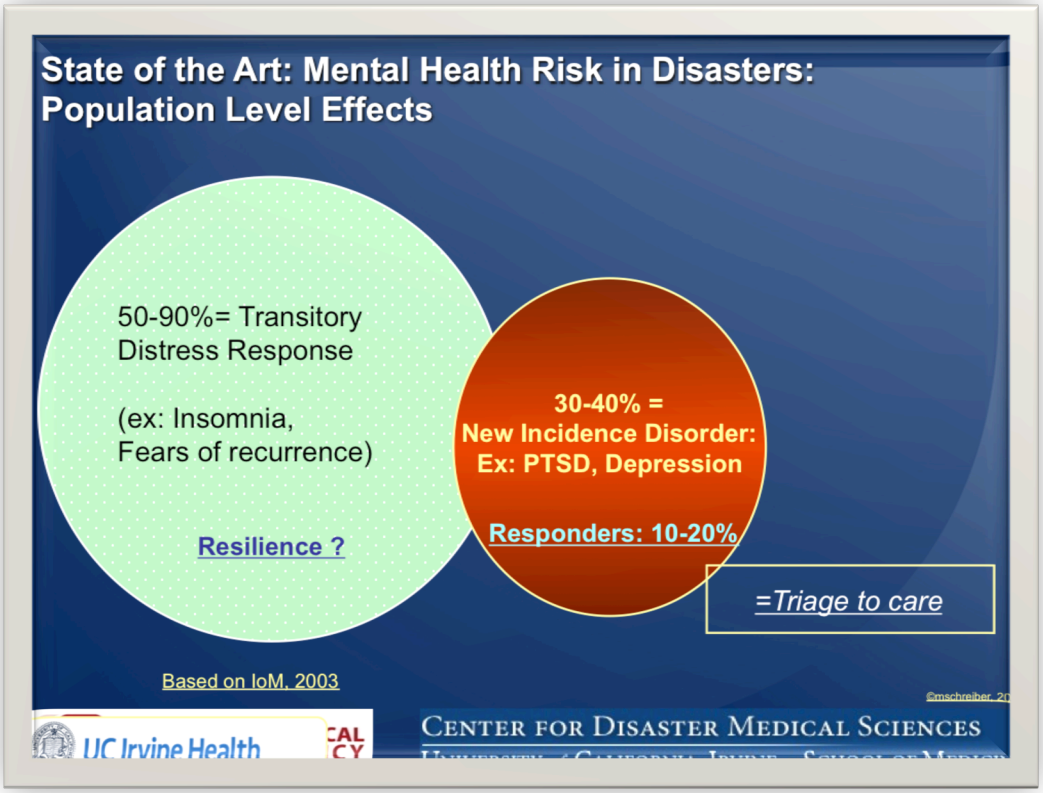

Let's review and understand risk in disasters to begin.

This slide is an adaptation that Dr. Schreiber created based on a report from the National Academy of Science Institute of Medicine called the "Psychological Consequences of Disasters and Terrorism." You'll notice two circles. The green one on the left refers to distress responses that are essentially normative reactions to a disaster experience. Examples include insomnia and a sense of vulnerability. These conditions are normative in that they are common, expectable, typically time limited and resolve without professional intervention of any kind. They don't necessarily suggest short or long-term impairment, but they are very common in the aftermath of disasters.

Depending on the study, somewhere between fifty and ninety percent of the population will have one or more discrete distress symptoms that are non-syndromal, in that they are not associated with a formal syndromal or syndromic diagnosis or new mental health disorder. These usually resolve in a relatively short period of time without any professional intervention. In an American Red Cross environment, we used to call this "normal reactions to abnormal events."

Moving down the diagram, the red circle on "new incidence disorders" refers to a portion of the population that would be exposed to the disaster and that would

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develop a new psychiatric disorder they didn't have prior. This is not referring to those individuals that may already have some kind of mental health disorder, or to those having a "severe mental health disorder" or a "severely emotional disturbed child," both of which are definitions used to indicate individuals that have a psychiatric disorder that is of a more serious nature. The circle encompasses those individuals who may have been sailing along well enough before the event and then after the incident, they develop a new disorder that they didn't have before, hence "new incidence disorder".

A classic example of that is Post Traumatic Stress Disorder(PTSD), but it is by no means the only disorder or diagnosis that can occur following a disaster. Major Depression is right behind PTSD in frequency of occurrence after an event. Even more to the point, Post Traumatic Stress Disorder and Major Depressive Disorder are frequently co-morbid, meaning they often go together after a disaster. Those are just two examples, and when we then look to see how many people might develop one of these disorders, we see that among victims directly impacted by the disaster somewhere between 30 – 40 % are going to be at risk for a new psychiatric or mental disorder they did not have pre-event.

There's been a lot of discussion about the impact of disaster on disaster responders. We used to think, as recently as the Oklahoma City bombing, that responders did not really develop new disorders as a function of the disaster. More detailed studies that have occurred after 9/11 and Hurricane Katrina suggest that in fact 10 – 20% of responders are at risk for a new disorder they did not have pre-event. We see that responders are relatively more resilient than direct victims and the vast majority of responders are not going to be at risk for a new disorder. That's also good news, but there will be a significant minority that might be at risk that we need to attend to.

That's what we know about the psychological consequences of disaster and terrorism. To summarize, some are going to have normative reactions that are time limited, are not syndromic, resolve on their own and are not associated with any functional impairment. There is a group that is going to be at risk for a new disorder they didn't have before, most commonly that is either PTSD or depression, although there are a number of other disorders that are possible. Somewhere between 30-40% of the victims directly experiencing the disaster are going to be at risk. Responders are more resilient than direct victims, but even 10 – 20% of responders might be at risk for a new disorder depending on the event. *However, it is critical to point out that responders can also be local direct victims and experience risk from both the responder role and their direct victim experiences.*

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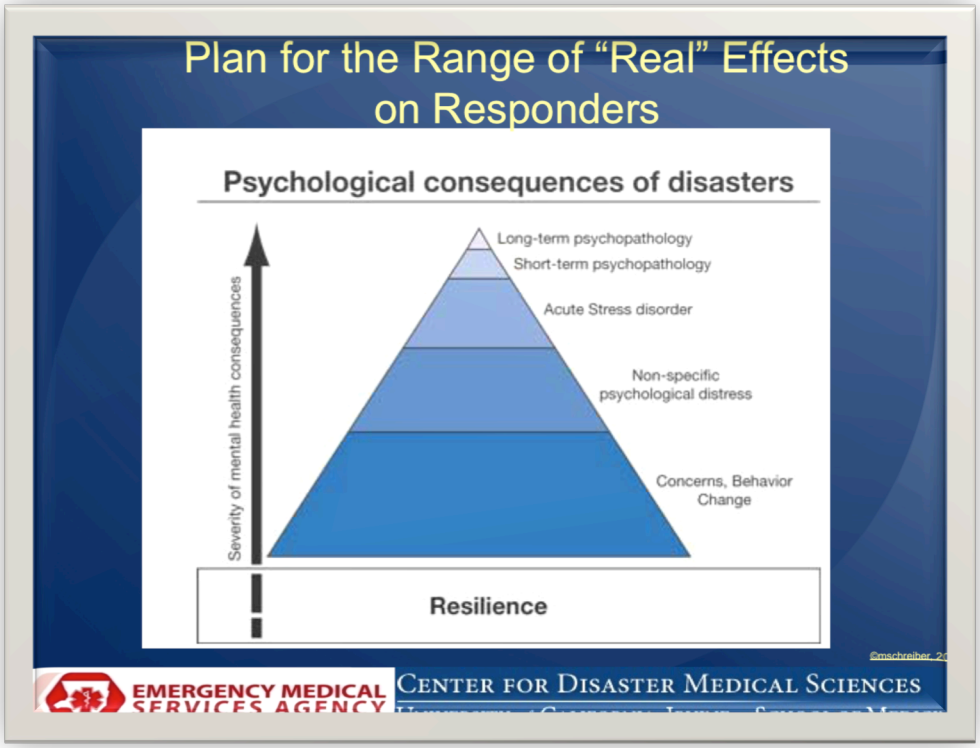

This slide also depicts the "continuum of risk" idea: One size does not fit all. There are a range of outcomes, most commonly "resilience" which we define in this course as the ability to withstand a potentially traumatic event with some level of distress but with a "rapid return to baseline" status in hours, weeks or days—depending on the magnitude of the stress you encountered and your baseline resilience status. Individuals move up the pyramid from resilience, to concerns/behavior changes, to non-specific distress and defined clinical disorder.

As one develops both symptoms and impairment (which refers to difficulty being able to carry out basic tasks at home and work), one or more clinical disorders can develop such as acute stress disorder, or longer term disorders such as Post Traumatic Stress Disorder (PTSD), Depression, substance abuse and others. Commonly, one or more discrete disorders co-occur, such as PTSD and depression and this entails greater levels of impairment (difficulty functioning) and multiple symptoms.

It is important to note that where one ends up on this scale or in the "distress" vs. disorder circles on the previous slide, depends on many factors, but your disaster or emergency experiences are a major source of risk. This course will help you understand different types of stressful "exposures" on how to determine your own risk based on exposure.

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Another key point is that that there are now effective interventions for PTSD, depression and the other possible consequences of stressful exposure or loss. Further, there is now mounting evidence of "golden month," where if high risk and distressed individuals are matched to certain, acute evidence based interventions, their risk of full-blown PTSD can be mitigated or even prevented. Therefore, it is important that you understand your risk for disorder based on your self-triage of exposure and your distress level and seek care early to prevent the effects of untreated clinical disorders.

Traditionally, first responders have not been open to these ideas. However, this is changing coupled with the fact that "one shot" interventions such as debriefing or psychological first aid do not appear to be sufficient for those at increased risk.

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This picture portrays the London bombing and one of the buses that was attacked. You will see the signs of the attack and then the same bus route the very next day with the display, “we are not afraid”. This is the idea we are after with this training. In our case, the “threat” is untreated stress. Just as the bus line resumed and faced the threat with the approach “we are not afraid”, we too can work to conquer stress and be “not afraid “ to manage stress proactively and openly.

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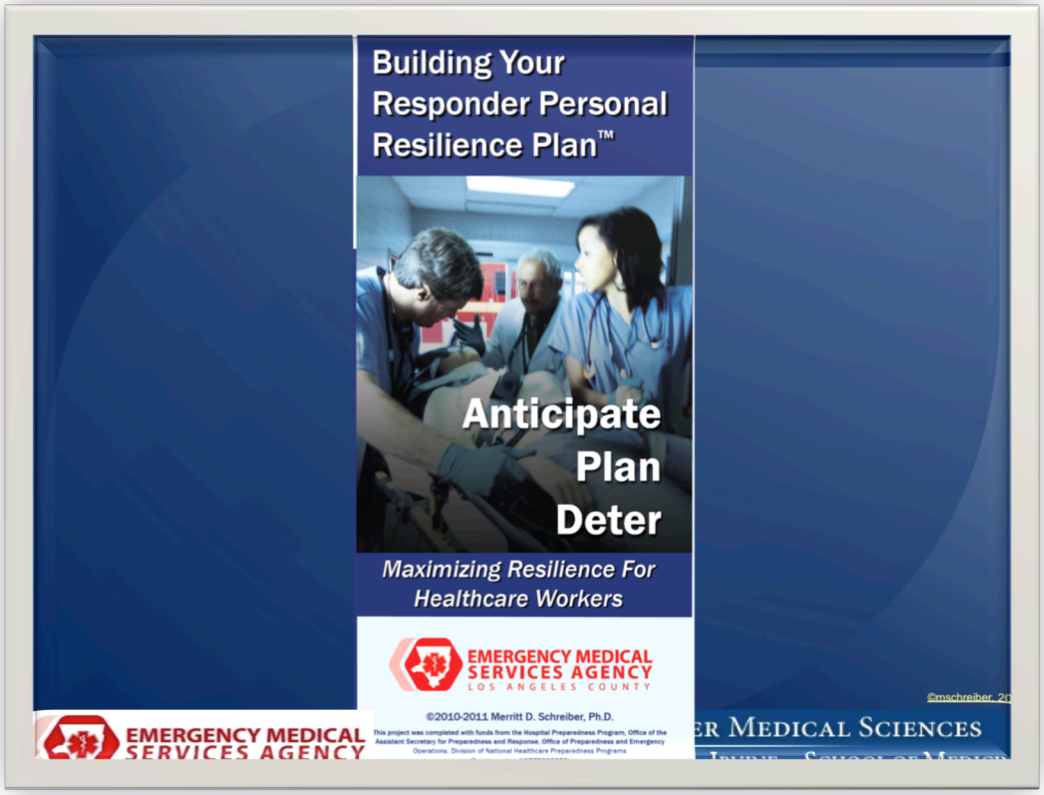

This is the personal resilience plan that we will focus on in today's training and you will develop your own version to take with you today.

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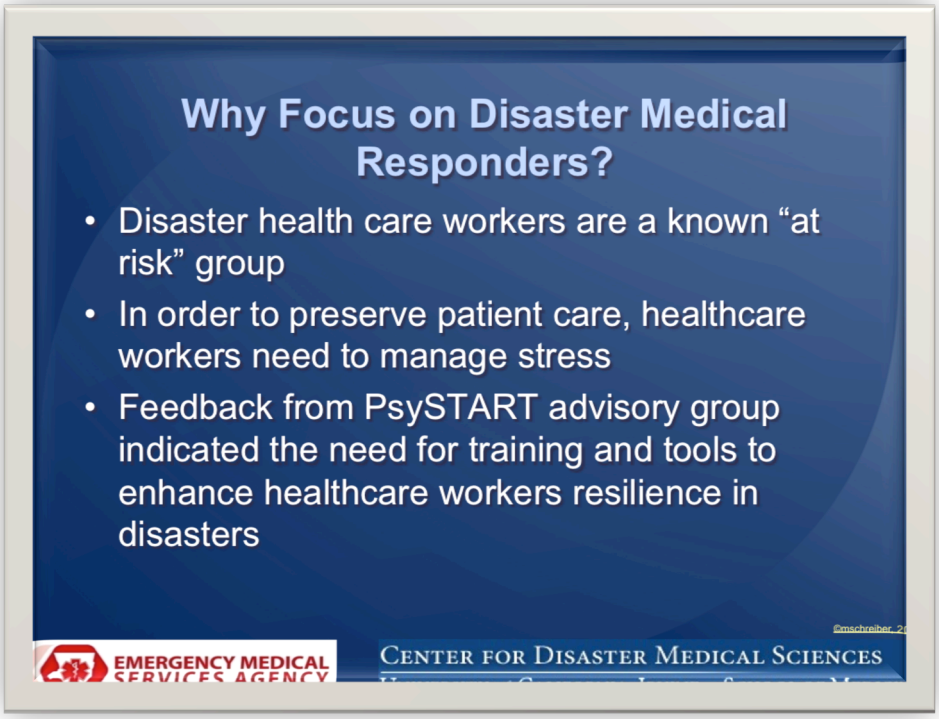

Why are we focusing on you? Because disaster health care workers are a known "at risk" group but also "hidden" and not frequently provided with resources to reduce the stressful impact of their work. In disasters and other emergencies, one goal is to preserve patient care and the health care system. This is done in many ways such as providing "decontamination" and use of Personal Protective Equipment (PPE). APD is designed to add to these critical efforts and provide "psychological decontamination" and "stress protective equipment".

Feedback from the LA County PsySTART Advisory Group indicated the need for training and tools to enhance healthcare workers' resilience in disasters. We want to briefly review some of the current science on disaster medical responders. Indeed, these concerns are borne out by research on the largest longitudinal study on the health effects of disaster workers is the 9/11 WTC health registry study coordinated by the CDC. The most recent findings revealed that 20% of WTC responders developed multiple posttraumatic stress symptoms and about 13% were estimated to have diagnoses of PTSD. Prior to the event, only 3% had used mental health services. This suggests a significant burden created by the WTC response. Over time, their sample of responders evidenced increased risk for acute stress disorder, PTSD and/or depression 7 and 13 months post 9/11.
The take home is: effective response depends on your resilience.

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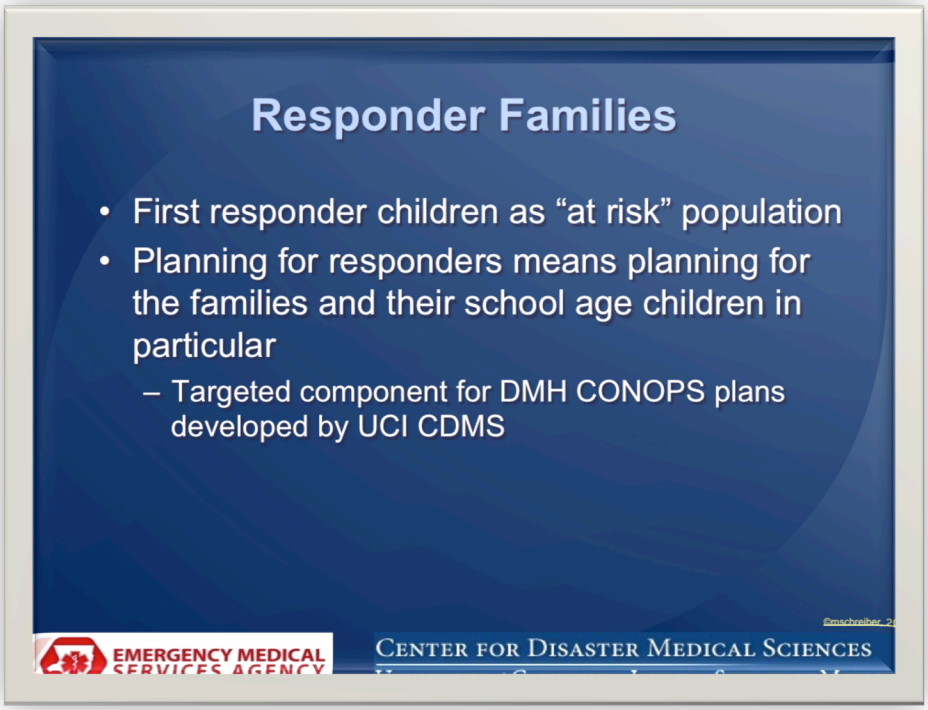

There is also some evidence that the children of EMT medical responders are at increased risk when assessed directly compared to children of law enforcement or non-medical fire personnel.

Although the exact mechanism of this finding is not completely clear, what is clear is that medical responders with school age children have unique concerns about the welfare of their children. In the SARS outbreak in Toronto, medical workers reported that among their most pressing concerns was the risk of infecting their families and children with the SARS virus. Anecdotally, the children of medical providers in Toronto during the height of SARS reported perceptions that others stigmatized their children due to their responder parent's hospital roles.
When approaching the impact of potentially stressful experiences on emergency and disaster health care workers, it is critical to take a family perspective and examine impacts on all members.

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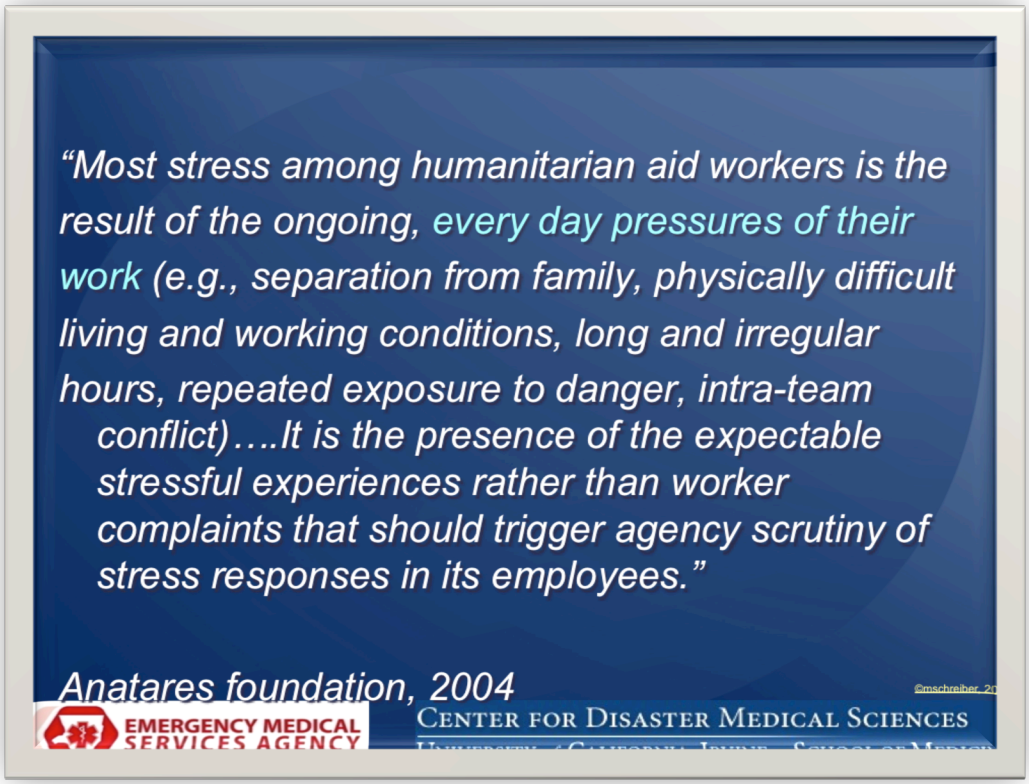

Read slide:
This slide from the Antares foundation presents some interesting ideas.
The key idea is that the management of expectable stressors reflecting the potentially traumatic exposures and cumulative stress is manageable. This is the idea we are striving for in "APD".

Entertain questions or comments at this point.

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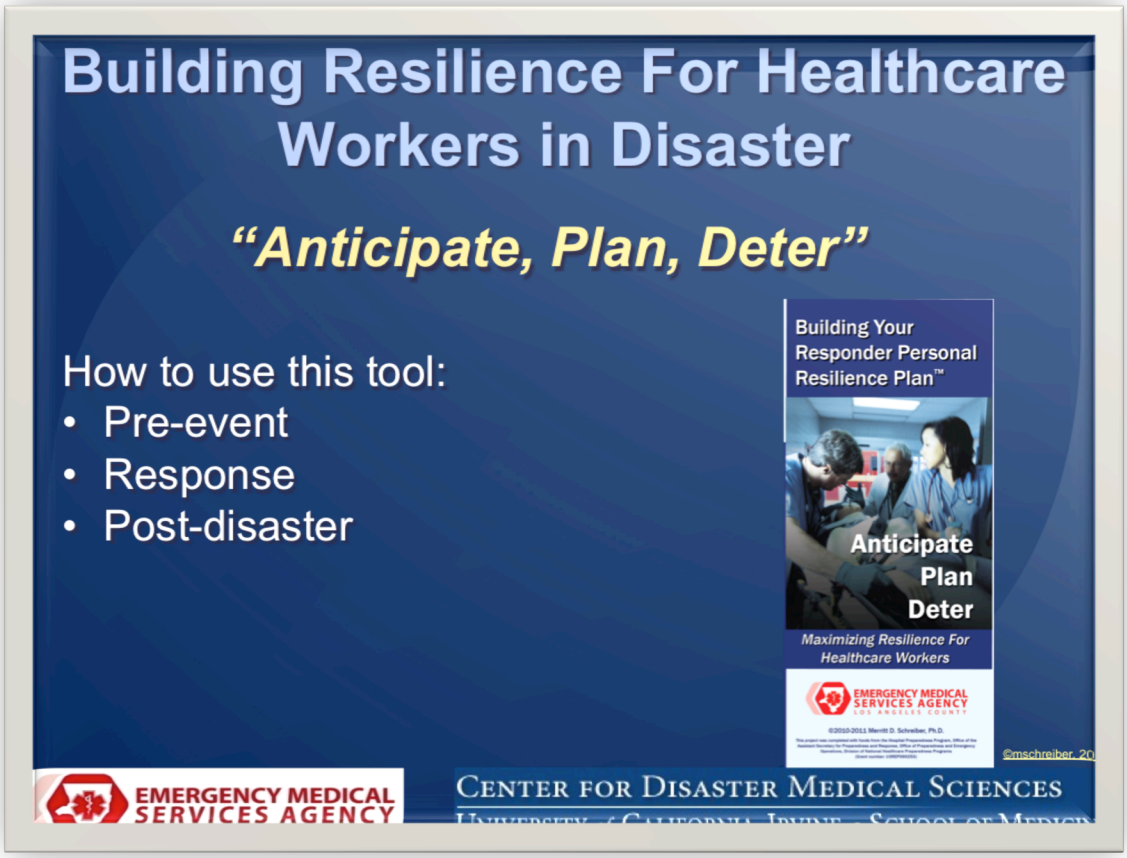

We will now start using your "personal resilience plan" and go through each of the three sections sequentially.

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The first step to our responder resilience model is learning to ***anticipate expectable*** stress situations and your own particular reactions. Beginning to conceptualize and visualize the "stress threats" you may face is the first step to build your own resilience. Once you know what the threats are, you are better able to develop effective "stress countermeasures" to combat expectable distress and build resilience.

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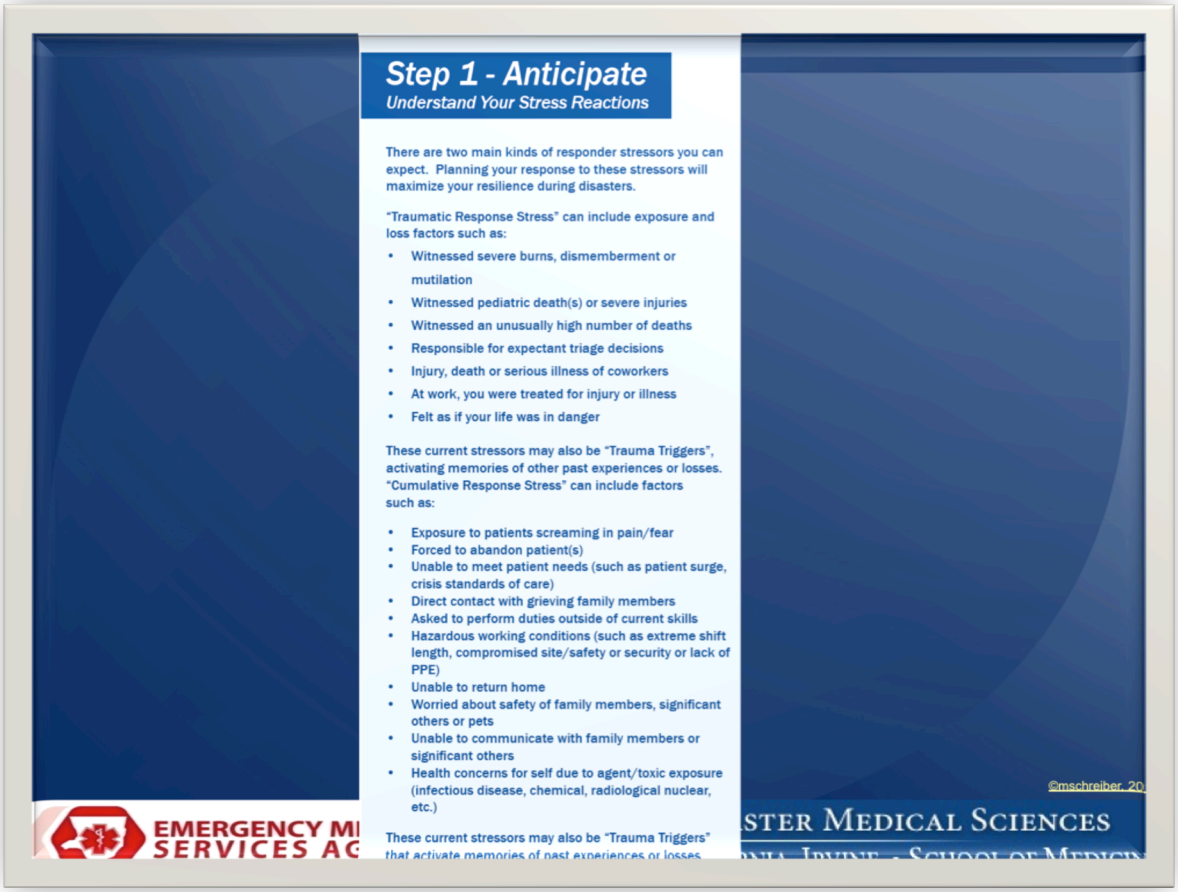

We will consider both potentially severe traumatic experiences or *Trauma Response Stress* and more common, *Cumulative response stress* that together contribute to stressful experiences in depth. First, we all have to think through what a "disaster" means to us. Everyone has a different threshold of what this means for them and this is where we start.

For example:
Next slide now

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Disasters are all not the same…big and small… disasters are in the eye of the beholder. For some of us, like the developer of the APD model, even a strong wind blowing over lawn furniture could be a disaster. For others, it is something larger.

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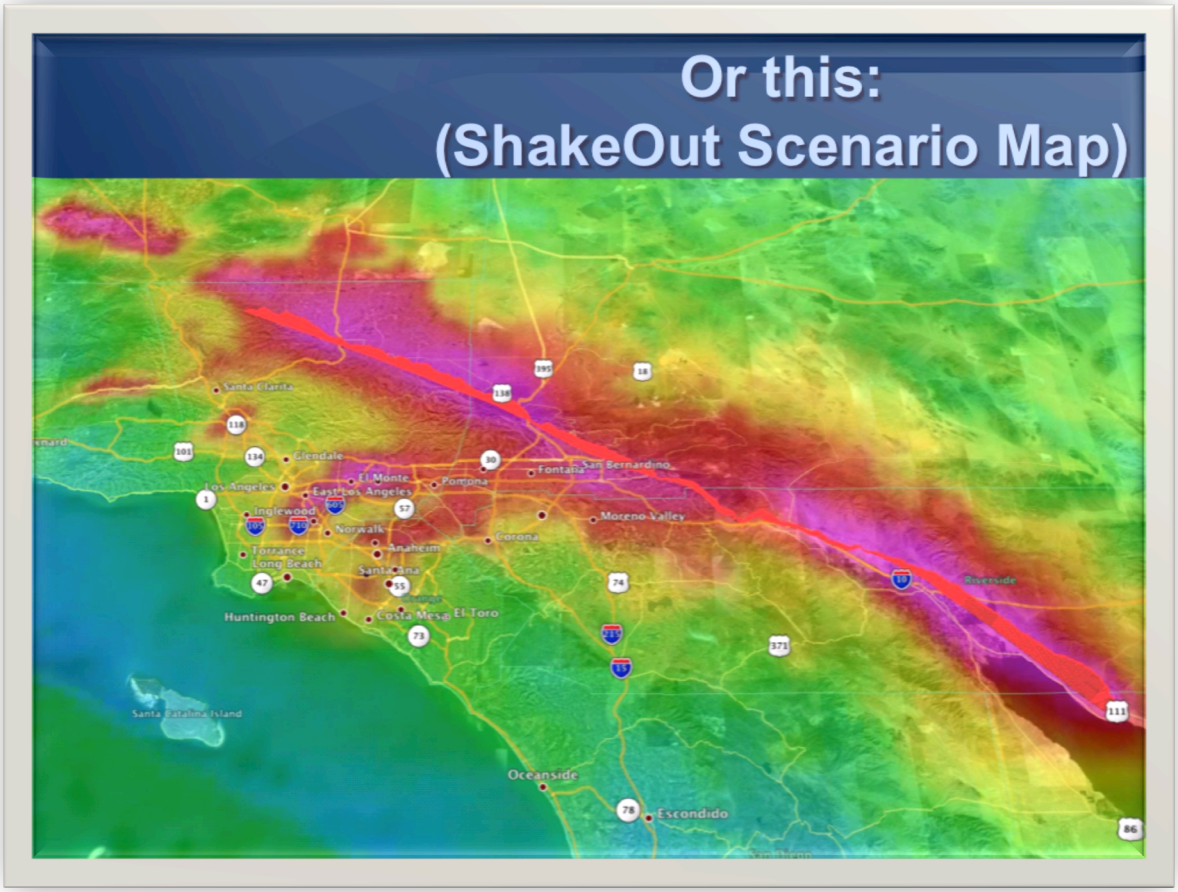

For example, this image reflects a catastrophic or what FEMA calls "Mega Catastrophic" event. This is just a visual example of the ShakeOut Scenario affecting Southern California. It involves a 7.8 Magnitude earthquake that starts near the Salton Sea in the lower right hand corner and then ground movement moves North and West into Riverside, San Bernardino, Orange, Los Angeles and Ventura counties. It is associated with a number of injuries, deaths, home loss, displacement, loss of transportation systems, communications and interruptions in a broad range of public safety services. The first step is trying to decide what your threshold is for when you are in a "disaster." This will guide you in when to deploy your soon to be developed "personal resilience plan."

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Although many of you are used to emergency scenes and other life and death situations in your daily work, disasters potentially involve much of the same as well as other novel experiences that you may never have encountered before. This is a scene from Super Typhoon Haayan in the Philippines. This is just "not another day" in your busy ED.

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Dealing with children who are frightened, scared, severely injured and separated from any caregivers can be quite demanding on healthcare workers and health care settings. How will you cope with many severely injured and upset pediatric patients? In this scene a health worker is attempting to do a radiation screening with a child after the Fukishma reactor meltdown.

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In this scene from the Catastrophic Earthquake in China, workers encountered many grieving parents who lost a child. This can be extremely difficult emotionally for those interacting with these parents.

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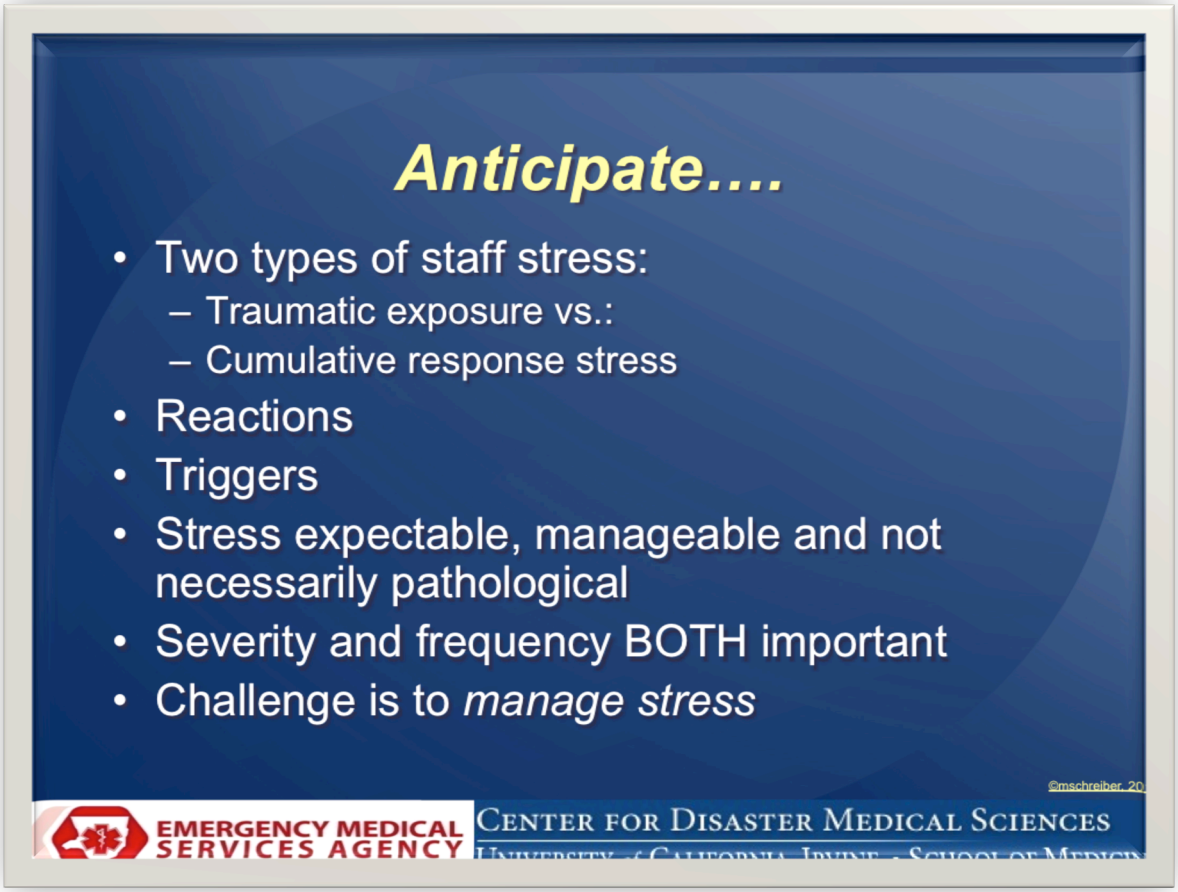

There are two types of staff stress- Traumatic exposure and cumulative response stress (direct participants to Step 1 in their personal resilience plan brochure).

- Review each Traumatic Exposure; ask participants to discuss thoughts about these items.
- Review each Cumulative stressor and ask them to describe their daily experiences with these. Then ask, how will this be different in a disaster?
- Reactions – We will be discussing this in Step 2.
- Triggers are: expectable, manageable and not necessarily pathological. Severity and frequency of stress factors are both important. The challenge is to *manage stress!*

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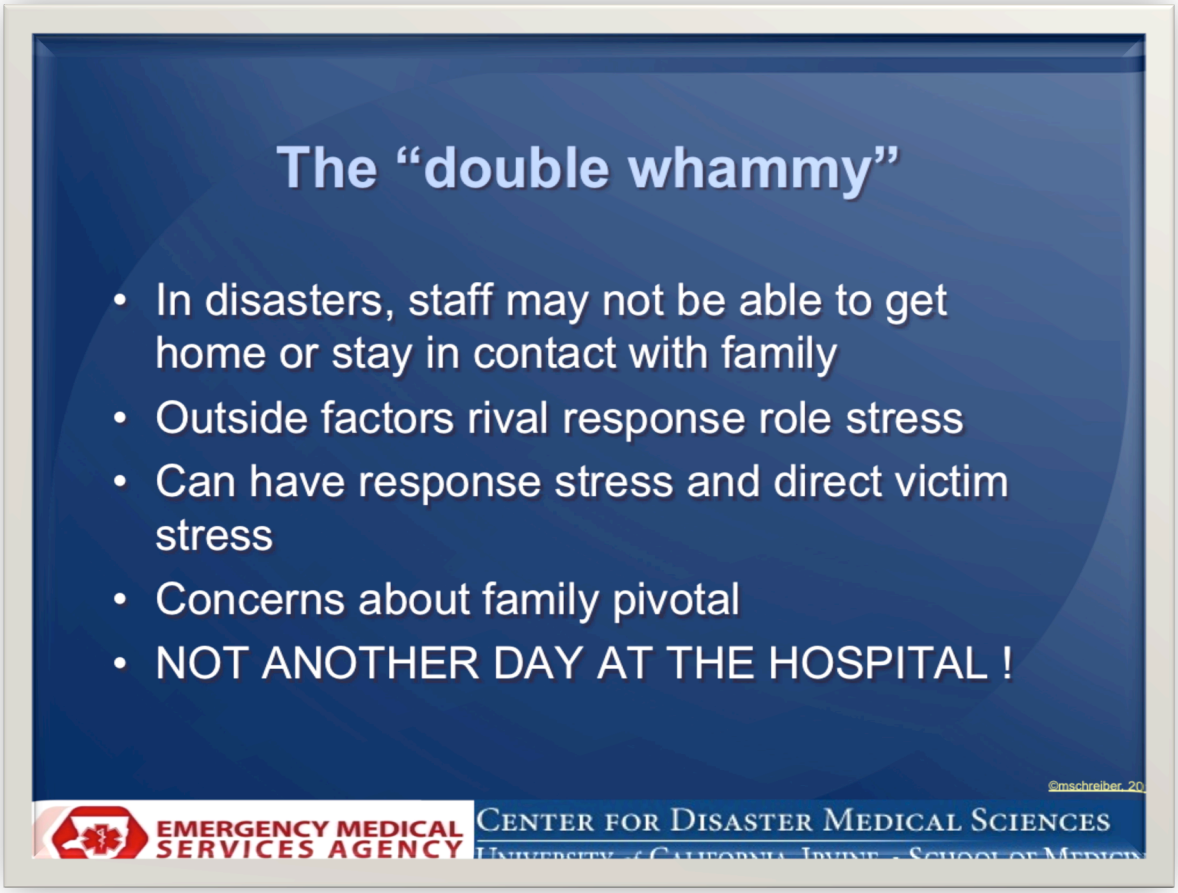

Disasters are "just not another day in the office" (hospital, ED , clinic, etc.)

How disasters are different:

1) You can't go home at the end of your shift
2) You can't reach any of your loved ones and don't know where or how they are for a protracted period.
3) These "outside factors" rival or can exceed stress as a medical responder.
4) If you are a "local" responder, you can have both stress (and risk) as a responder and also simultaneously be at risk from direct stress in your home/family life.
5) There is considerable evidence that concerns about family, their status and possible risks to them from your work are very powerful. These stresses can be addressed and mitigated but the first step is recognition ("Anticipate").

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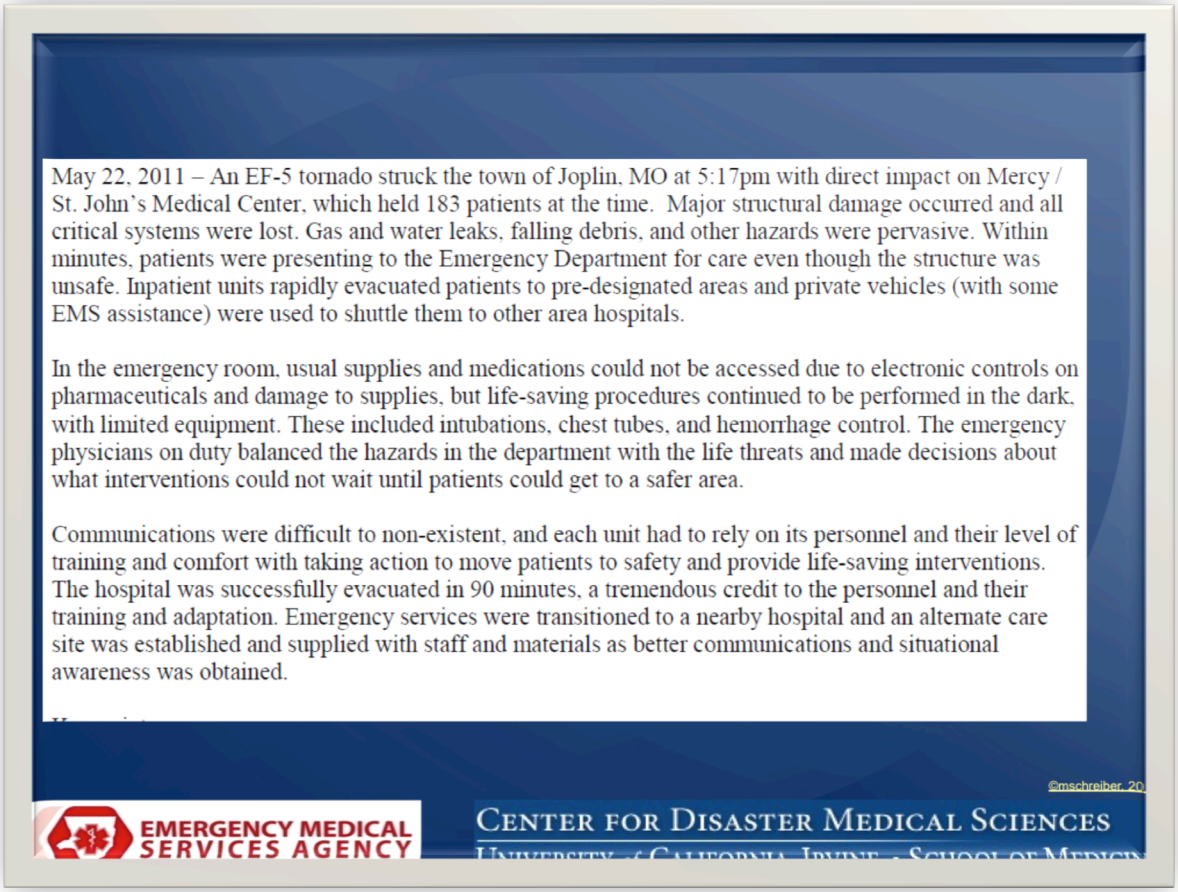

Read this experience in the Joplin Tornado at St. John's Hospital ED. Reinforce the "not another day at the office" concept.

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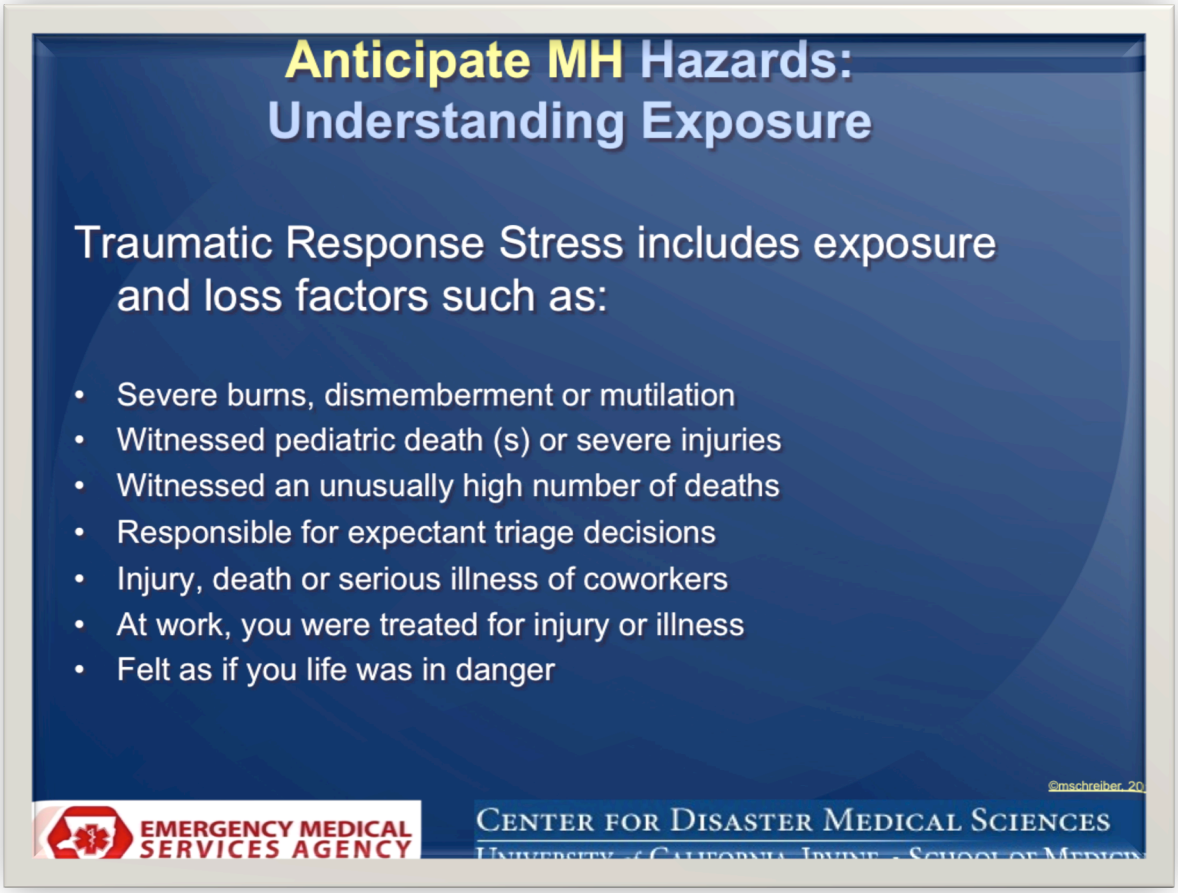

Traumatic response stress experiences include these factors on the slide above.

These factors are based on some research with US Air Force medical teams in a combat context. Review each of these items and get comments from participants.

- Ask if anyone knows what "expectant triage" is (Instructor will need to familiar with this concept and be prepared to explain).
- Ask if anyone has direct experience with expectant triage and wants to disclose.
- Discuss changes from "care as usual" to catastrophic care or crisis standards of care here.

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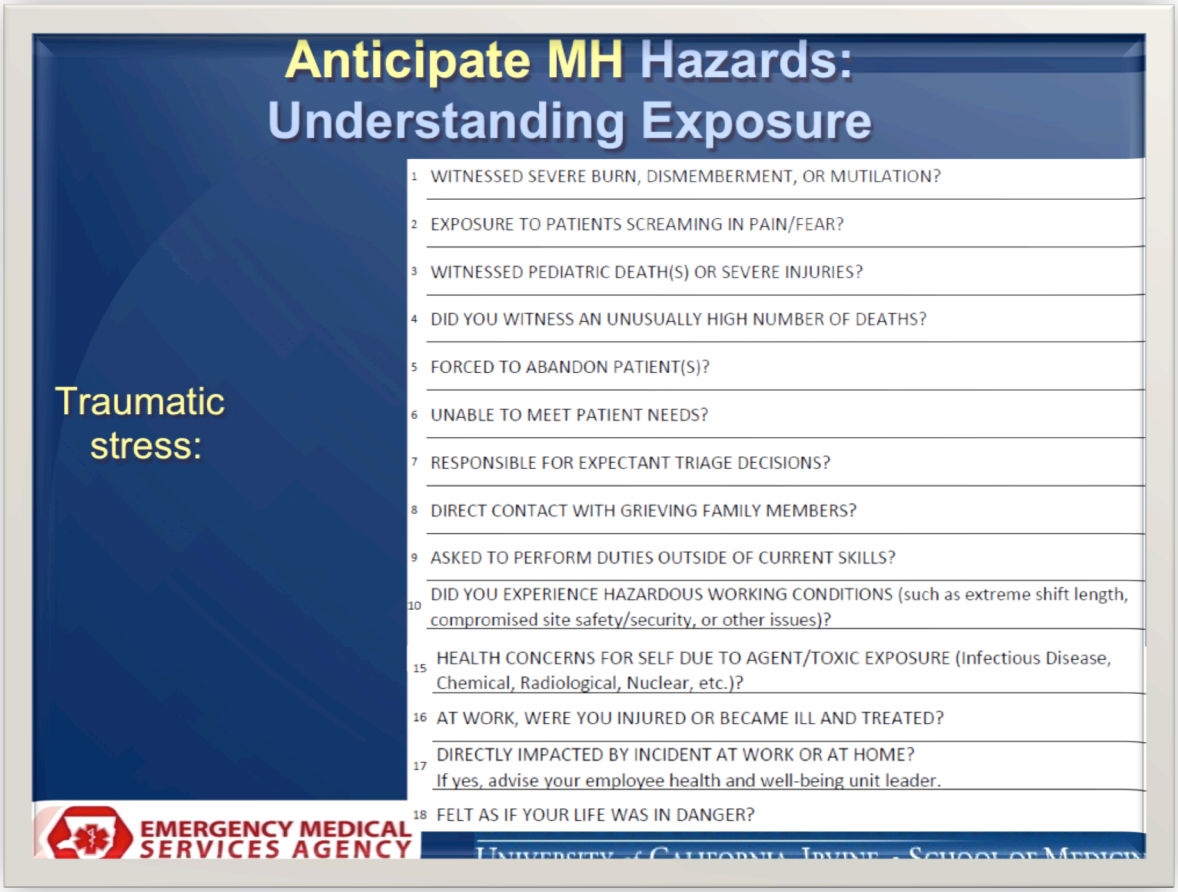

These are a number of potential disaster medical response stressors tied to:

1) Certain types of patient injuries and outcomes (severe burns, traumatic amputations, pediatric deaths or mutilating wounds, higher levels of mortality).

2) Role specific stressors such as having to perform expectant triage decisions that involve the action of not providing definitive care due to surge demand, (see also crisis standards of care idea the previous slide), working with patients outside current skills (such as a pediatrician working with adult patients).

3) Personal impacts to the provider i.e. feeling as if their own lives are in danger, directly impacted by the incident at home or at work (including becoming injured or ill themselves), and also concerns over possible toxic exposure to biological, chemical or radiological materials, etc.

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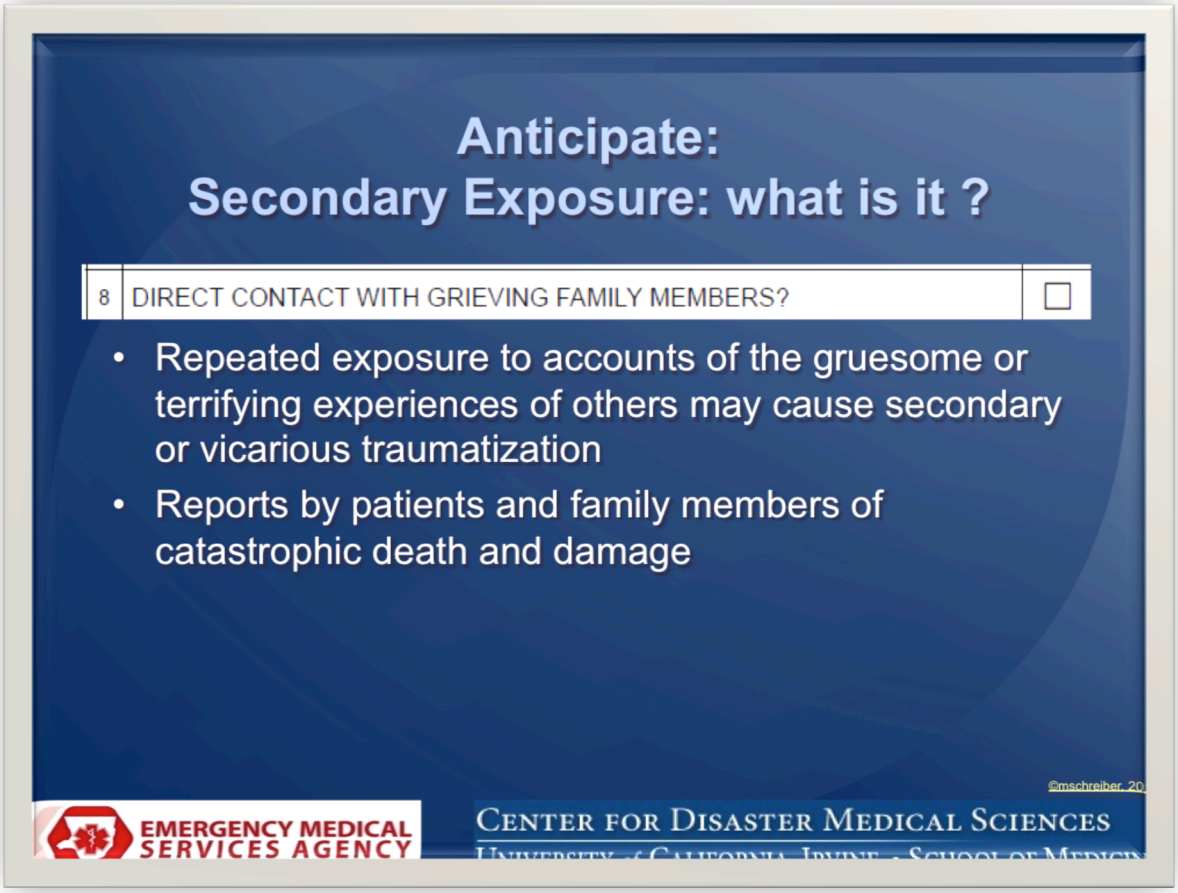

This slide above shows stressors that impact disaster healthcare workers when they are exposed to patient's stories of trauma and loss.

- This is known as "secondary exposure" or vicarious exposure and is known to also convey some risk to individual healthcare workers.
- Please read each bullet.
- Based on time, ask for participants to share brief experiences of this type.

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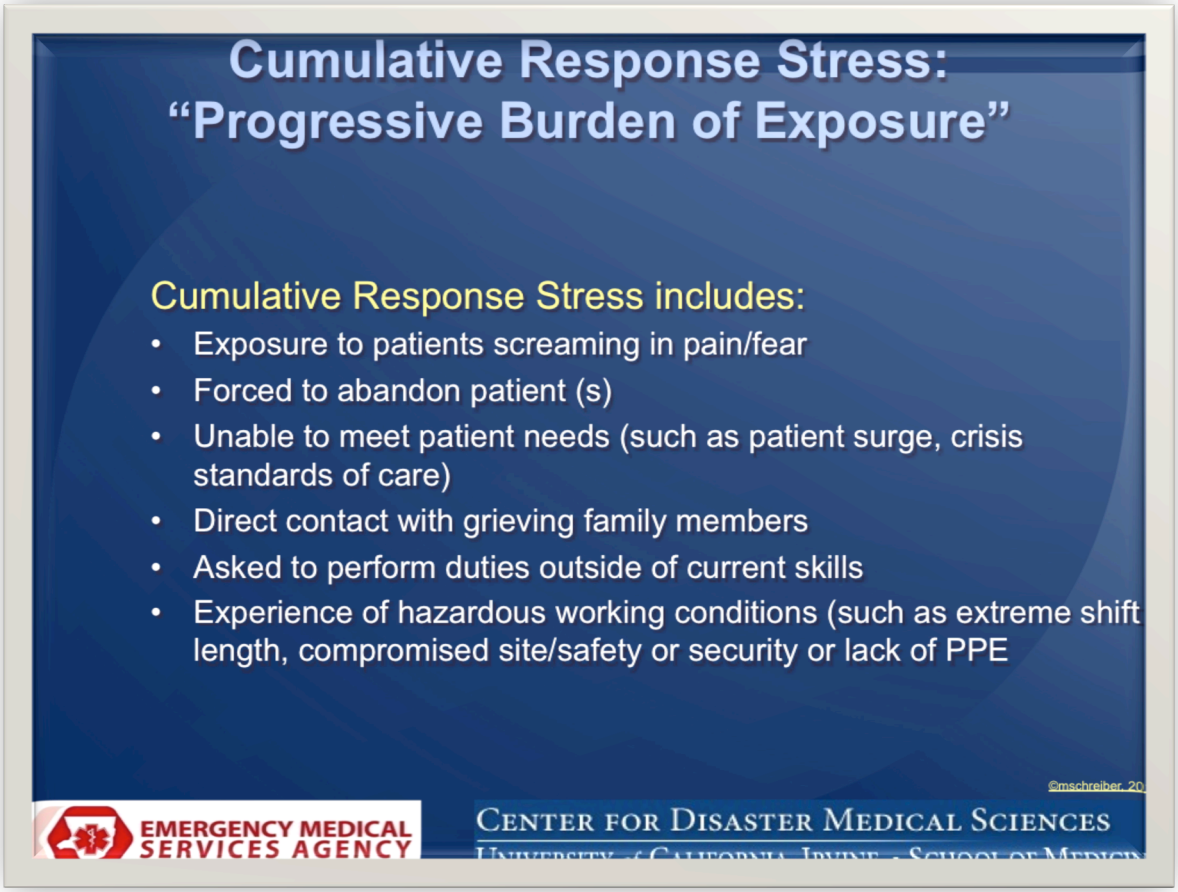

Direct participants to *panel 2* of the APD personal resilience plan -Step 1 Anticipate.

These stress experiences may be more common:

- Patients screaming in pain or fear
- Direct contact with grieving family members.

Others here may be less commonly encountered:

- Forced to abandon patients
- Working outside current skills (adult providers with kids or vice versa)
- Extreme danger in the work setting or Hazmat in the work setting
- Unable to meet patient needs because of the disaster response context (i.e. because too many patients to do care as usual or you run out of supplies).

It is important to make sure participants understand what each risk factor is so they can triage themselves later on in the "Deter" cycle of APD.

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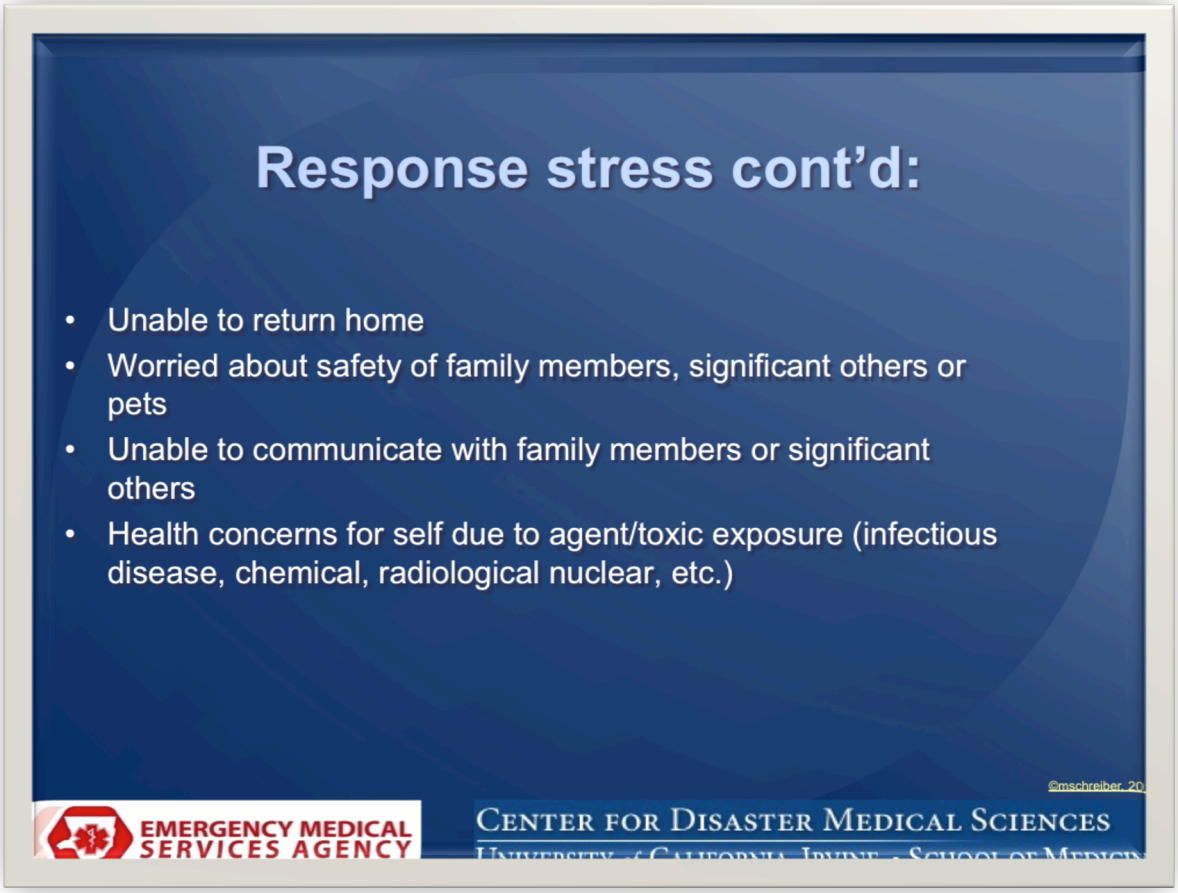

Above slides shows some additional response stressors that are tied to family concerns. Research has shown that when the responders own significant others and family are involved, it is the key element of responder stress.

Read each bullet

- Responders may also be concerned about their family or significant others due to on-going events in their lives.

- Responders need to be aware of these risks in addition to all the others they face in their direct work with patients in disaster contexts.

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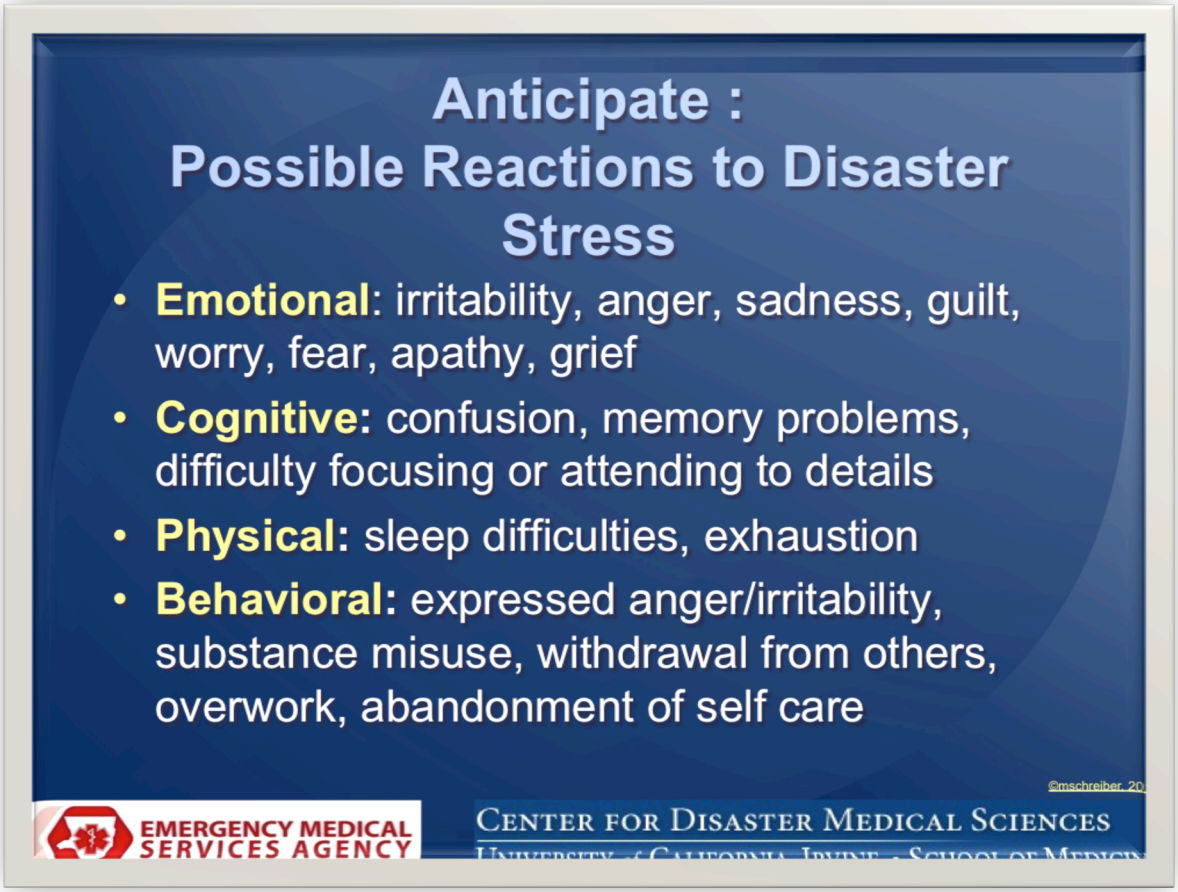

There are many different ways in which reactions to stress can manifest, emotional, cognitive, physical or behavioral (read all examples above).

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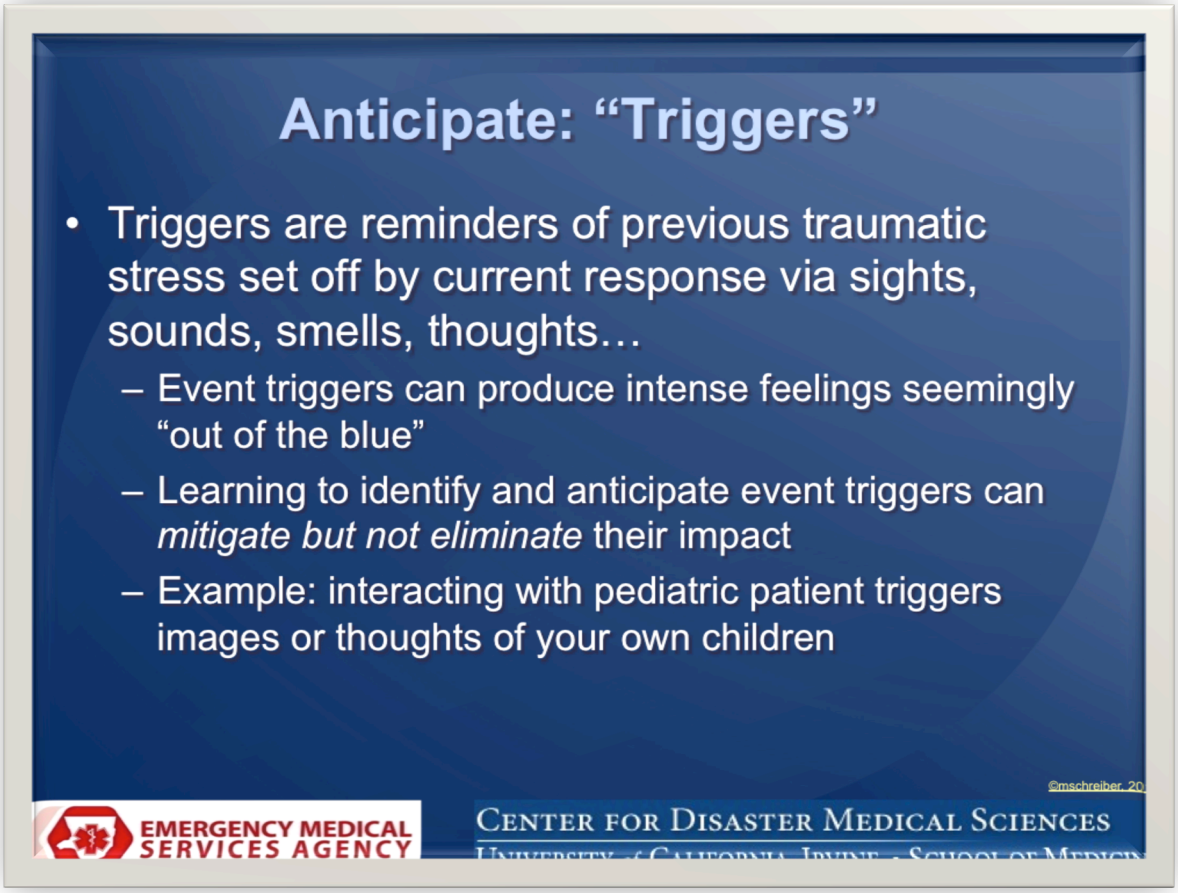

"Triggers" or "Trauma triggers" refer to features in the current response that remind the individual of other traumatic events in their lives.

- A sight, odor or thoughts can set off a trigger: "Wow the last time I thought that was after…(insert another example of a disaster that has occurred in the past here).
- Sometimes, these triggers can produce intense distress - especially if the person does not identify the reaction as a "trauma trigger". When this happens, it seems as if the trigger reaction is "coming out of the blue" and can be very disturbing to the individual.
- Although the reactions to trauma triggers may not be eliminated, it is still helpful to be aware of them and to realize that they are an expectable part of disaster work.
- The individual can use components of their coping plan (that follows) to help manage trauma triggers. The things that work for the individual to manage distress will likely help with trauma triggers as well.
- An example could be treating a gravely injured pediatric patient and being reminded of your own child.

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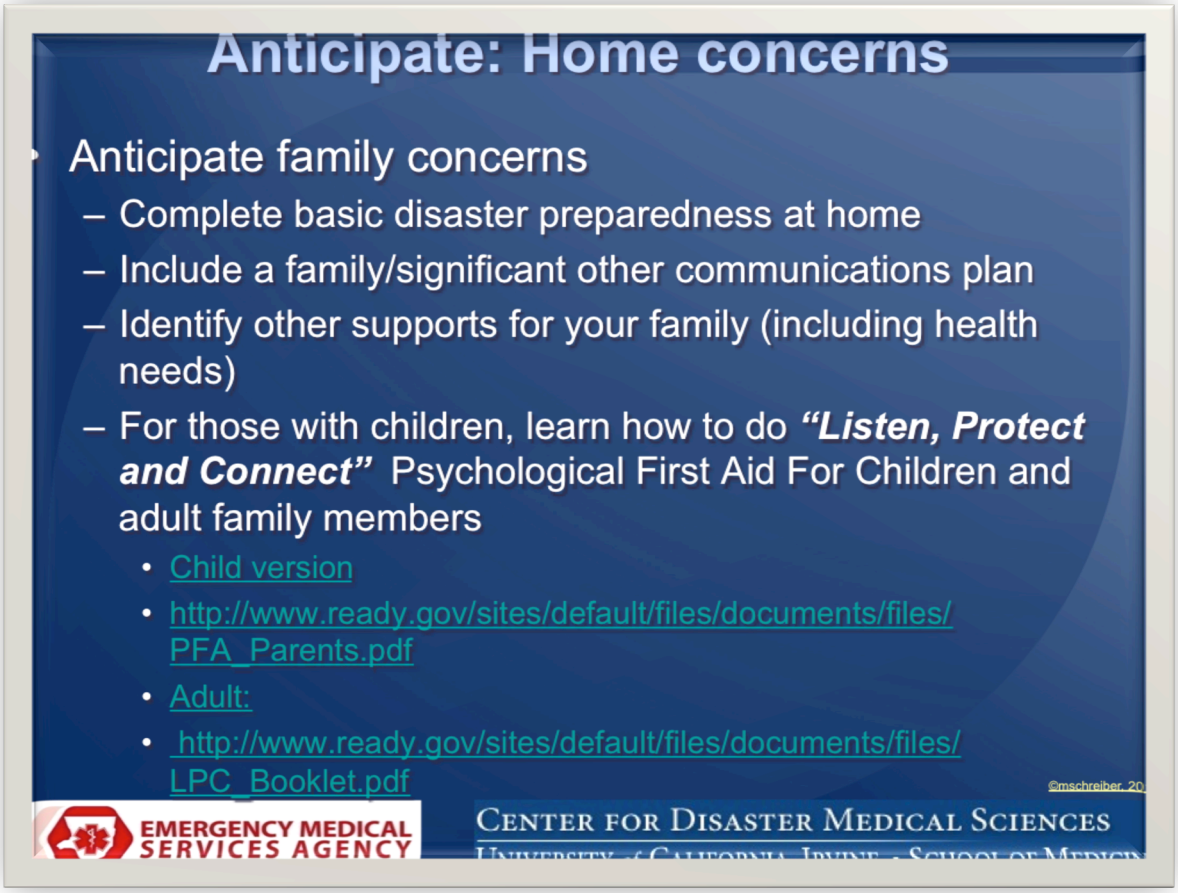

As described earlier, "home concerns", (i.e., concerns about significant others, family members and pets) can be a major area of concern and stress for healthcare workers. One way to mitigate that is by home preparedness activities. This includes preparation of a disaster kit, family disaster communications plan, and other sources of support for the family if the responder is not able to return home.

Responders can also provide basic psychological first aid to their own family members, including school age children using the Listen, Protect and Connect Psychological First Aid model (LPC). Instructions on how to learn this are available at: www.cdms.uci.edu/lpc
An all ages LPC Neighbor to Neighbor; family-to-family is available at:
http://www.ready.gov/sites/default/files/documents/files/LPC_Booklet.pdf

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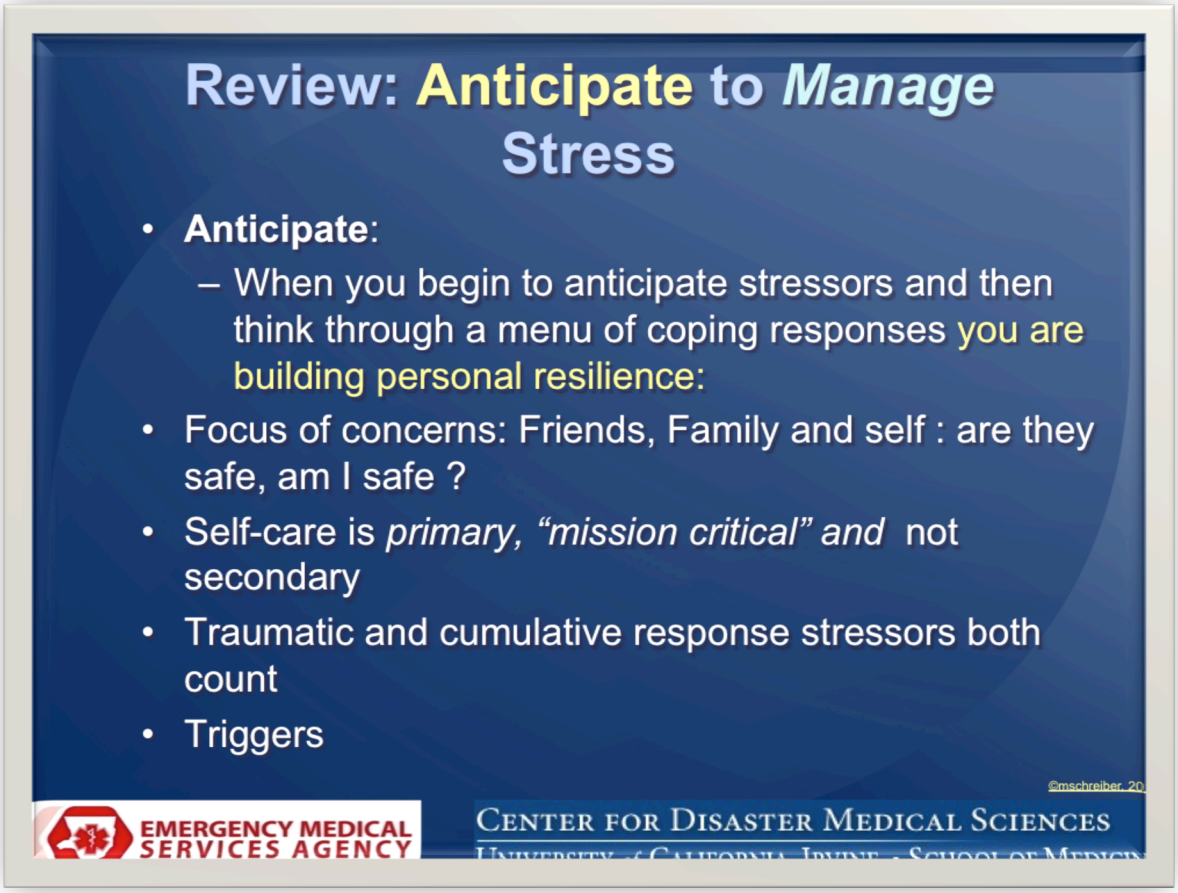

Resilience begins with staring to anticipate your response role and conditions.

- Consider the different types of stressors you might experience, consider the sights and types of disaster situations you might face and consider how a disaster response is *not another day at the office*.
- Anticipate the focus of your potential concerns: family issues, for local responders weigh heavily on responder stress. When deployed, using APD may markedly reduce your stress.
- If we are concerned about the quality of the medical mission, then self-care of healthcare responders is mission critical and needs to be integrated before, during, and after a response. It is not sufficient to have a single session sharing of "worst moments" (debriefing) following a disaster response and nothing else, particularly for healthcare workers who where highly impacted by the event.
- Working as a healthcare worker is a "marathon, not a sprint". Healthcare workers are obligated to engage in good personal stress management on a daily basis and during a disaster, healthcare workers must "step up" their stress management plan to meet the emotional demands of the disaster.

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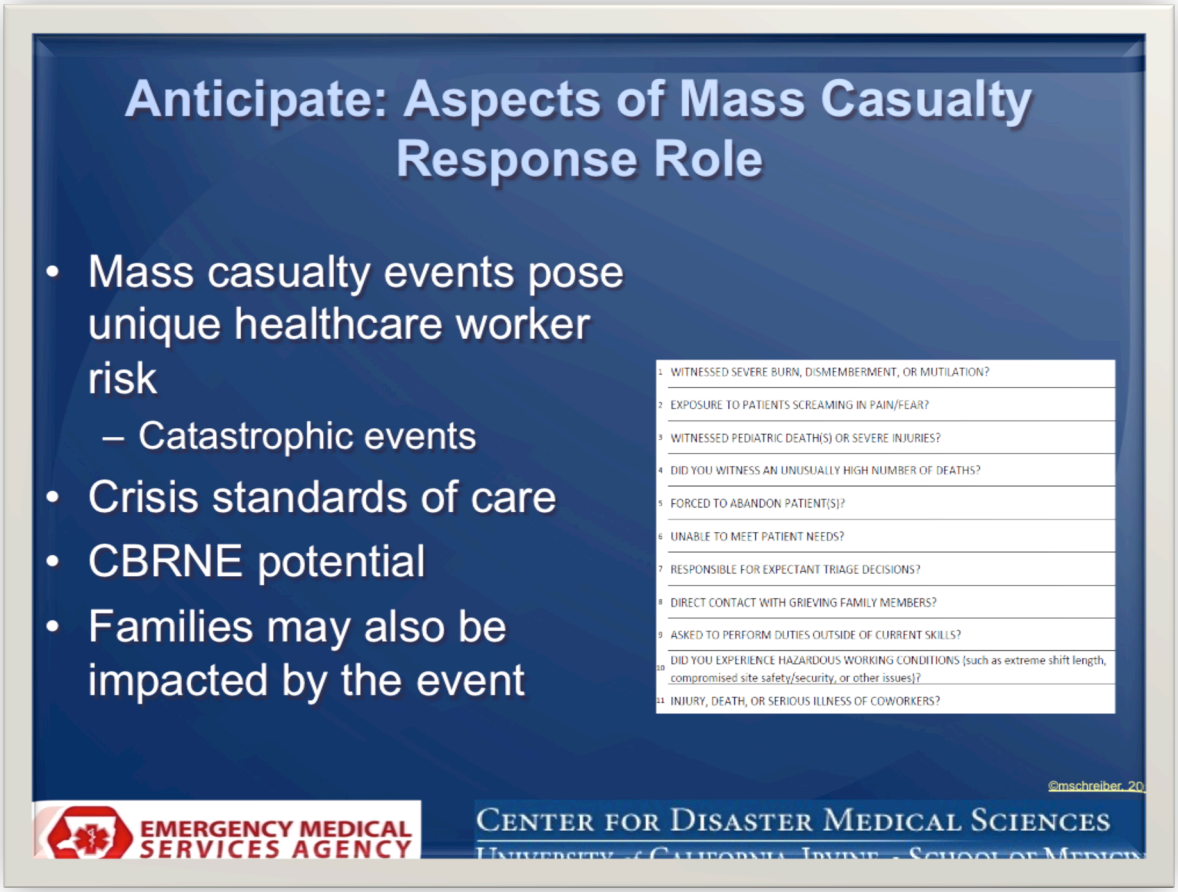

Crisis standards of care represent an ethical and rational approach to allocate resources in hospitals and other settings. Participants are also encouraged to read the IOM Crisis Standards of Care report available without cost at: http://www.iom.edu/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx

When the response event involves chemical, biological, radiological or nuclear agents, this adds significant further stress potential for the healthcare responder. Unlike medical risk, just the threat or perception of these materials being present can be enough to trigger long-term posttraumatic stress reactions in responders. There is considerable lack of familiarity with these agents, their health effects, PPE and concerns about personal exposure and secondary exposure to family members. This may add tremendous additional burden to medical workers in these events. Additionally, the larger the scale of disaster, the more likely that the healthcare workers social network of friends and family will be directly impacted.

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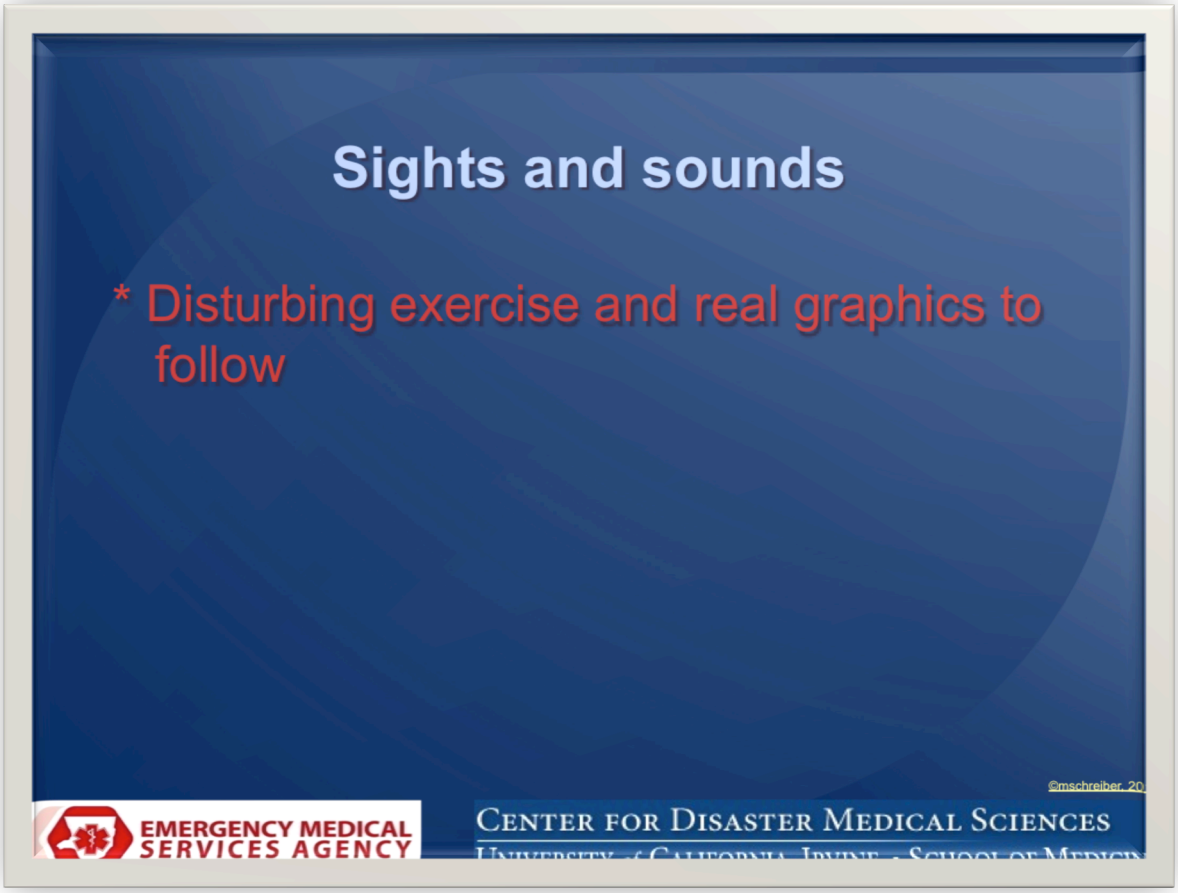

The next series of slides are images of various types of disasters and catastrophic events of the type you might find yourself encountering as a disaster healthcare responder. The purpose of these slides is to expose you to the types of difficult situations you may very well encounter in a disaster response. You can consider these different types of situations as you continue to refine your "personal resilience plan". The images begin with depictions of various full-scale exercises involving mass casualty disasters and terrorism. They continue with various aspects of these situations such as mass casualty triage, field decontamination, disaster medical field operations venues (such as a Mobile Field hospital, etc.). The images continue on to real world events involving property destruction, including the images of damage to a local hospital from the EF5 Tornado in Joplin Missouri in May of 2011, makeshift medical operations in the Philippines and the Russian Beslan School Massacre in 2004. In this terrorist event, many children, parents and teachers were killed in a fire with gunshot wounds and fragmentation injuries. These are likely to be the most disturbing images in this section.

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This slide depicts a very large scale exercise from the federal TOPOFF2 exercise in Seattle. This image depicts care and decontamination of potentially contaminated patients (this is a radiation exercise event). This is similar to what you might encounter in a "dirty bomb" event or other CBRNE response.

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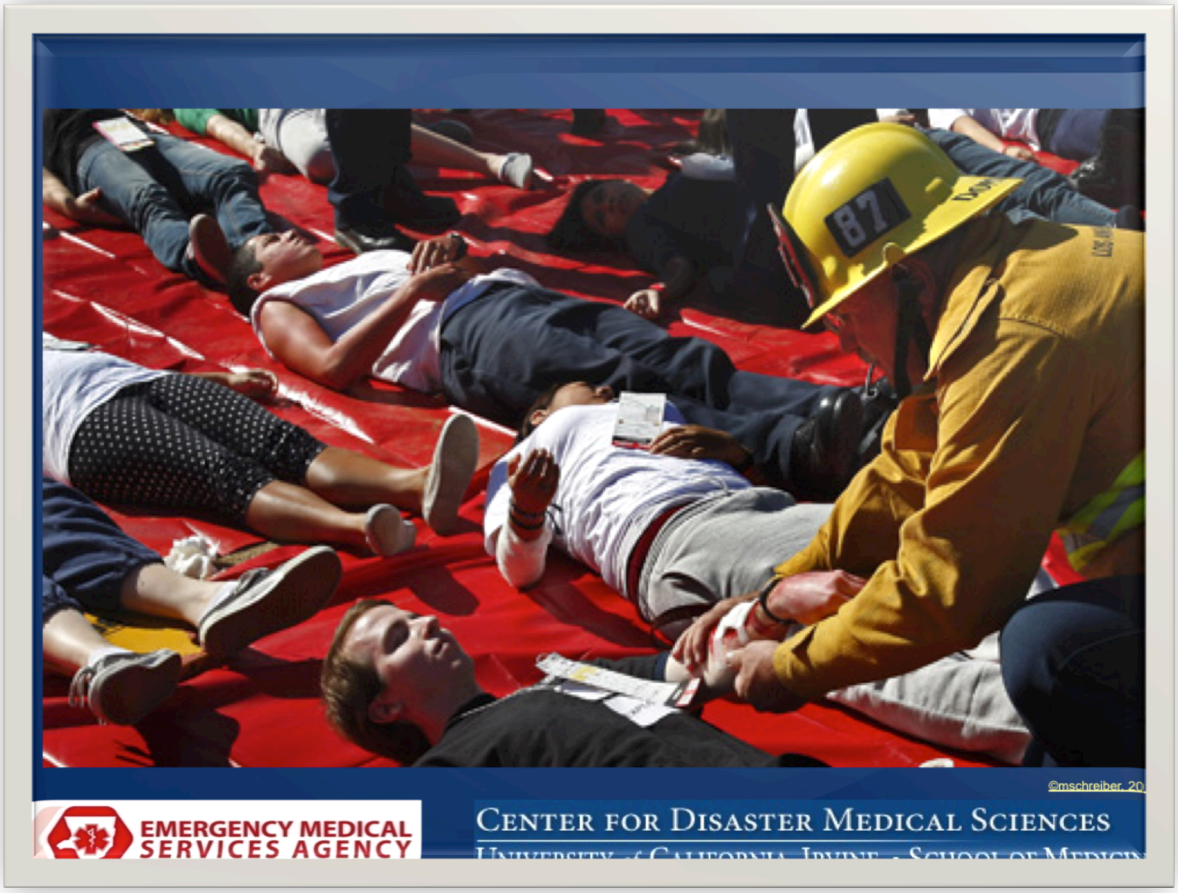

This image shows mass casualty triage from National TOPOFF2 Seattle exercise. You might be called on to support mass casualty triage operations.

What do you observe as potential exercise artificiality?
(Calm orderly, all patients perfectly lined up)

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Instructor optional slide

This exercise shows a mass casualty terrorism chemical weapon in a mall.
Here patients are being rescued and transport by LAFD in full Level A Personal Protective Equipment.

What additional burdens does working in PPE place on the responder?

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This is another image of treatment in a contaminated environment and in this case with military medical professionals delivering care while wearing PPE (Personal Protective Equipment).

Imagine how a pediatric patient might experience by these providers in PPE ?

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This image is from the Kobe disaster and depicts the massive infrastructure damage following a catastrophic event as well as the shock that survivors encounter as they return home. You may hear about these scenes in patients you treat or that you may see directly yourself in the community.

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Also from the Kobe disaster, this image depicts the frequent occurrence in large-scale disasters where victims are separated from family members and use simple postings to locate them. In some disasters, members of the public will come to the ED/clinics and other healthcare facilities searching for their missing, injured or dead loved ones. Being prepared to encounter these individuals is part of your own resilience preparedness.

Key point: It is also important for disaster responders to have a plan for communicating with their own family members following a disaster.
There are three key strategies to consider, if you have already included these in your personal resilience plan:

1) Use the American Red Cross family locator system at www.safeandwell.org, you can load this on your smart phone now.
2) You can also download the ARC Earthquake and wildfire phone apps for free for IPhone and Android and this includes the “safe and well” function.
3) If no communications are available in large events such as earthquakes, prepare your family now that this may occur and does not necessarily mean anything happened to you. It is normative for this type of event.

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This slide depicts a patient med-evac in a catastrophic medical event—Southeast Asian Tsunami.

This medevac reflects international disaster relief with United States Navy Nurses from the USNS Mercy and German army providers. In catastrophic disasters, medical response involves differences in care, patient type, patient mortality, and settings. You may be called in to work with novel collaborations and partners such as shown here with the US Navy and German Military in Banda Aceh.

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This scene from the Philippines Super Typhoon Disaster Haiyan depicts medical provider operations in an austere, heavily damaged hospital environment. Anticipate that your facility might be damaged and how you might cope with that.

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First Responders and healthcare workers may experience the injury or death of co-workers. You may also know many of these responders and co-workers from your job and be impacted because of your personal relationships with them.

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Dealing with many grieving family members, in the context of a mass casualty event, where "crisis standards of care" has been implemented, also poses stressors for healthcare workers.

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As in the previous slide, interacting with parents who have lost a child (or children) will be difficult for healthcare workers to cope with.

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Research shows that coping with seriously injured children is particularly challenging for all types of responders, including healthcare responders.

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This image and next three slides that follow all depict children lost in the Beslan School tragedy. Whereas you might very well have experience with pediatric deaths, hopefully you have not been exposed to many multiple pediatric fatalities. It is likely that the context of this event, human caused violent terrorism, contributes to the stress of healthcare workers who may be involved in these cases.

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Rapidly move through these slides, do not allow extended viewing time, this is a glimpse of exposures

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Although you may never be exposed to a mass morgue such as the one pictured here in Belsan Russia, a mass casualty event will be challenging for all of us in the community.

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The slides capture potential indirect exposures you might encounter involving mass mortality and body recovery challenges in a large scale disaster.

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This slide is shows expectant triage in a mass casualty disaster (Hurricane Katrina).

Instructor should ask: "How you will handle these types of decisions in your role as a healthcare worker?"

(See the IOM Crisis Standards of Care report for further information on this)

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Although hospitals are built to different standards than other structures, they too can be damaged in certain large-scale events. This picture shows damage to a hospital in an earthquake in Los Angeles County in the 1970's.

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This picture is of a local hospital that was damaged in the 2011 Tornado in Joplin Missouri. Imagine how stressful it was for healthcare workers to witness the destruction of their hospital and the aftermath of trying to take care of patients and rebuild the hospital ?

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Less traumatic perhaps but reflecting some of the PsySTART Responder stressors discussed earlier, this image depicts heating and air-conditioning systems support at a hospital on Long Island in the aftermath of Superstorm Sandy in October of 2012. Consider the additional stress staff and patients would face without power or environmental systems operational.

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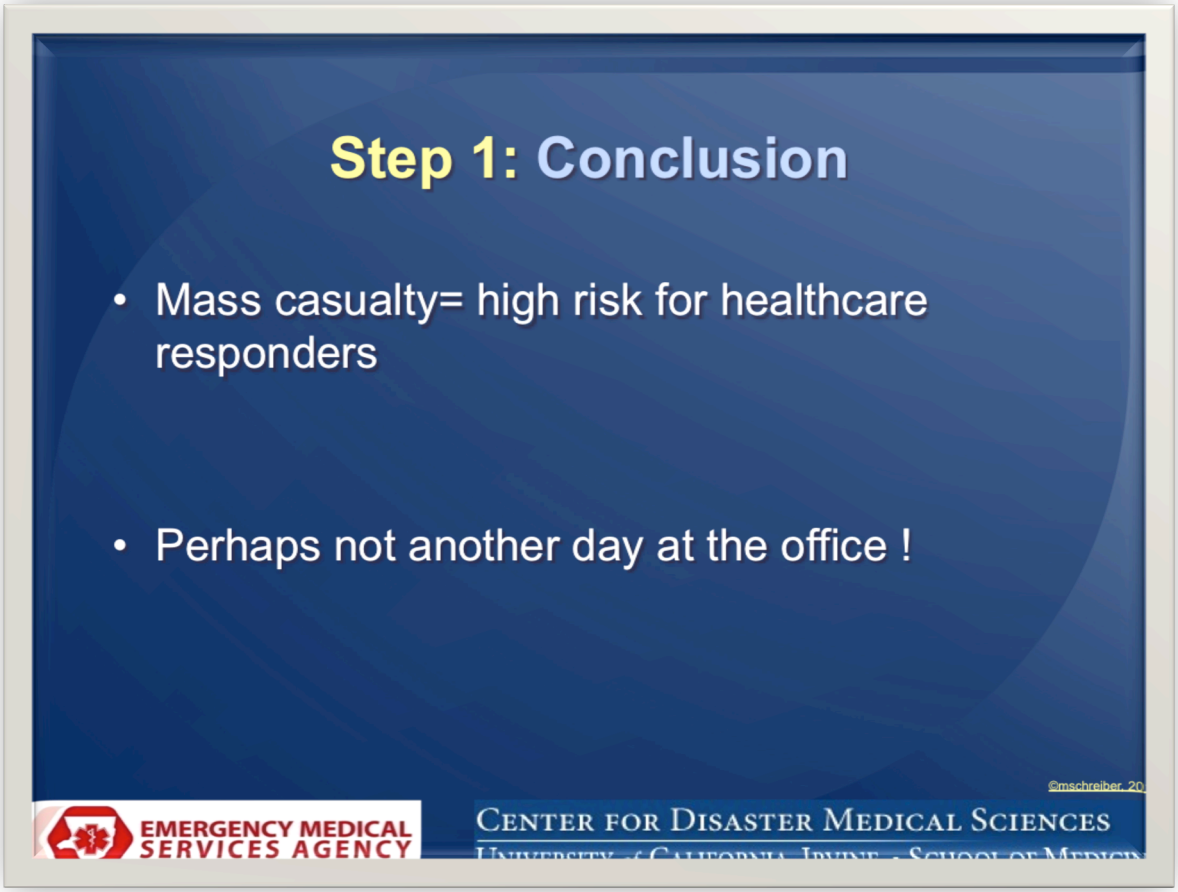

Discuss these key points and address any questions or confusion to this point.

- Mass casualty disasters involve both significant qualitative and quantitative stressors including aspects of differences in each of these areas and "Not just another day at the office":
- Qualitative and Quantitative differences in these areas:
  - Personal impact factors
  - Setting impacts
  - Patient factors
  - On-going climate of threat for responders and their families
  - Family concerns

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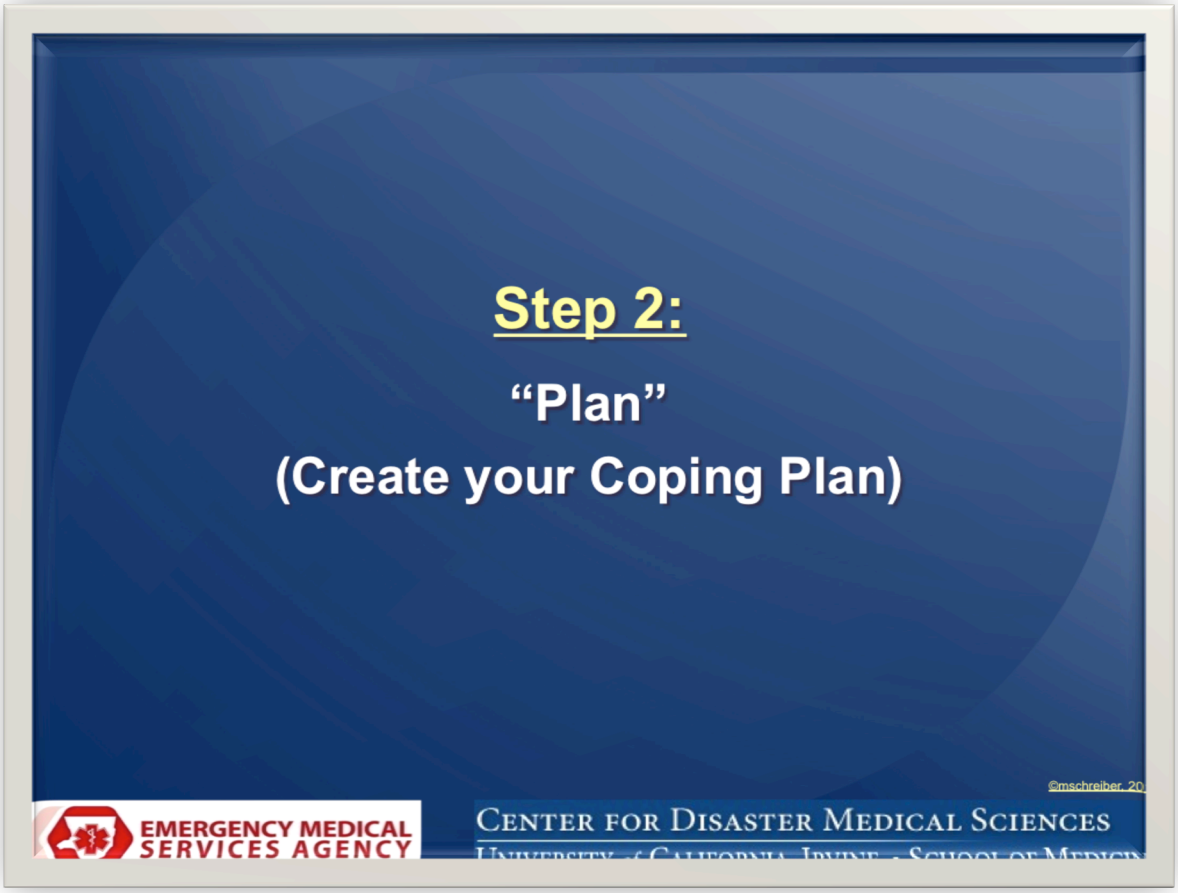

NOW WE MOVE TO STEP 2.
In step one we considered a range of stressors and explored some possible exposure risks you may face as a healthcare responder. That is the "Anticipate" part of APD. Now it is time for Step 2 OR "Plan" OF APD.

Now that you have "Anticipated" your stress reactions for a disasters/mass casualty event, we will focus on what you can do about it. In APD "what to do" starts in Step 2 – Plan for Your Response Challenges. We will use this next step to help you create your own personalized coping plan. This plan is just for you to use. We hope you consider this as a key part of your personal "go kit" or as a part of your "personal protective equipment" during a disaster.

Based on your existing coping strategies and coping resources, you can facilitate your personal resilience following a disaster. APD is a "strengths based" approach where you will leverage your resilience factors to help you cope better with stressors in disasters and mass casualty events.

APD will offer you some additional choices on how to cope, however, this strategy mainly relies on your already considerable strengths and coping skills that you use

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daily on the job. With APD we are building on your resilience in advance of the next disaster, public health emergency, or mass casualty event.

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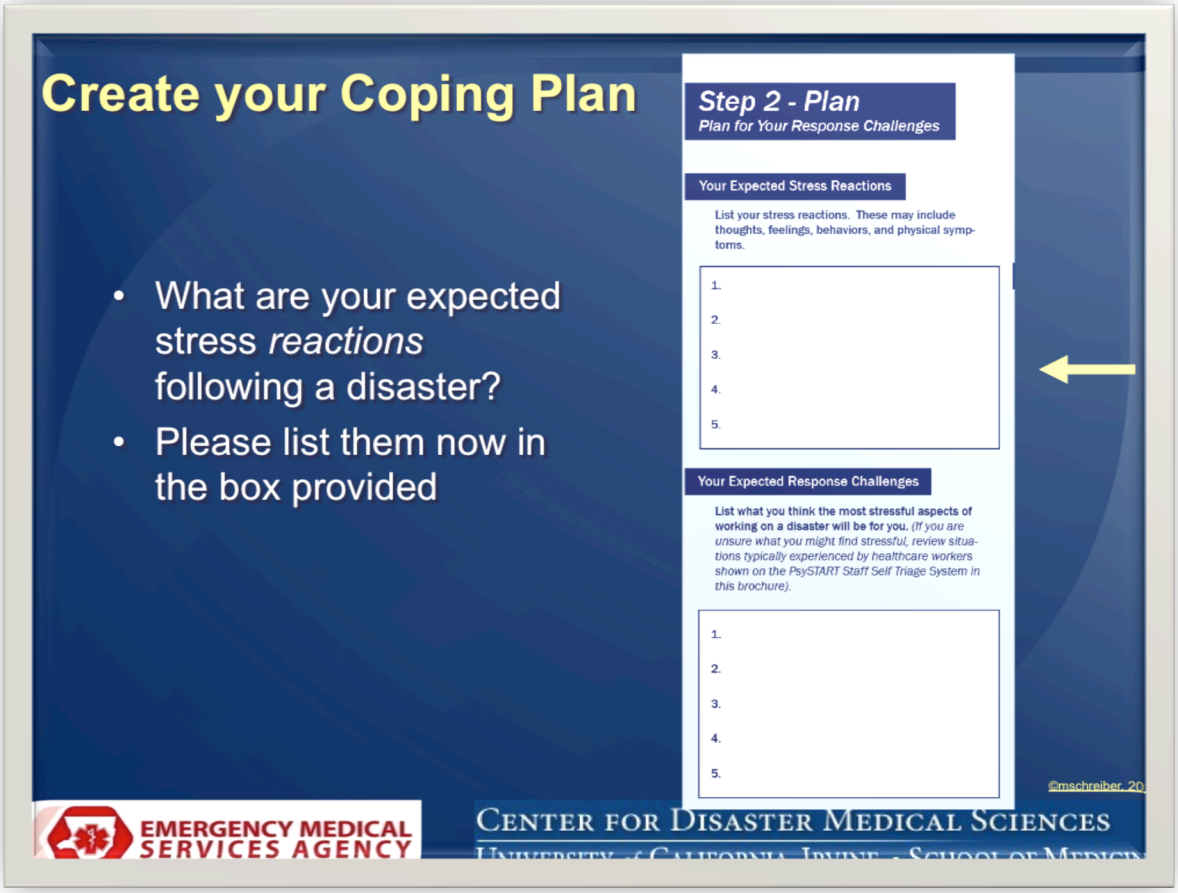

When you leave today, we hope you will have each section of your APD "Personal Resilience Plan" filled out with your own "coping" ideas. If you leave sections blank, then fill in your answers at home. Remember, APD is customized to you based on your anticipated concerns and your own coping styles and resources.

The first step of the plan is to list what your expected reactions might be to a large disaster. (The Instructor should refer participants to the "Step 1 Anticipate" section of their brochure to review the "Traumatic" and "Cumulative" stressors before writing in their responses to this section.)

- Give participants time to fill in this section.
- Ask for volunteers to share examples.

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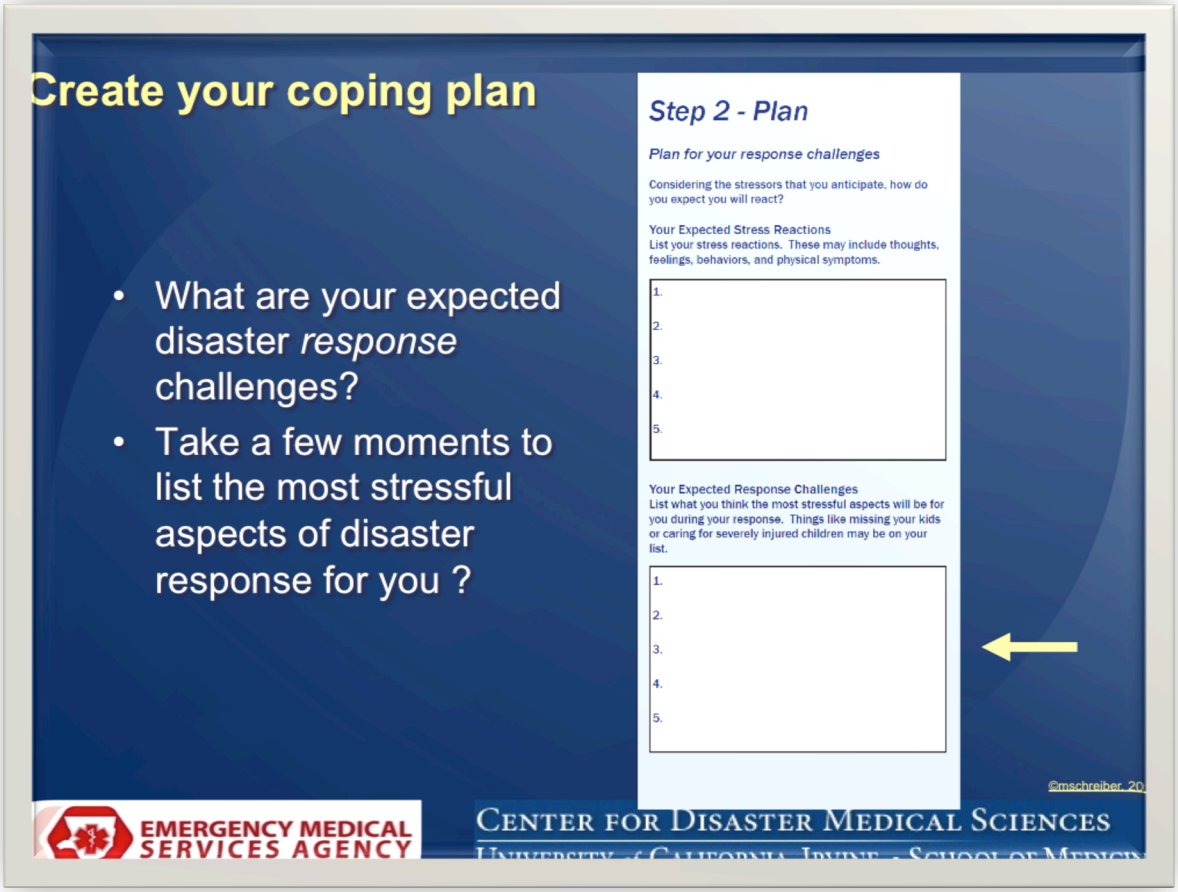

Next on the same page of your APD Plan Brochure under "Your expected response challenges":

- Consider and write in the space provided what you now think your biggest response challenges would be?
- The Instructor should remind the group of "potential reactions" discussed earlier in the class and write up to five reactions.
- Ask if anyone is willing to share their response challenges with the group.

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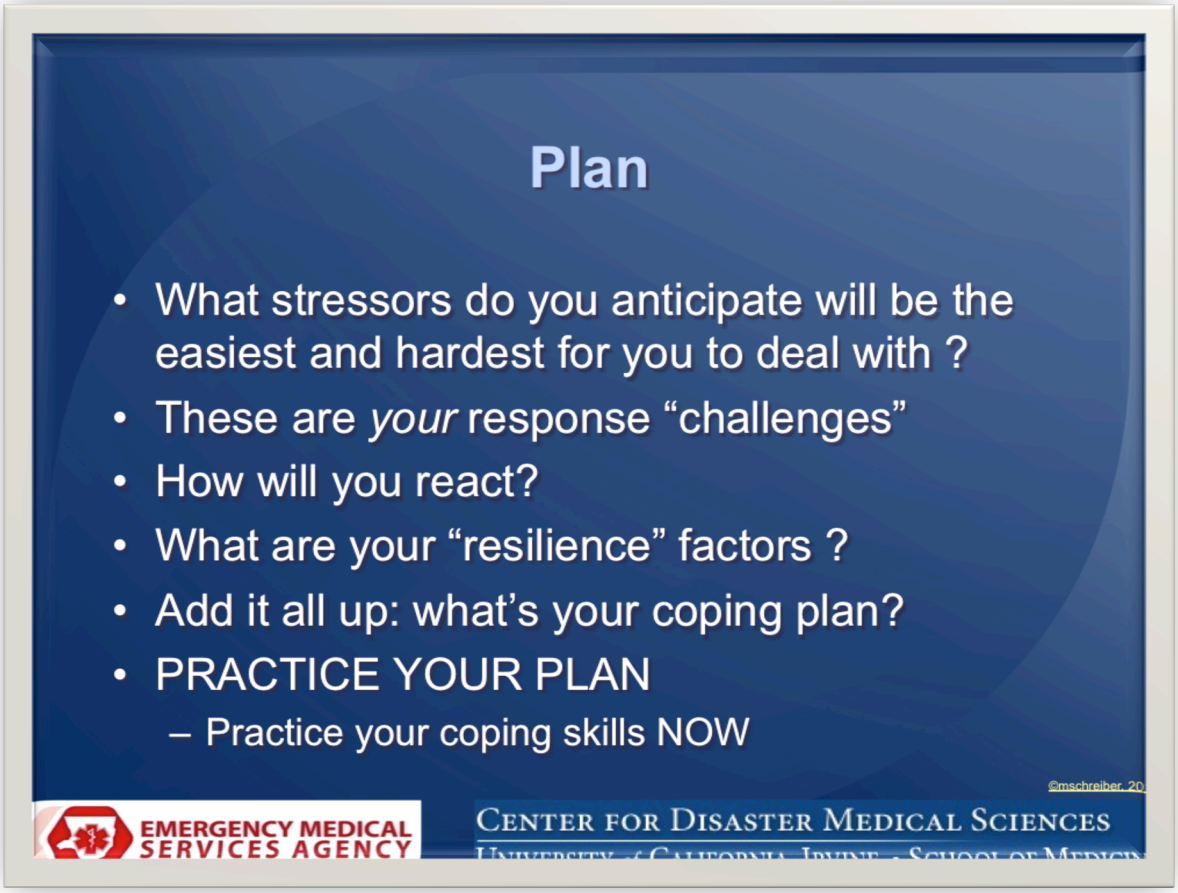

This reviews the first page of their plan and transitions to the resilience and coping sections. "Plan" means develop a range of possible coping tools and strategies to manage the stress impact of those elements you identified as potentially stressful experiences (PSE's) in the Anticipate section of your personal resilience plan.

- Review each of these, if not already mentioned by group members in the previous slide.
- You can talk about each of these or some of these as time permits and based on group inputs that may have already occurred.

Now, we are going to consider how to manage those stressors you have anticipated.

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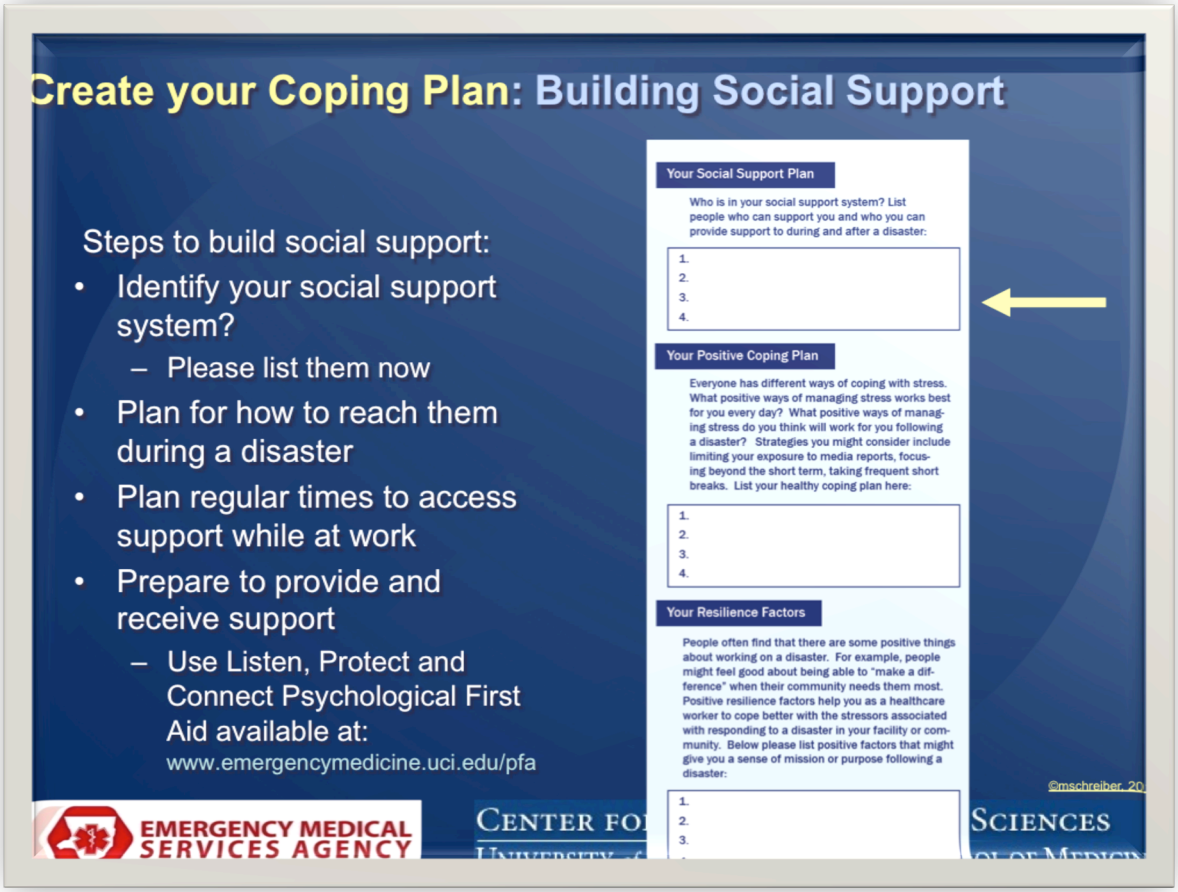

Let's build on your own current resilience factors. One key coping dimension that has received considerable research support is the link between stress and the effects of social support.

So thinking about your social support system, discuss with them how you might outreach to them during a big event and consider how you want to reach them in a disaster context (talking to them, texting them, video chat, email?) what is your preference? What is most practical in a busy mass casualty event?

How will you use your social media? What is the upside and the downside of using your social media?

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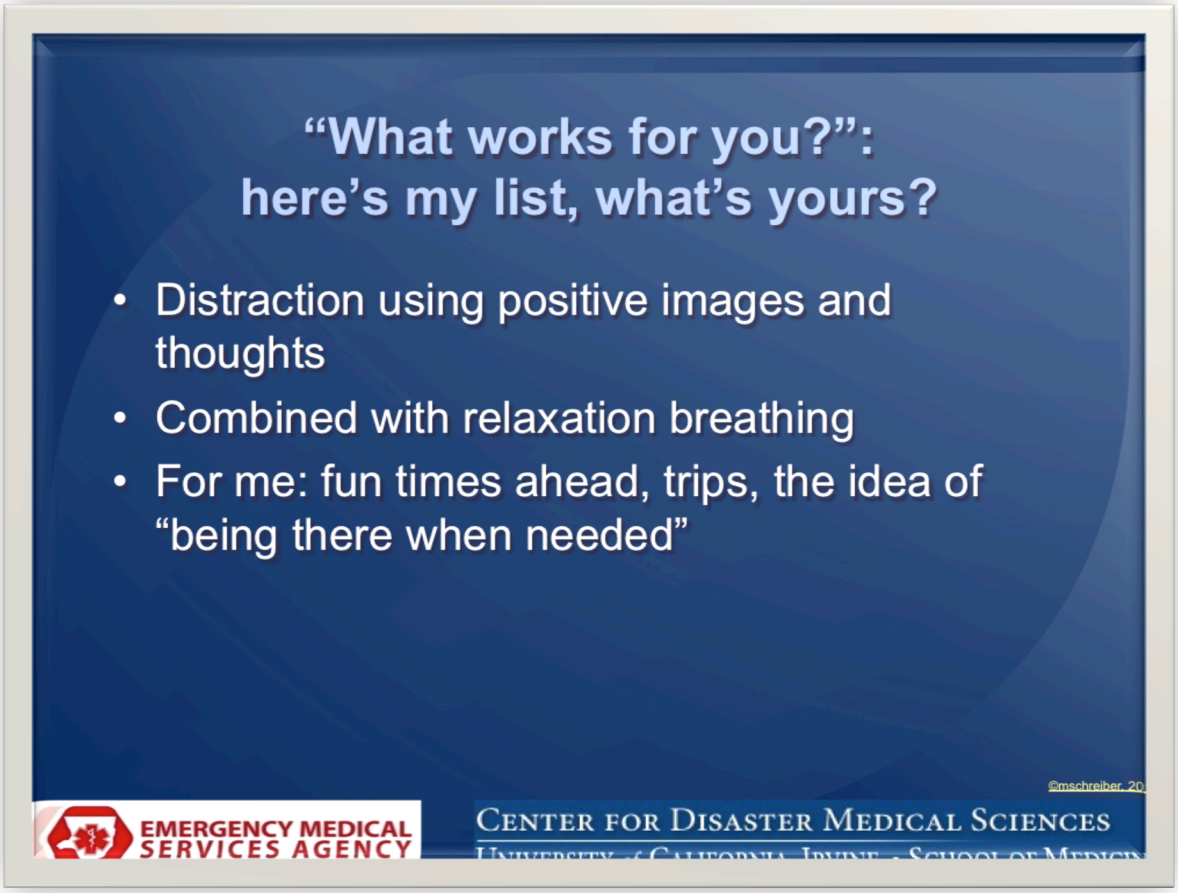

Here the instructor shares their list of coping strategies and asks group to share theirs.

- Include positive imagery they can use from their own experiences
- Future positive activity planning
- Other strategies they mention that involve active coping

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One strategy the developer of APD uses is a variant of "guided imagery". This slide shows preselected an image that is enjoyable and relaxing for you. In this case, this is an image of Tuolumne Meadows area in the Sierra Nevada Mountain.

The developer of this course keeps this image on his phone or as a photo in his go kit. When stressed or even at the end of an operational period, he views the image and practices self-relaxation tied to the image.

- Encourage participants to identify similar images they can use for themselves.

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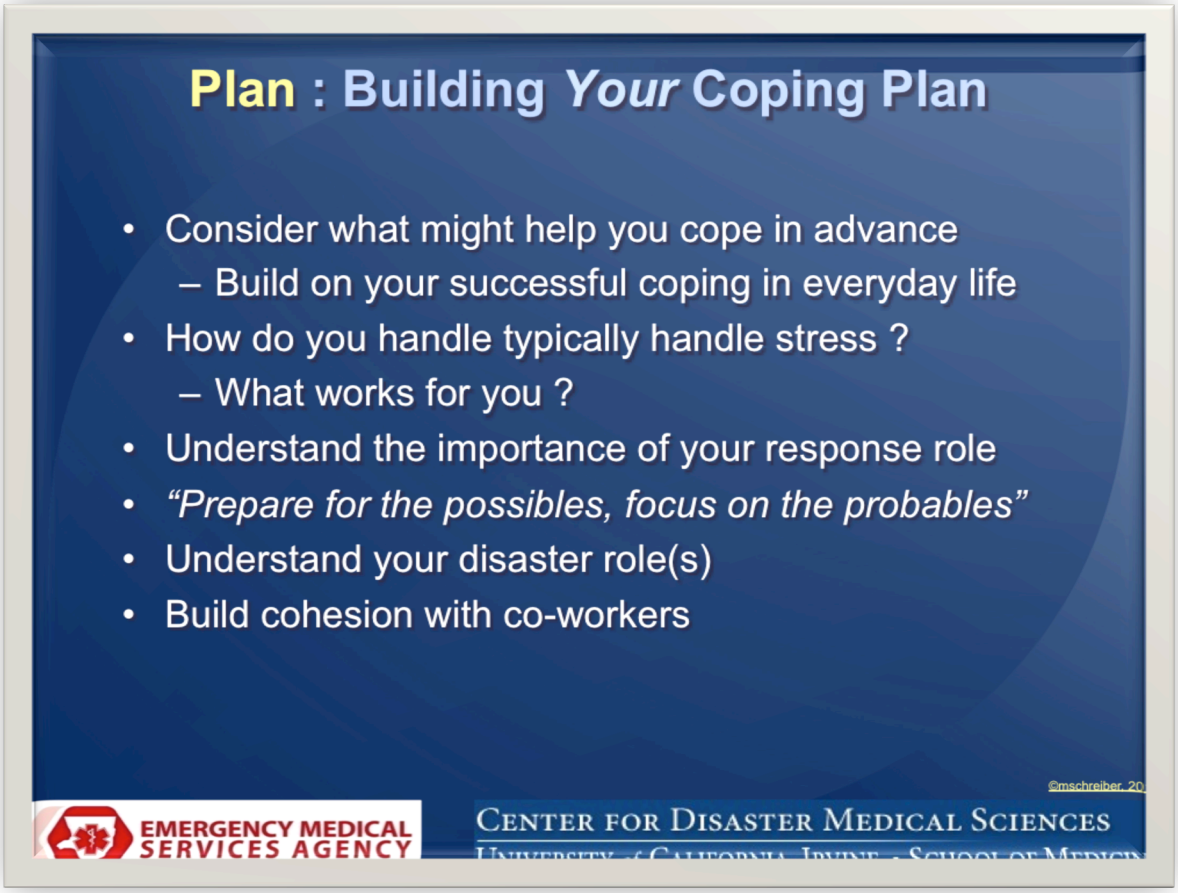

In the next section we build on other strategies and skills you already use on a daily basis.

Your Personal Support Plan – We will be asking you to identify people who help you cope with stress during difficult times.

Your Positive Coping Plan – We will be asking you to identify positive ways they typically manage their stress on a daily basis. Be prepared for a range of possible stressors now. During a disaster, remember your expected stress reactions, response challenges and coping strategies, as well as the rest of the strategies we will discuss next for APD. Also remember that building cohesion with your coworkers is a key part of enhancing your social support system.

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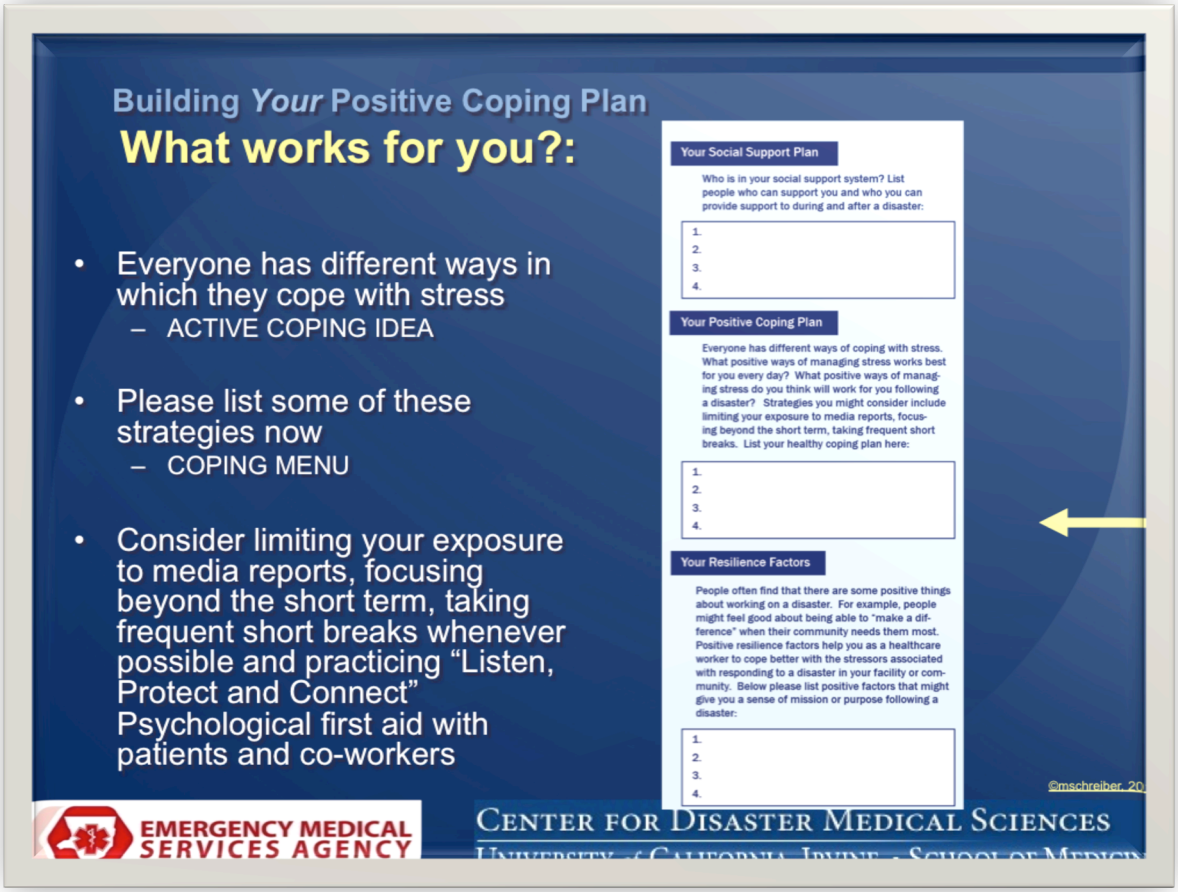

Your Personal Support Plan – Ask participants to take a few moments to list people who help them cope with stress during difficult times. This should include individuals they can talk to following a disaster. Talking with people they trust following a disaster is a key element of their APD "coping plan".

Your Positive Coping Plan – Ask participants to list positive stress management strategies that they could actually use in a disaster. One way to discuss this is to talk about the difference between "positive" and "negative" coping. (If alcohol, food, other substances are mentioned, be prepared to discuss why that may not be the best strategy: i.e. not active coping, blunts feelings but does little to manage the stress or situation per se and reinforces "numbing" but not active coping.) List as many positive strategies as you can. This can be your "coping menu" during a disaster.

One thing that everyone can include is a plan to manage his or her exposure to media reports. These reports can be informative but also a cumulative stressor when viewed over and over again.

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Another strategy that can help you and your co-workers is learning about how to administer Psychological First Aid. If you are interested in learning Psychological First Aid, your facility can contact Sandra Shields, Disaster Program Manager at the LA County EMS Agency to receive training on psychological first aid using the "Listen, Protect and Connect Family to Family, Neighbor to Neighbor" training program.

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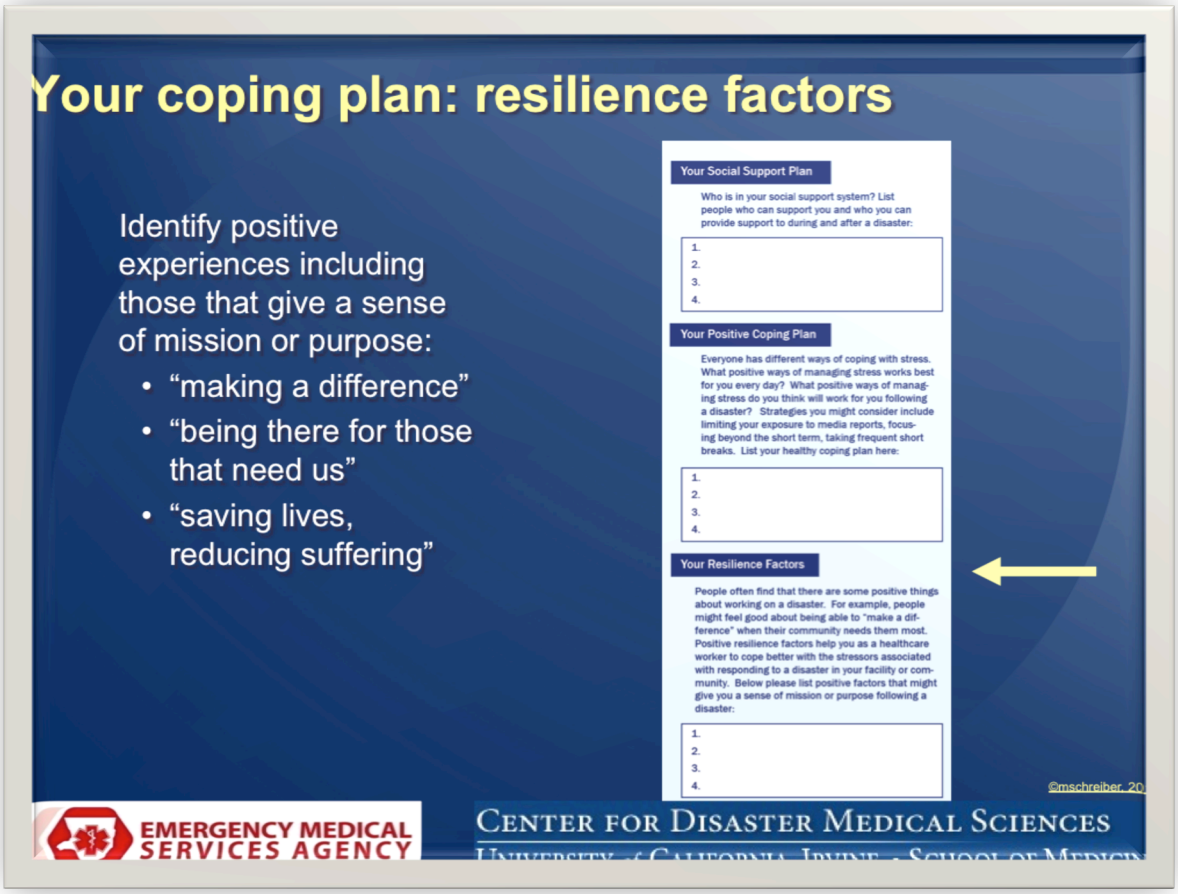

The last section of their plan is the "Your Resilience Factors" section. Here participants are asked to consider other resilience factors they may have like a "life mission" or "personal philosophy" for their work in healthcare and also, their work helping people following a disaster. For some, it is the positive satisfaction from doing hard work to relieve suffering and save lives and a sense of "being there for others that need us." Use the section provided to list their resiliency factors that will also help them cope and reduce their stress.

Instructors ask for volunteers to share their "resiliency factor" ideas with the group.

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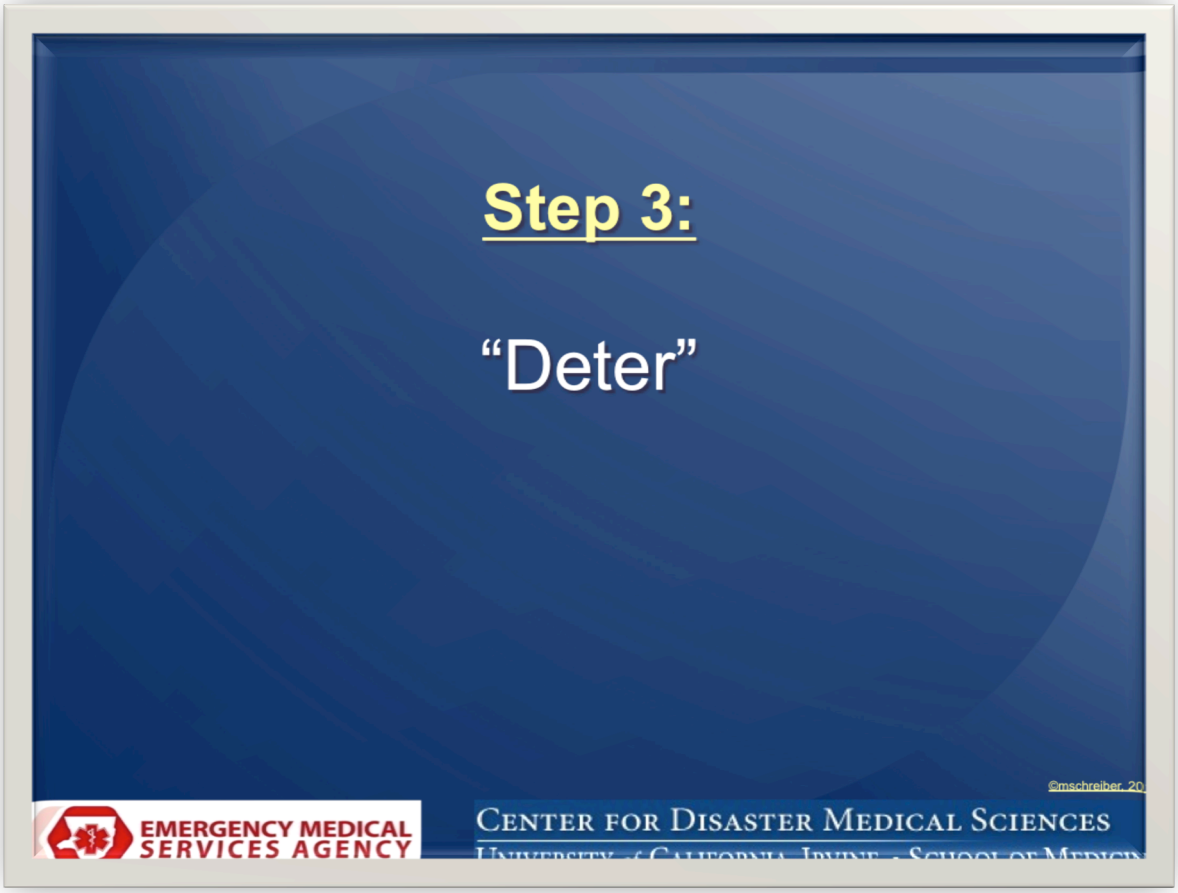

Now we move to Step 3 –
The "Deter" component of APD. Here we take all we have learned so far and discuss how to use their APD coping plan during a large event.

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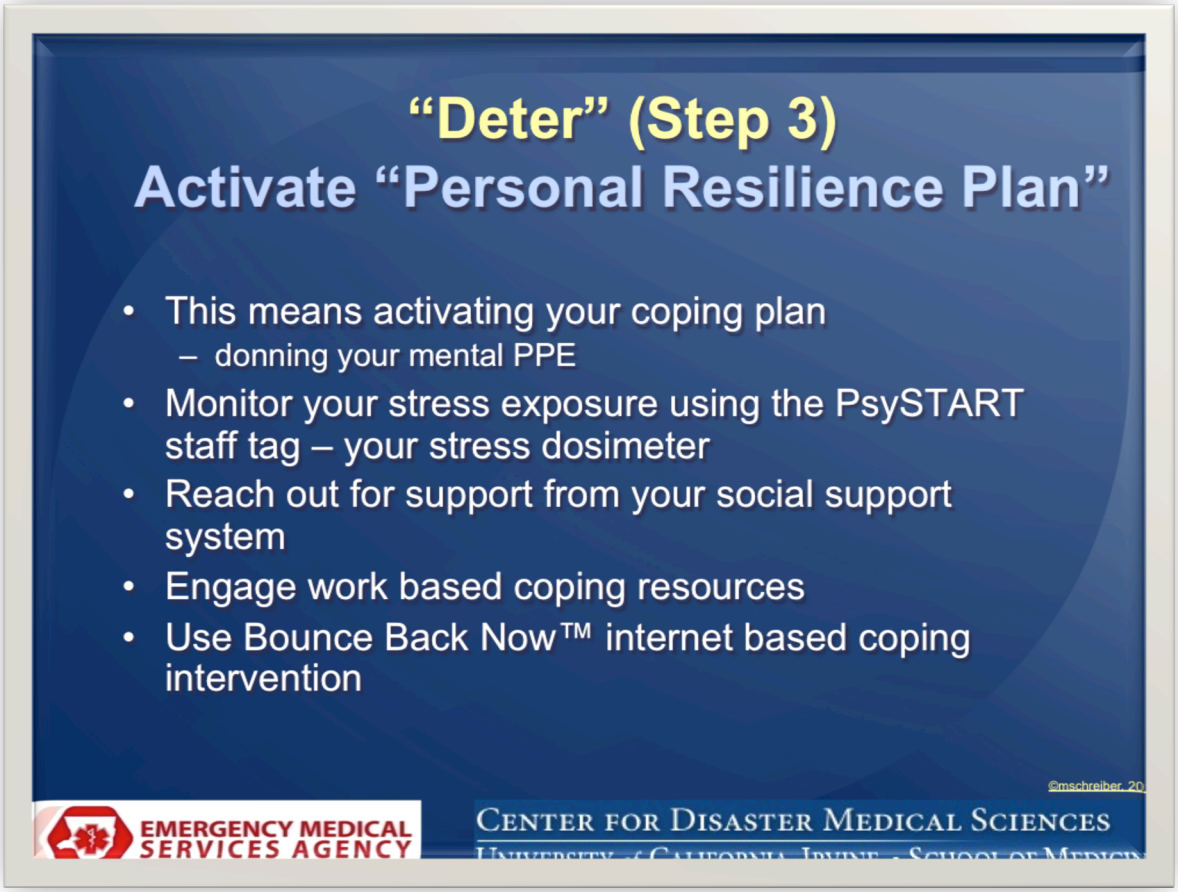

Deter means activating or "donning" your coping plan much as you would "don" your personal protective equipment in a Hazmat. In this context, the hazard is to your health stress and your coping plan is your "mental health PPE". The first step is monitoring your stress exposures using the PsySTART responder self-triage system. You may consider this your "personal stress dosimeter". Using these next steps will help you to take proactive steps to reduce or mitigate the stress you are experiencing.

- Remember, you can always use your personal social support system irrespective of your self-triage. Talking with a supportive friend is helpful for most of us.

Another resource that we are piloting is "Bounce Back Now", an online, anonymous program that you can use to gain more information and coping tools. (Instructors should direct participants to the information on "Bounce Back Now" under the Deter section in their APD brochure.) Again, "Bounce Back Now" is an online, confidential resource that you can use if you feel the need for additional coping tools. It focuses on posttraumatic stress symptoms including depression, anxiety, and substance use.

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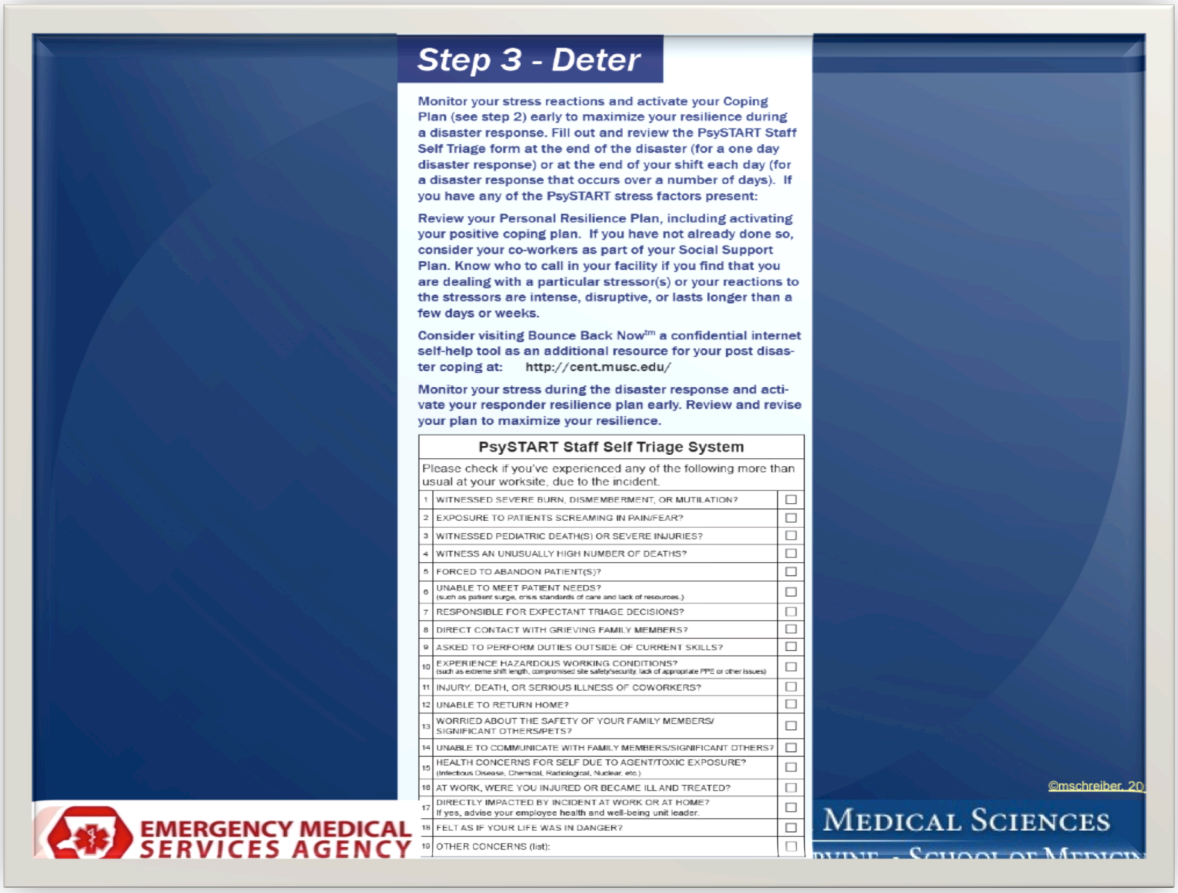

Under the "Deter" section you will also find the PsySTART Staff Self -Triage System checklist. This is a tool you can use for a single day disaster event. You can use this Self-Triage checklist to monitor the traumatic and cumulative stress items you experienced over one day. We also will be discussing the multi-day PsySTART Responder Self-Triage form that you can use to monitor what you have experienced over a multi-day response to do self-triage. We will now teach you about PsySTART responder self triage in some detail given its potential importance to you as you cope in disasters and other emergencies.

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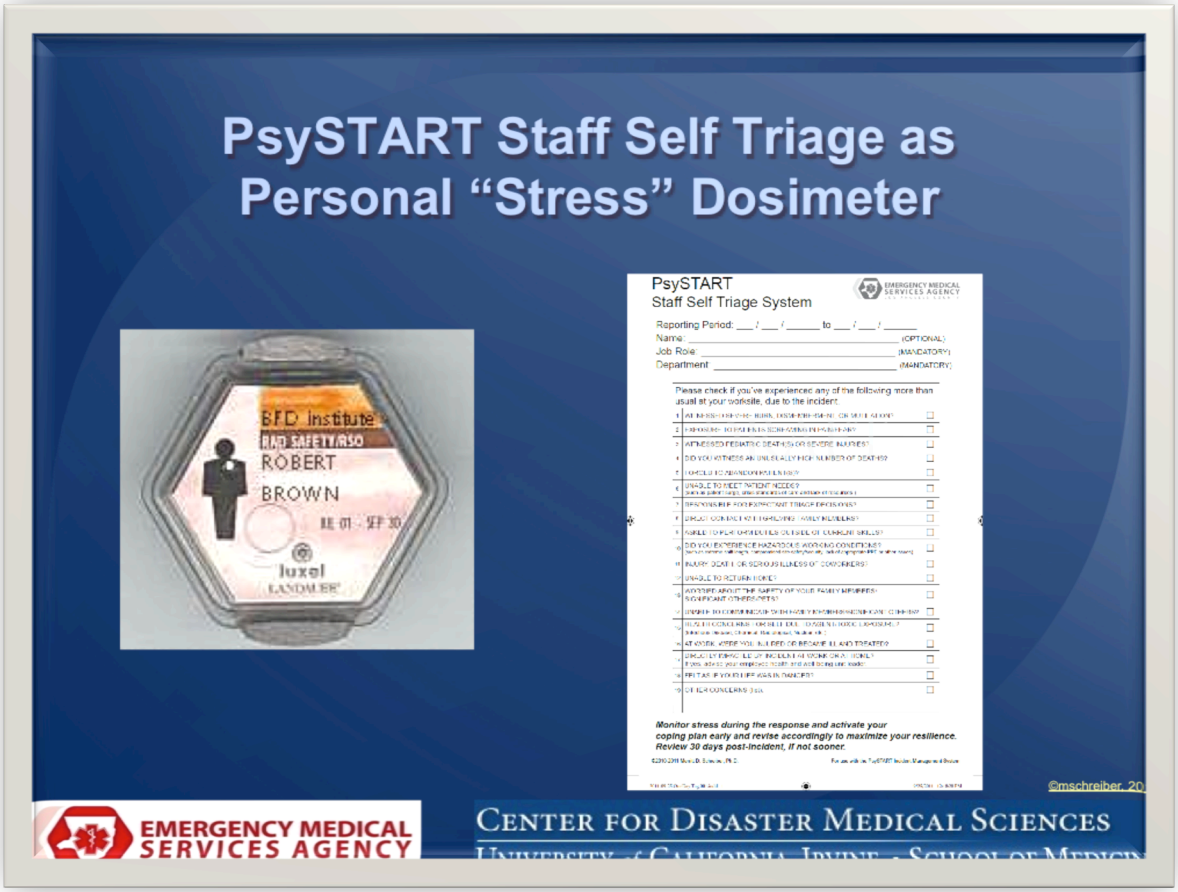

If you worked in radiation risk environment, you might be issued a personal radiation badge, which is a type of radiation dosimeter. As we discussed previously, PsySTART Responder Self Triage can be thought of as a method to gauge your stress exposure and risk so you can act to protect yourself early, before stress is overwhelming and impacts your response role.

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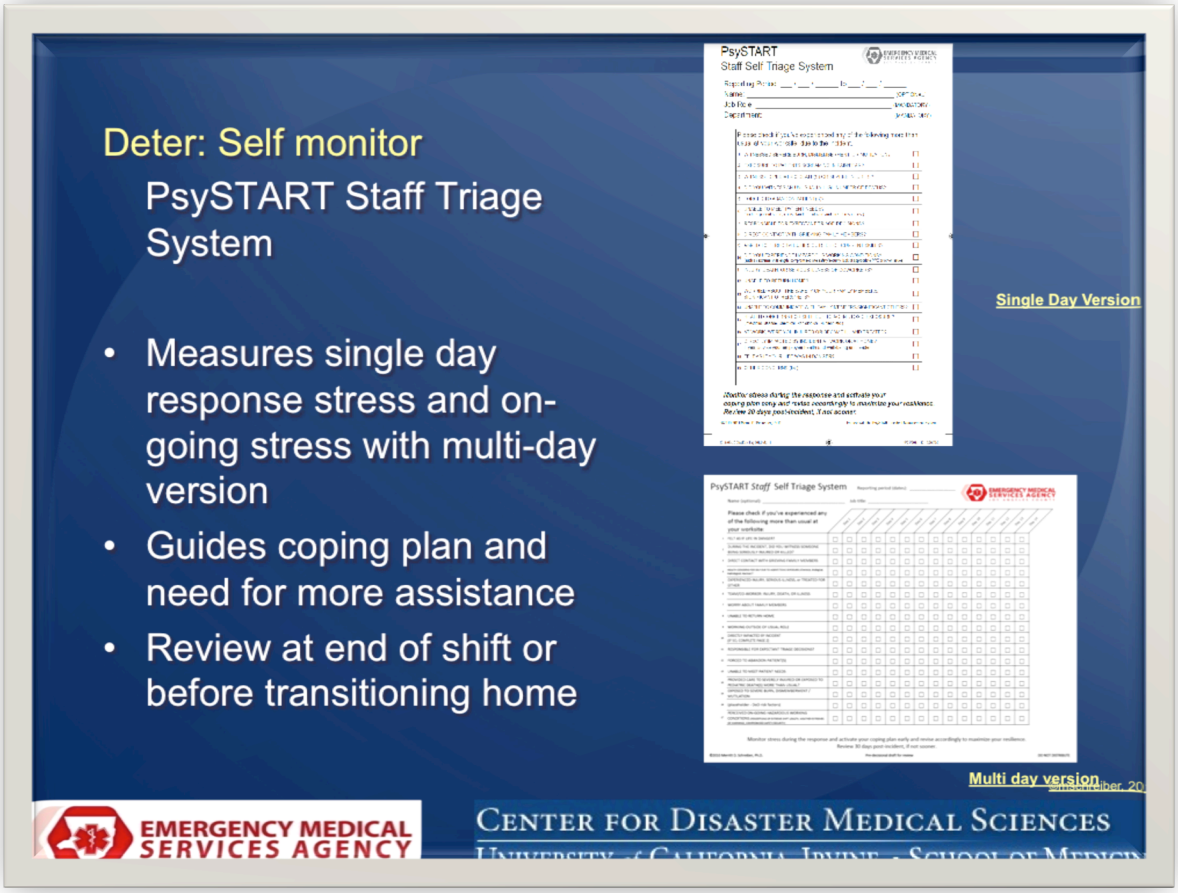

There are two versions of PsySTART Staff Self-Triage form. There is the single day version on your APD brochure that we have already discussed, and there is the Multi-day version that is the exact same form but allows for several consecutive days to be completed on one form. Both versions can be used to monitor your traumatic and cumulative stress experiences and help you guide your coping plan.

Instructors should have hard copies of both forms to distribute to participants. Forms can be found in the LA County EMS Agency website at: http://ems.dhs.lacounty.gov/Disaster/PsyStart.htm or by contacting Sandra Shields.

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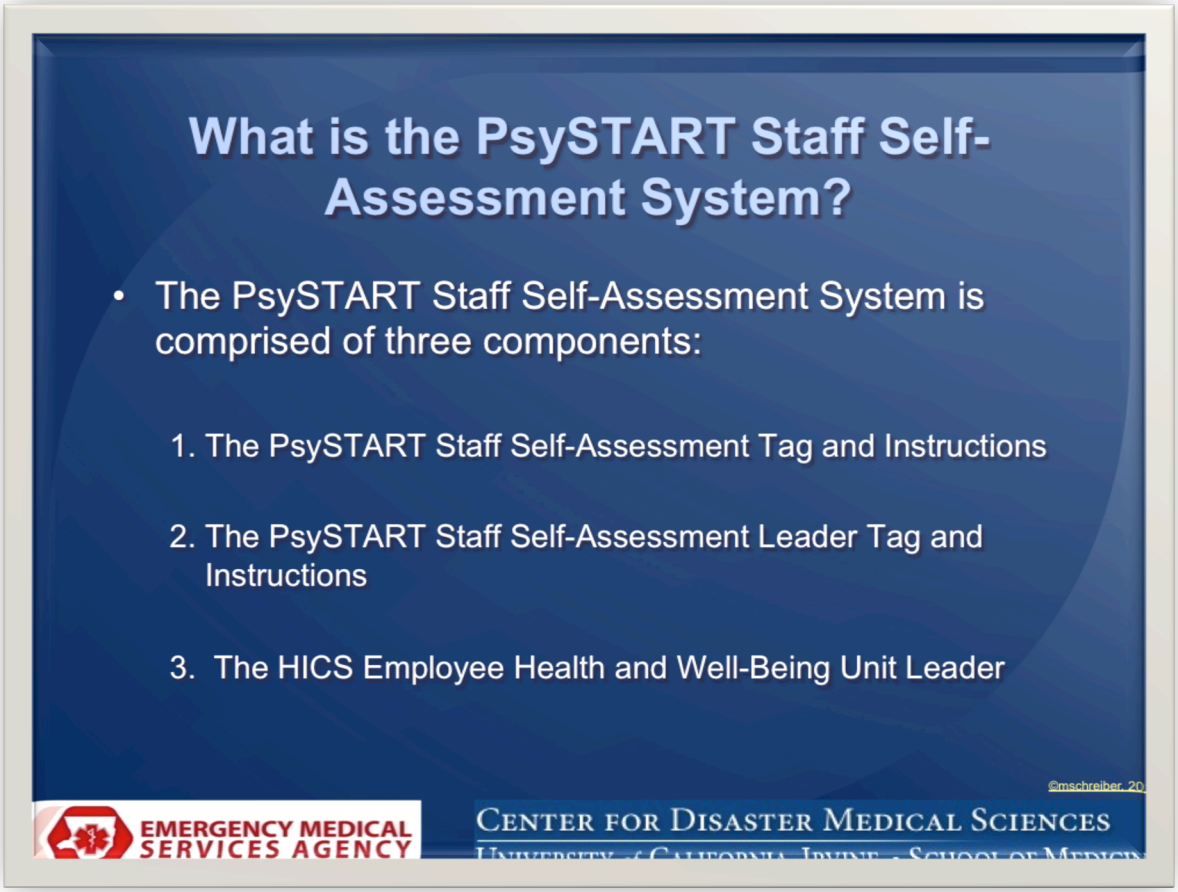

Let's start with the basic idea:
What is the PsySTART Staff Self-Assessment System?
It is comprised of three elements:
1. The PsySTART Staff Self-Assessment Tag and Instructions (single and multi-day versions)
2. The PsySTART Staff Self-Assessment Leader Tag version and Instructions
3. The Hospital Incident Command (HICS) Employee Health and Well-Being Unit Leader
We will discuss these in the slides to follow.

- The third component is a "leader" version of the self-assessment form that can be used as part of the employee health and well-being function to monitor the risk of the entire workforce.
- The completion of this form can be accomplished in a variety of ways that facilities will determine locally, based on their own decision process. This may include employees sharing their own self-assessment information with an employee health and well being team member, designated mental health/social services staff, or spiritual care staff.

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- The leader version can be also filled out based on having other indirect information about the items without direct sharing by staff. This would be an estimating technique since it is not based on individual reporting.

In addition, staff or their family members who have also been a direct victim of the incident are encouraged to discuss this with their employee health and well being unit leader and complete a regular PsySTART direct victim tag to consider the additional direct incident stress beyond their work role. This will help both the individual employee and HICS Employee Health and Well Being Unit Leader estimate needs and resource gaps to meet staff needs.

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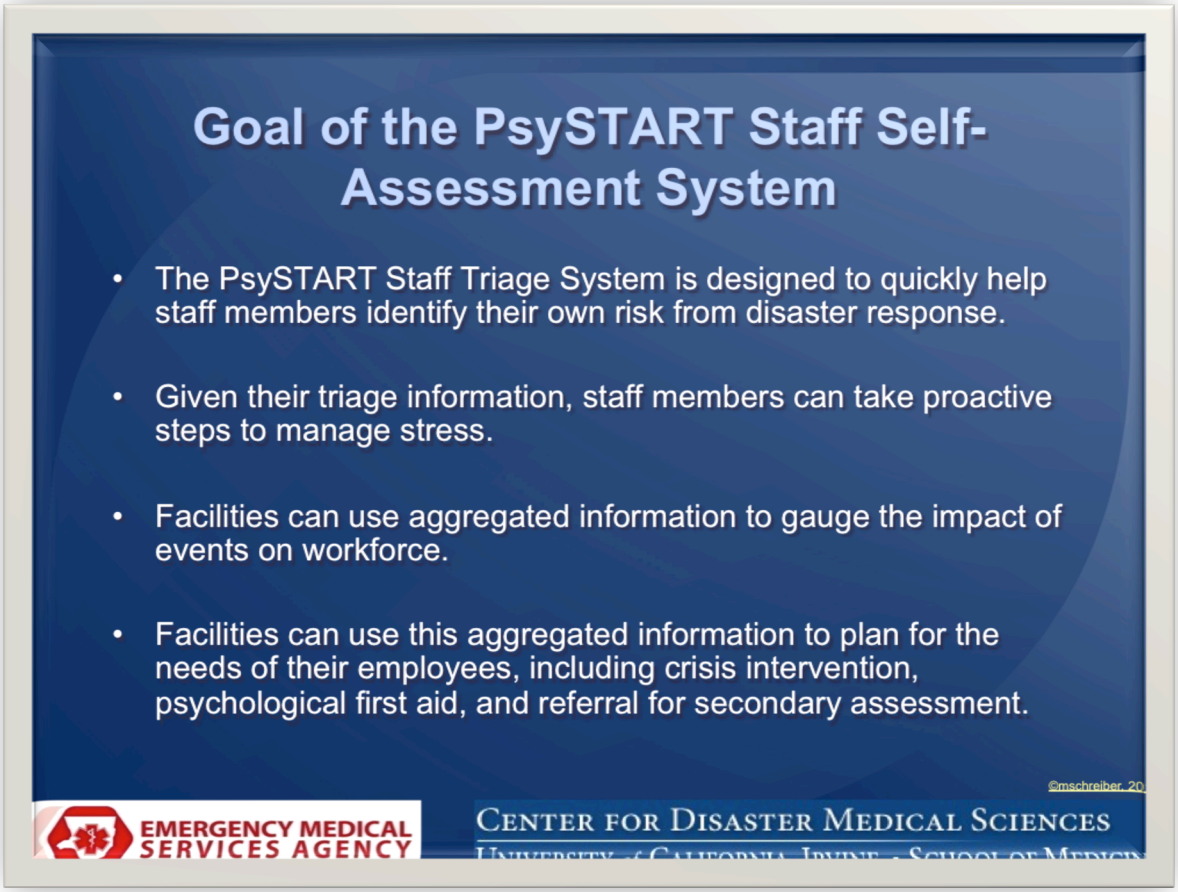

The PsySTART Staff Self-Assessment System is designed to help staff members quickly assess their own risk at a particular point in time and cumulatively across sustained disaster operations. The central idea is that armed with their own self assessment data, staff can take early, small proactive steps to mitigate their own risks. *The PsySTART Self-Assessment tool is not designed to be used as a "stand alone" but as one part of broader individual stress management and facility resilience building efforts.*

- If staff share their own self-assessment data with their facility (even de-identified), facilities can use this "aggregated" staff self-assessment to gauge overall impact on workforce.
- In this way, facilities can use this information to support the HICS employee health and wellness protocol, estimate needs for crisis intervention, psychological first aid and referral for secondary assessment later.

Why are we concerned about early identification of staff at risk? There is increasing evidence that certain interventions applied in the "golden month" to high-risk individuals can reduce or prevent long-term trauma leading mental health consequences. This potentially results in better outcomes for staff and their families

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and also preserves the essential medical response capability of the county with a more resilient workforce.

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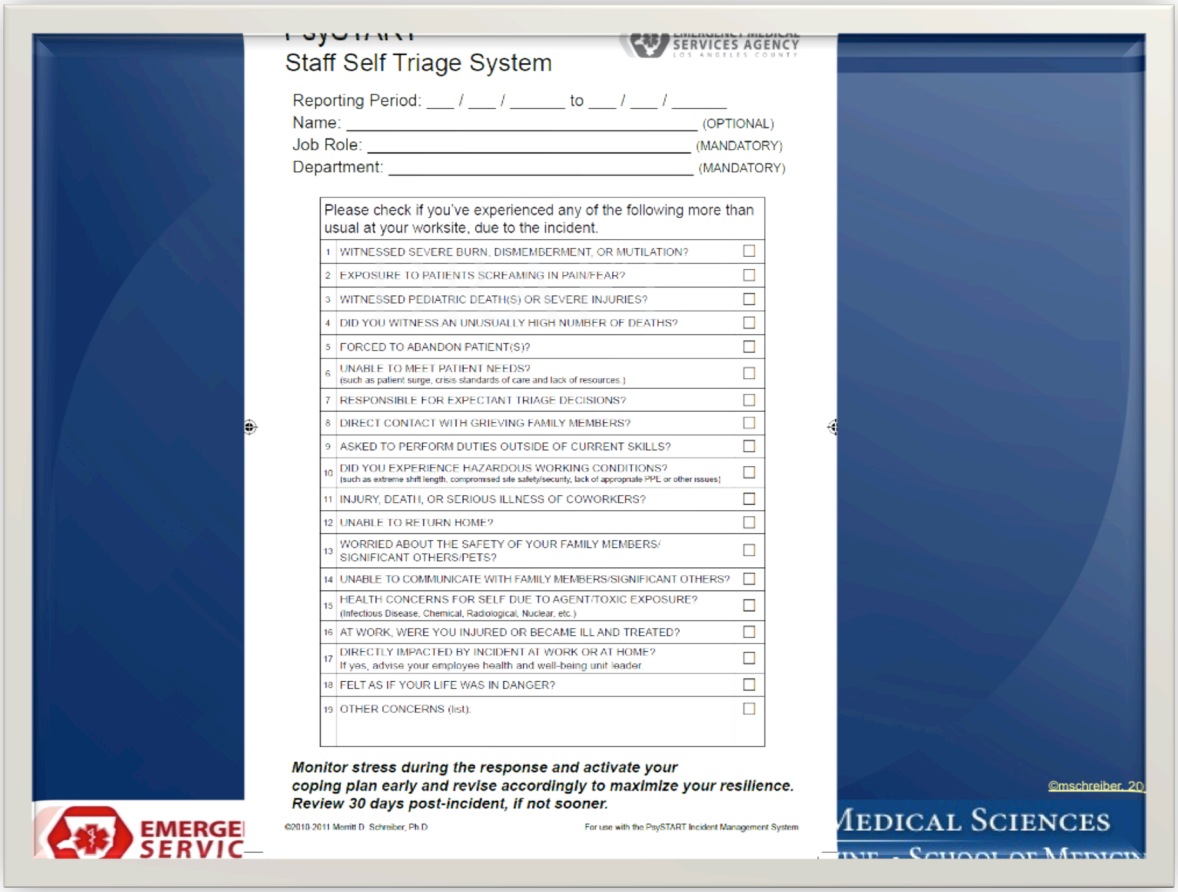

Staff Self Triage System

Reporting Period: ___ / ___ / _____ to ___ / ___ / _____
Name: _____ (OPTIONAL)
Job Role: _____ (MANDATORY)
Department: _____ (MANDATORY)

	Please check if you've experienced any of the following more than usual at your worksite, due to the incident.	
1	WITNESSED SEVERE BURN, DISMEMBERMENT, OR MUTILATION?	☐
2	EXPOSURE TO PATIENTS SCREAMING IN PAIN/FEAR?	☐
3	WITNESSED PEDIATRIC DEATH(S) OR SEVERE INJURIES?	☐
4	DID YOU WITNESS AN UNUSUALLY HIGH NUMBER OF DEATHS?	☐
5	FORCED TO ABANDON PATIENT(S)?	☐
6	UNABLE TO MEET PATIENT NEEDS? (such as patient surge, crisis standards of care and lack of resources.)	☐
7	RESPONSIBLE FOR EXPECTANT TRIAGE DECISIONS?	☐
8	DIRECT CONTACT WITH GRIEVING FAMILY MEMBERS?	☐
9	ASKED TO PERFORM DUTIES OUTSIDE OF CURRENT SKILLS?	☐
10	DID YOU EXPERIENCE HAZARDOUS WORKING CONDITIONS? (such as extreme shift length, compromised site safety/security, lack of appropriate PPE or other issues)	☐
11	INJURY, DEATH, OR SERIOUS ILLNESS OF COWORKERS?	☐
12	UNABLE TO RETURN HOME?	☐
13	WORRIED ABOUT THE SAFETY OF YOUR FAMILY MEMBERS/ SIGNIFICANT OTHERS/PETS?	☐
14	UNABLE TO COMMUNICATE WITH FAMILY MEMBERS/SIGNIFICANT OTHERS?	☐
15	HEALTH CONCERNS FOR SELF DUE TO AGENT/TOXIC EXPOSURE? (Infectious Disease, Chemical, Radiological, Nuclear, etc.)	☐
16	AT WORK, WERE YOU INJURED OR BECAME ILL AND TREATED?	☐
17	DIRECTLY IMPACTED BY INCIDENT AT WORK OR AT HOME? If yes, advise your employee health and well-being unit leader.	☐
18	FELT AS IF YOUR LIFE WAS IN DANGER?	☐
19	OTHER CONCERNS (list).	☐

Monitor stress during the response and activate your coping plan early and revise accordingly to maximize your resilience. Review 30 days post-incident, if not sooner.

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For use with the PsySTART Incident Management System
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EMERGE SERVIC
EDICAL SCIENCES

Just to review – This is the single day PsySTART Form. It is also on your APD brochure. We will practice with this shortly.

- The directions for the single day form are to check all boxes that indicate any traumatic or cumulative stress items you experienced during your disaster response that day.
- Please note that it is optional to sign your name and turn in your form to your Department. By the request of the PsySTART Advisory group, it is mandatory for staff to at least enter their Job Role and Department.
- This will help facilities to track trends of staff impact following a disaster. Please note that this form does not specify psychological symptoms. There is no diagnosis of any kind. Tracking exposure is a non-stigmatizing way to track the impact of a (one day in this case) disaster response of staff.
- We encourage healthcare facilities to use this form.

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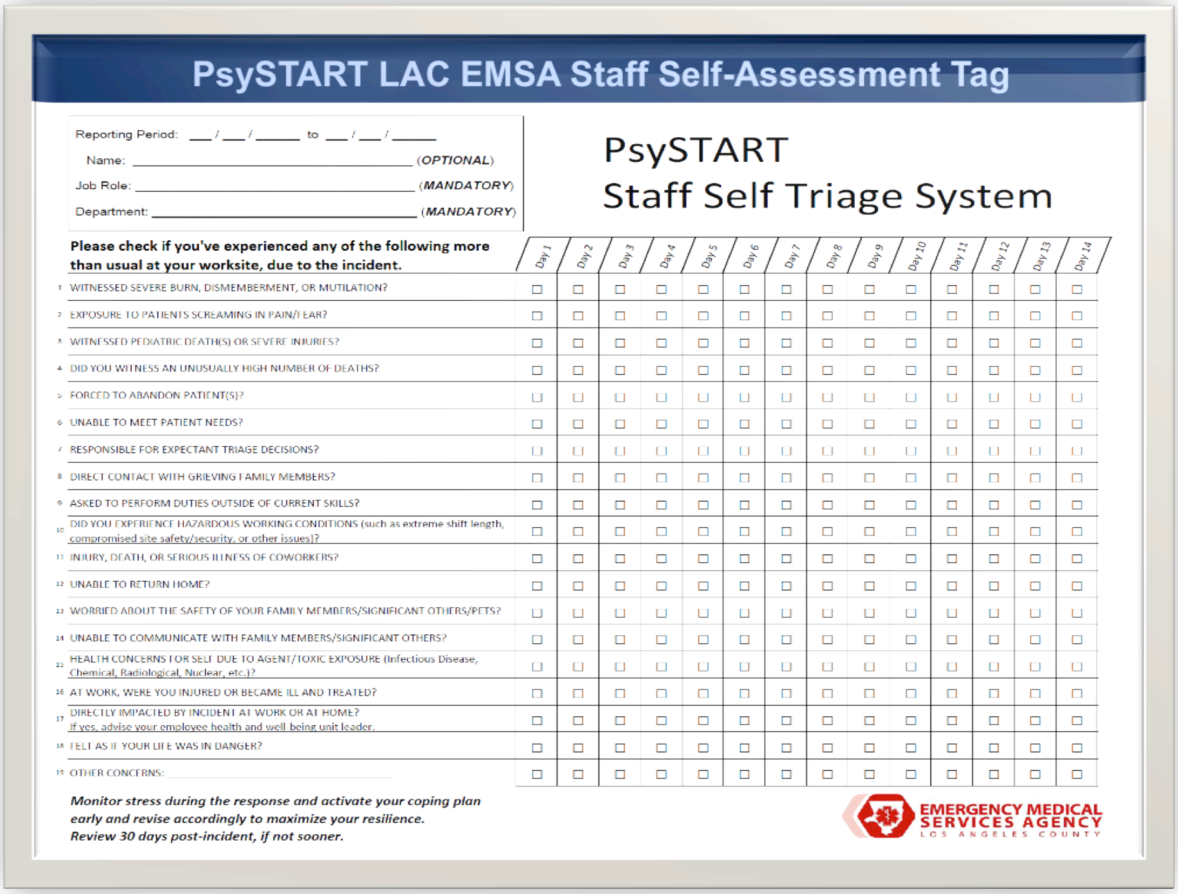

PsySTART LAC EMSA Staff Self-Assessment Tag

Reporting Period: ___/___/_____ to ___/___/_____

Name: _____ (OPTIONAL)

Job Role: _____ (MANDATORY)

Department: _____ (MANDATORY)

PsySTART
Staff Self Triage System

Please check if you've experienced any of the following more than usual at your worksite, due to the incident.

		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
1	WITNESSED SEVERE BURN, DISMEMBERMENT, OR MUTILATION?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2	EXPOSURE TO PATIENTS SCREAMING IN PAIN/FEAR?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3	WITNESSED PEDIATRIC DEATH(S) OR SEVERE INJURIES?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4	DID YOU WITNESS AN UNUSUALLY HIGH NUMBER OF DEATHS?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5	FORCED TO ABANDON PATIENT(S)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6	UNABLE TO MEET PATIENT NEEDS?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7	RESPONSIBLE FOR EXPECTANT TRIAGE DECISIONS?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8	DIRECT CONTACT WITH GRIEVING FAMILY MEMBERS?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9	ASKED TO PERFORM DUTIES OUTSIDE OF CURRENT SKILLS?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10	DID YOU EXPERIENCE HAZARDOUS WORKING CONDITIONS (such as extreme shift length, compromised site safety/security, or other issues)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11	INJURY, DEATH, OR SERIOUS ILLNESS OF COWORKERS?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12	UNABLE TO RETURN HOME?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13	WORRIED ABOUT THE SAFETY OF YOUR FAMILY MEMBERS/SIGNIFICANT OTHERS/PETS?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14	UNABLE TO COMMUNICATE WITH FAMILY MEMBERS/SIGNIFICANT OTHERS?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15	HEALTH CONCERNS FOR SELF DUE TO AGENT/TOXIC EXPOSURE (Infectious Disease, Chemical, Radiological, Nuclear, etc.)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16	AT WORK, WERE YOU INJURED OR BECAME ILL AND TREATED?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17	DIRECTLY IMPACTED BY INCIDENT AT WORK OR AT HOME? If yes, advise your employee health and well being unit leader.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18	FELT AS IF YOUR LIFE WAS IN DANGER?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19	OTHER CONCERNS: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Monitor stress during the response and activate your coping plan early and revise accordingly to maximize your resilience.
Review 30 days post-incident, if not sooner.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

This is the first component of the PsySTART Staff Self-Assessment System. This is the PsySTART Staff Self-Assessment Tag for a MULT-DAY EVENT. The instructions are found on the back of the form.

- The tag lists the same traumatic and cumulative stress items as the single day version.
- Staff can fill out this form at the end of each shift. This form can record up to fourteen days of response work.
- Additional days will be on supplemental pages.

Please note once again that just like the single day form, it is optional to sign your name and turn in your form to your Department. By the request of the PsySTART Advisory group, it is mandatory for staff to at least enter their Job Role and Department. This will help facilities to track trends of staff impact following a disaster. Please note that this form does not specify psychological symptoms. There is no diagnosis of any kind. Tracking exposure is a non-stigmatizing way to track the impact of a multi-day disaster response of staff. We encourage healthcare facilities to use this form.

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The information is captured at the end of each shift and/or can be collected at the end of the incident. This is performed by health staff to self-monitor stress and remember to activate their APD coping plan before stress levels become overwhelming. This system also helps supervisors to identify a trend of stress exposure with staff and develop strategies to mitigate staff stress during and after a disaster response.

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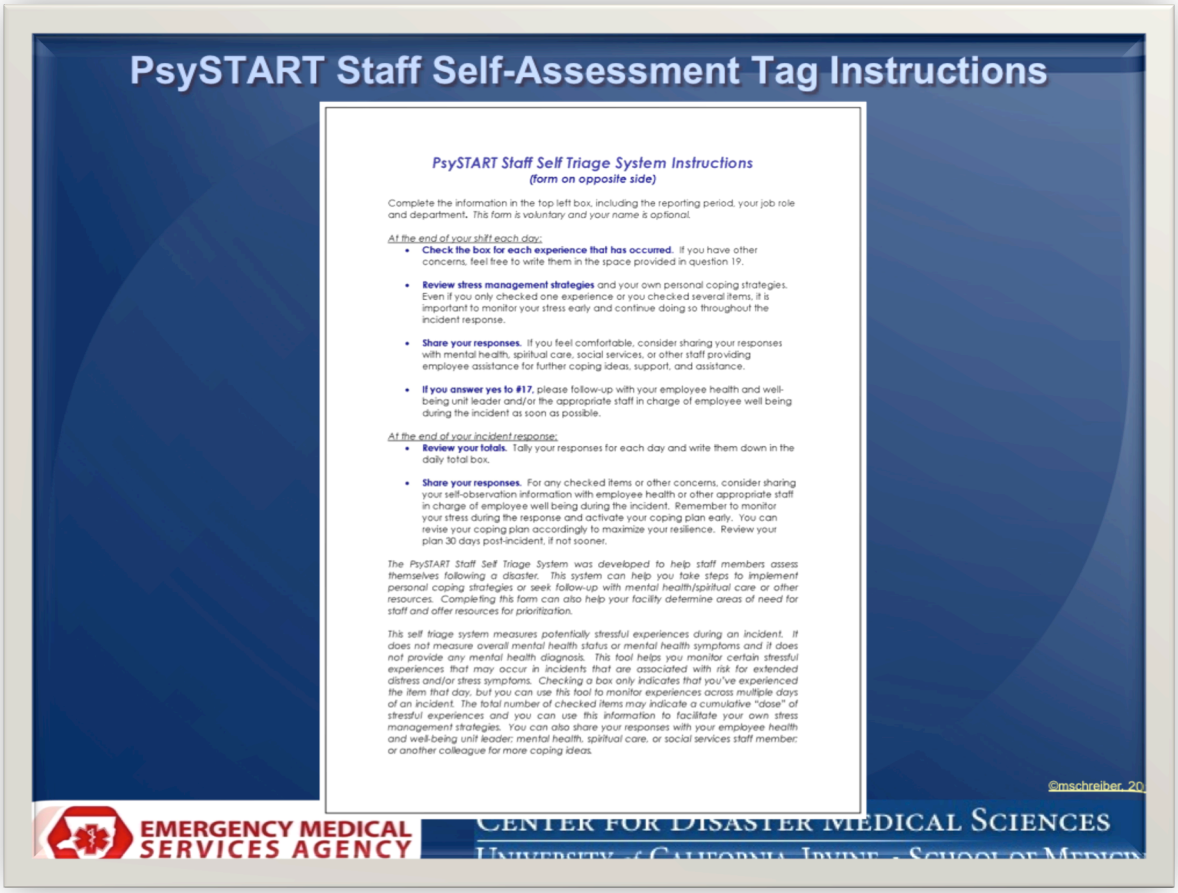

This slide is an image of the first component of the PsySTART Staff Self-Assessment system. It is the PsySTART Staff Self Triage System Instructions for the multi-day form and is located on the back of the form.

Please review this now briefly.

Instructors can pass out copies of this form and give participants a moment to review it. Forms can be downloaded from the EMS Agency website at: http://ems.dhs.lacounty.gov/Disaster/PsyStart.htm or contact Disaster Program Manager Sandra Shields at the EMS Agency.

Instructors should ask participants if they have any questions.

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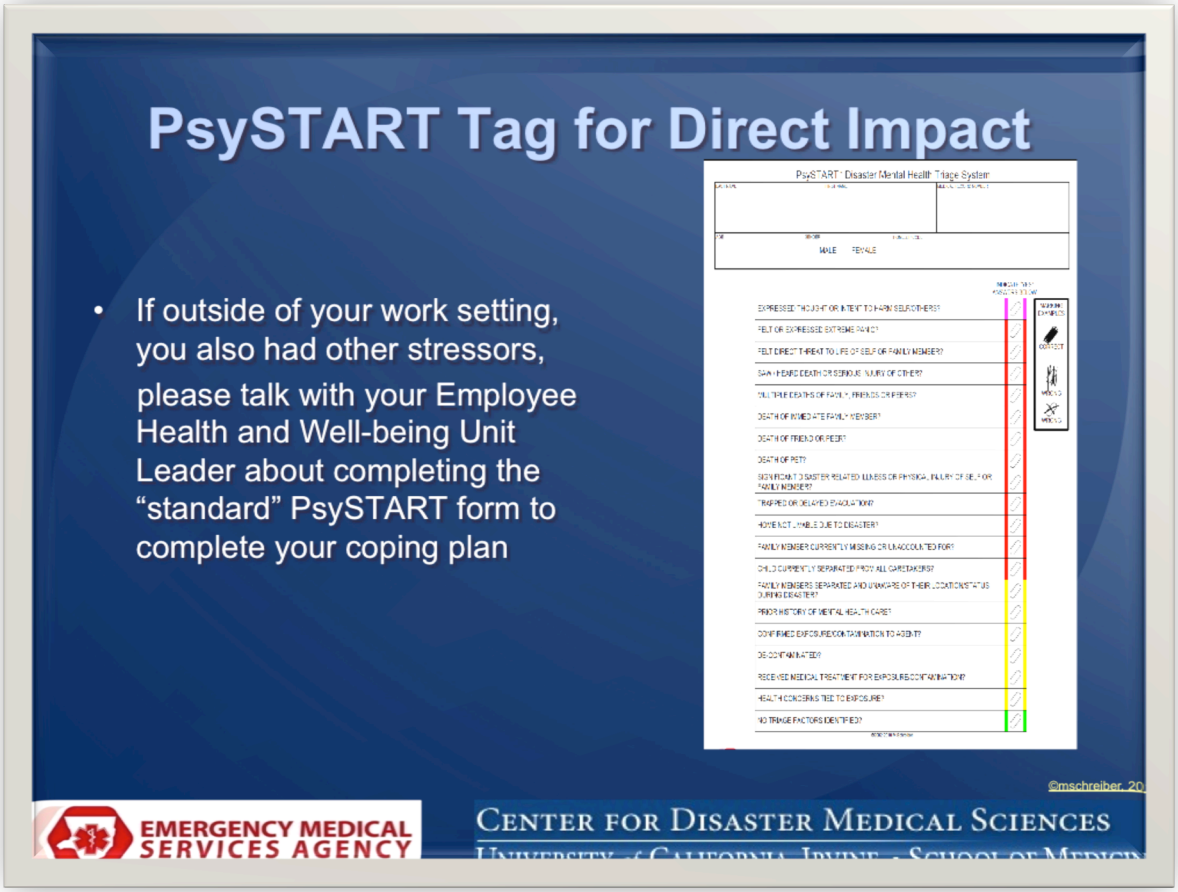

Although the PsySTART Staff Self Assessment System is designed primarily for stress in your emergency response role, healthcare workers may also experience stress related to being in a disaster impacted area.

Staff who have experienced significant events outside of work can fill out the regular PsySTART (patient/client) mental health form. It is strongly recommended that staff who have experienced disaster related stress exposure outside of the work setting discuss this with their supervisor and if appropriate, with the Employee Health and Well Being Unit Leader in Incident Command. Completing this triage information will help give you and your employee support team specific assistance to manage the overall impact of the disaster on your well being.

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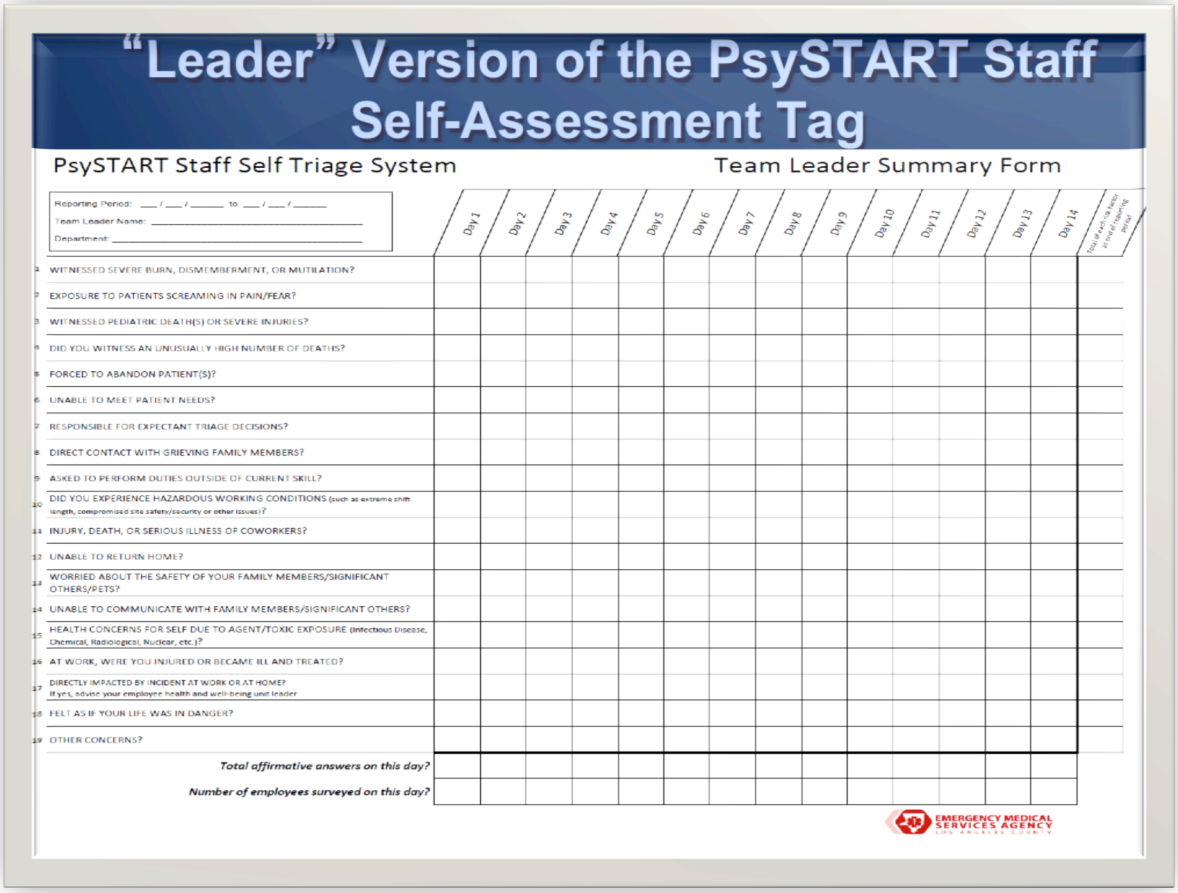

"Leader" Version of the PsySTART Staff Self-Assessment Tag

PsySTART Staff Self Triage System — Team Leader Summary Form

Reporting Period: ___ / ___ / _____ to ___ / ___ / _____
Team Leader Name: _____
Department: _____

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Total # with a new affirmative answer
1 WITNESSED SEVERE BURN, DISMEMBERMENT, OR MUTILATION?															
2 EXPOSURE TO PATIENTS SCREAMING IN PAIN/FEAR?															
3 WITNESSED PEDIATRIC DEATH(S) OR SEVERE INJURIES?															
4 DID YOU WITNESS AN UNUSUALLY HIGH NUMBER OF DEATHS?															
5 FORCED TO ABANDON PATIENT(S)?															
6 UNABLE TO MEET PATIENT NEEDS?															
7 RESPONSIBLE FOR EXPECTANT TRIAGE DECISIONS?															
8 DIRECT CONTACT WITH GRIEVING FAMILY MEMBERS?															
9 ASKED TO PERFORM DUTIES OUTSIDE OF CURRENT SKILL?															
10 DID YOU EXPERIENCE HAZARDOUS WORKING CONDITIONS (such as extreme shift length, compromised site safety/security or other issues)?															
11 INJURY, DEATH, OR SERIOUS ILLNESS OF COWORKERS?															
12 UNABLE TO RETURN HOME?															
13 WORRIED ABOUT THE SAFETY OF YOUR FAMILY MEMBERS/SIGNIFICANT OTHERS/PETS?															
14 UNABLE TO COMMUNICATE WITH FAMILY MEMBERS/SIGNIFICANT OTHERS?															
15 HEALTH CONCERNS FOR SELF DUE TO AGENT/TOXIC EXPOSURE (Infectious Disease, Chemical, Radiological, Nuclear, etc.)?															
16 AT WORK, WERE YOU INJURED OR BECAME ILL AND TREATED?															
17 DIRECTLY IMPACTED BY INCIDENT AT WORK OR AT HOME? If yes, advise your employee health and well-being unit leader															
18 FELT AS IF YOUR LIFE WAS IN DANGER?															
19 OTHER CONCERNS?															
Total affirmative answers on this day?															
Number of employees surveyed on this day?															

EMERGENCY MEDICAL SERVICES AGENCY LOS ANGELES COUNTY

This is an image of second component of the PsySTART Staff Self-Assessment System: the Team Leader Summary Form. The instructions are located on the back of the form.

Instructors can pass out copies of this form and give participants a moment to review it. Forms can be downloaded from the EMS Agency website at: http://ems.dhs.lacounty.gov/Disaster/PsyStart.htm or contact Disaster Program Manager Sandra Shields at the EMS Agency.

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These are the instructions for using the "leader" version of the tool and corresponds quite directly with a modification to the HICS Employee Health and Well Being Job Action Sheets (JAS). Facilities will need to develop a strategy for integrating the leader version into their own internal processes and resources to suit their own particular facilities' needs.

Instructors can pass out copies of this form and give participants a moment to review it. Forms can be downloaded from the EMS Agency website at: http://ems.dhs.lacounty.gov/Disaster/PsyStart.htm or contact Disaster Program Manager Sandra Shields at the EMS Agency.

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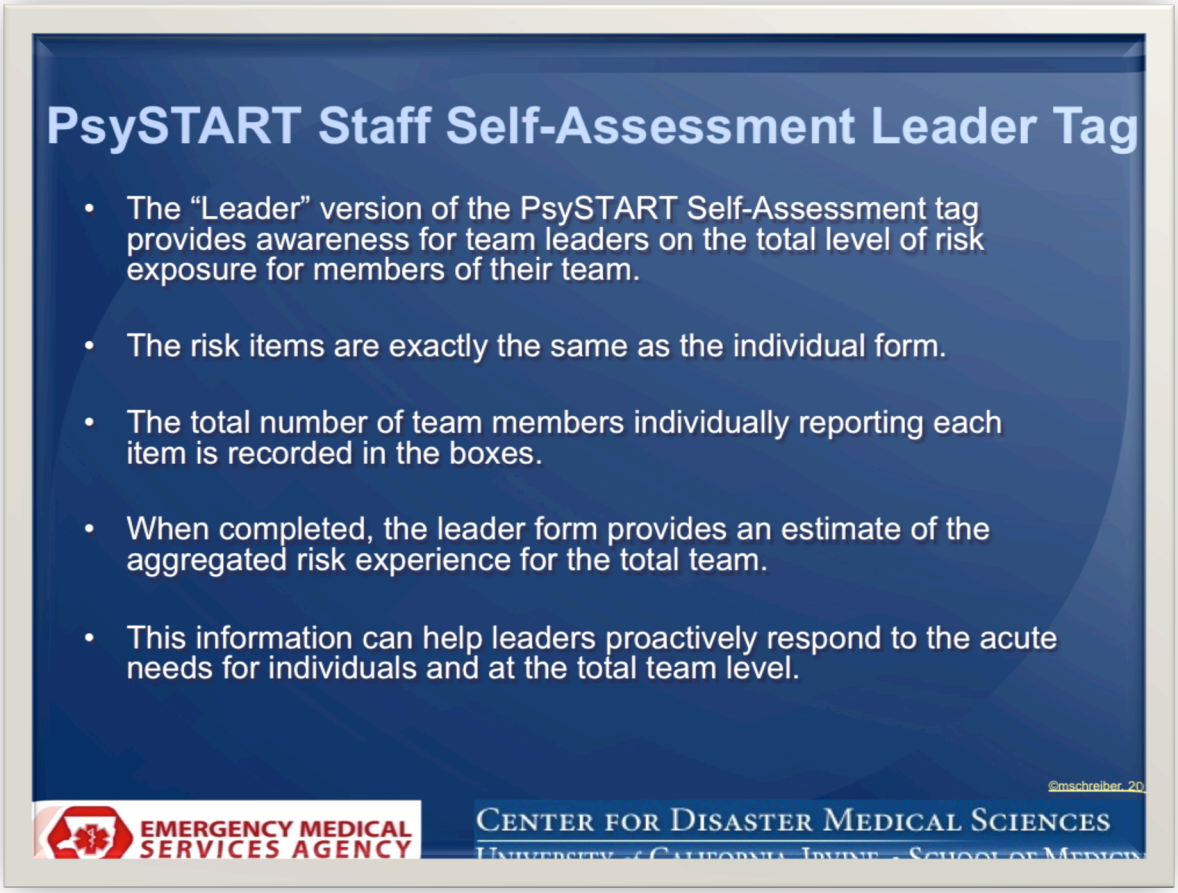

As a reminder, the purpose of the leader form is to help facilities and team leaders develop situational awareness on what staff are experiencing as a total workforce. The risk items are exactly the same as on the self-assessment tool. The difference is that this form allows for the anonymous reporting of the overall level of stress exposure. When completed, it provides information on the aggregated risk for those staff members in a particular time frame.

The central idea of this strategy is that rather than waiting for the negative effects of on-going stressors to surface, facilities are able to develop timely responses to mitigate the effects on the team.

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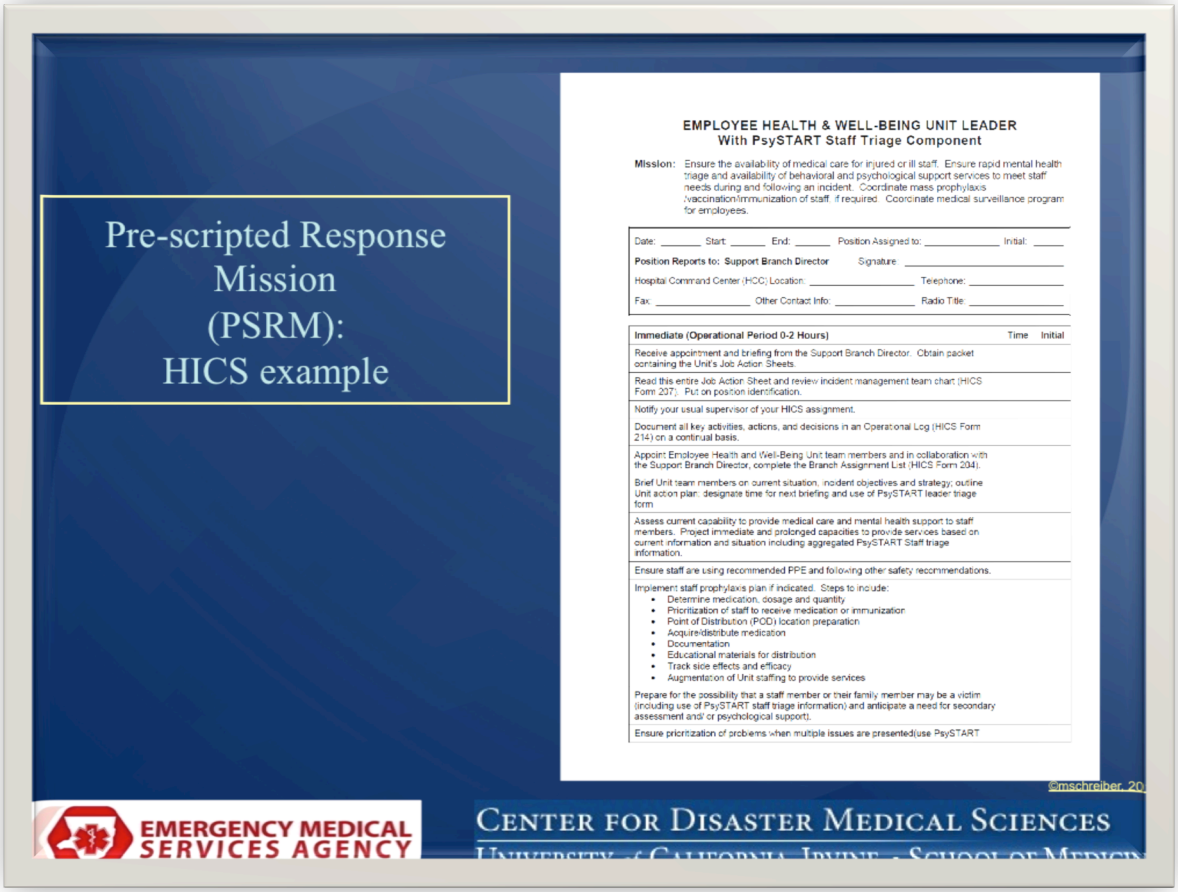

This is an image of the third component of the PsySTART Staff Self-Assessment System. This is an adaptation of a standard HICS job action sheet for the Employee Health and Well Being Unit Leader that is adapted to include PsySTART triage.

Instructors can pass out copies of this form and give participants a moment to review it. Forms can be downloaded from the EMS Agency website at: http://ems.dhs.lacounty.gov/Disaster/PsyStart.htm or contact Disaster Program Manager Sandra Shields at the EMS Agency.

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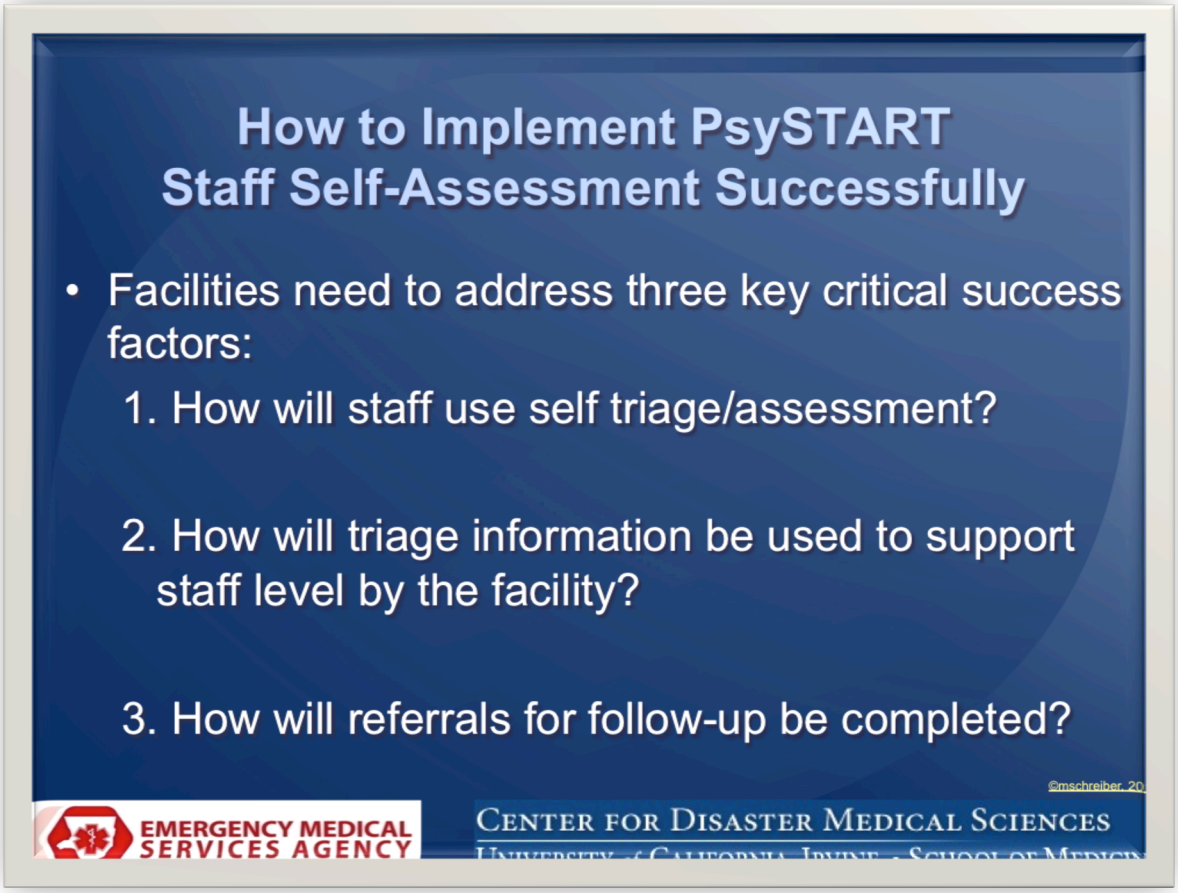

In order to implement the PsySTART Staff Self Assessment System in the most successful manner, three critical factors need to be addressed. Pre-event, it is important to have conversations to determine how staff can maximize the use of the self-triage/self assessment tool.

Facilities will need to work with staff to determine how their information can be shared to inform overall stress response strategies and how this will be integrated into the Employee Health and Well Being activities locally. For example, if staff experience high levels of stress at work or home and desire further assessment or support, how will this be handled?

Facilities are encouraged to download the LAC EMS PsySTART CONOPS and the PsySTART Exercise Guide from the EMS Agency website for further discussion at their facility on how to implement the tool.

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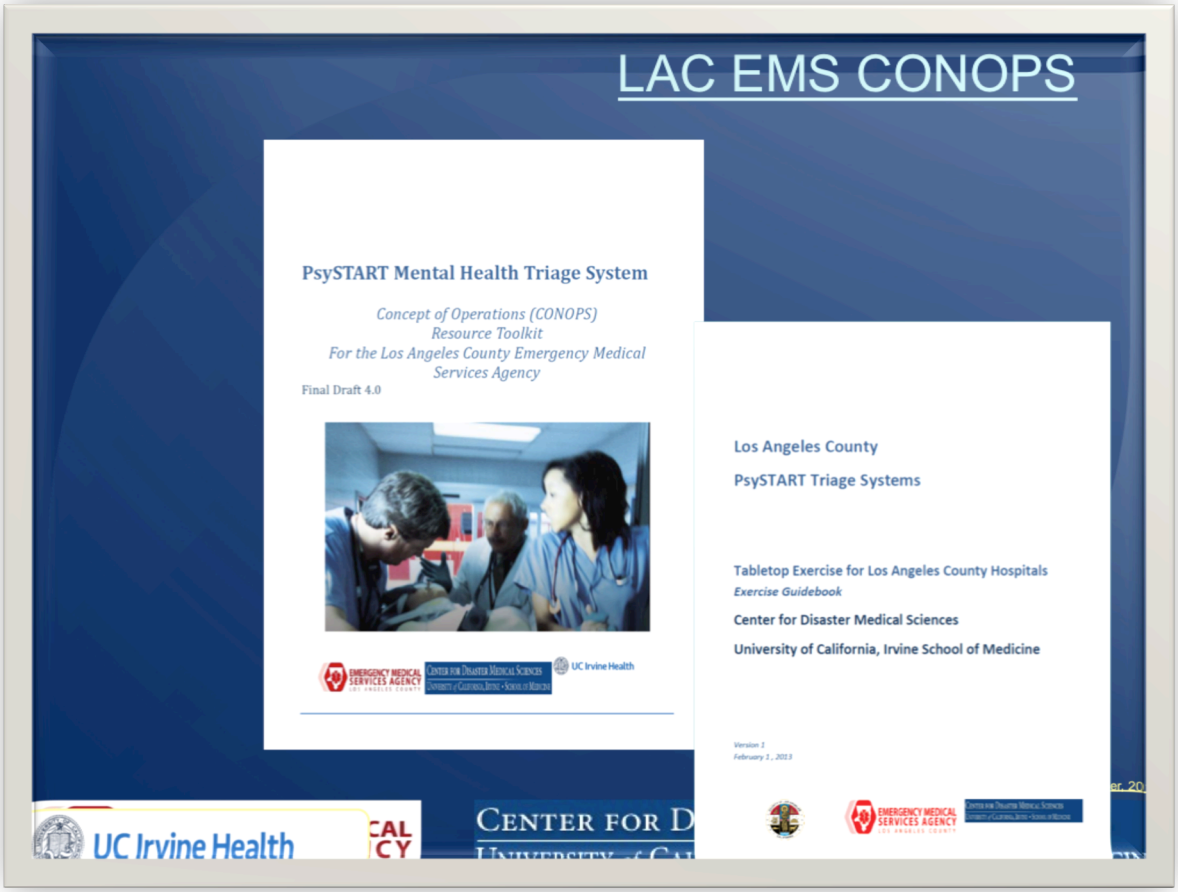

The PsySTART Concept of Operations Plan for LA County EMS provides an integrated strategy for managing the psychological consequences of disasters, terrorism and other community emergencies for LA County Hospitals and Clinics. This is available on the LAC EMS Website. Anticipate, Plan and Deter is included in this CONOPS and can be adapted by facilities to meet their own needs and resources.

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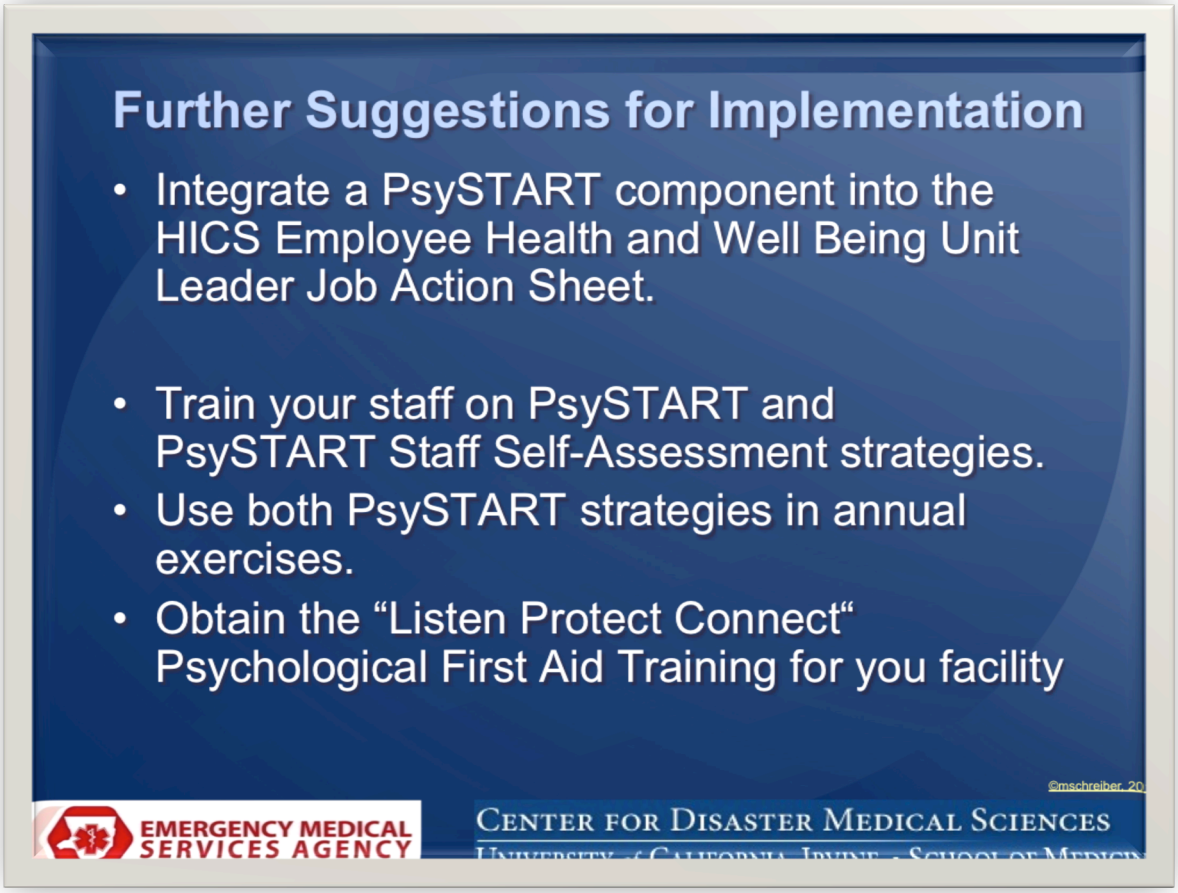

The PsySTART Staff Self-Assessment System allows for a number of customized options at the site or facility level. It is recommended that the team leader information collected be fully integrated into the Employee Health and Well Being Unit leader job action sheet and procedures. Training in the use of the tool and strategies to mitigate stress are recommended and can be tied to your existing facility disaster exercise program. If included in exercises, staff will be more likely to use it in real world events.

The Listen, Protect, Connect Psychological First Aid Training which has evidence of a positive impact on LAC Medical Reserve Corps members is available to you at no cost from LAC EMS. Contact Sandra Shields for more information on scheduling this.

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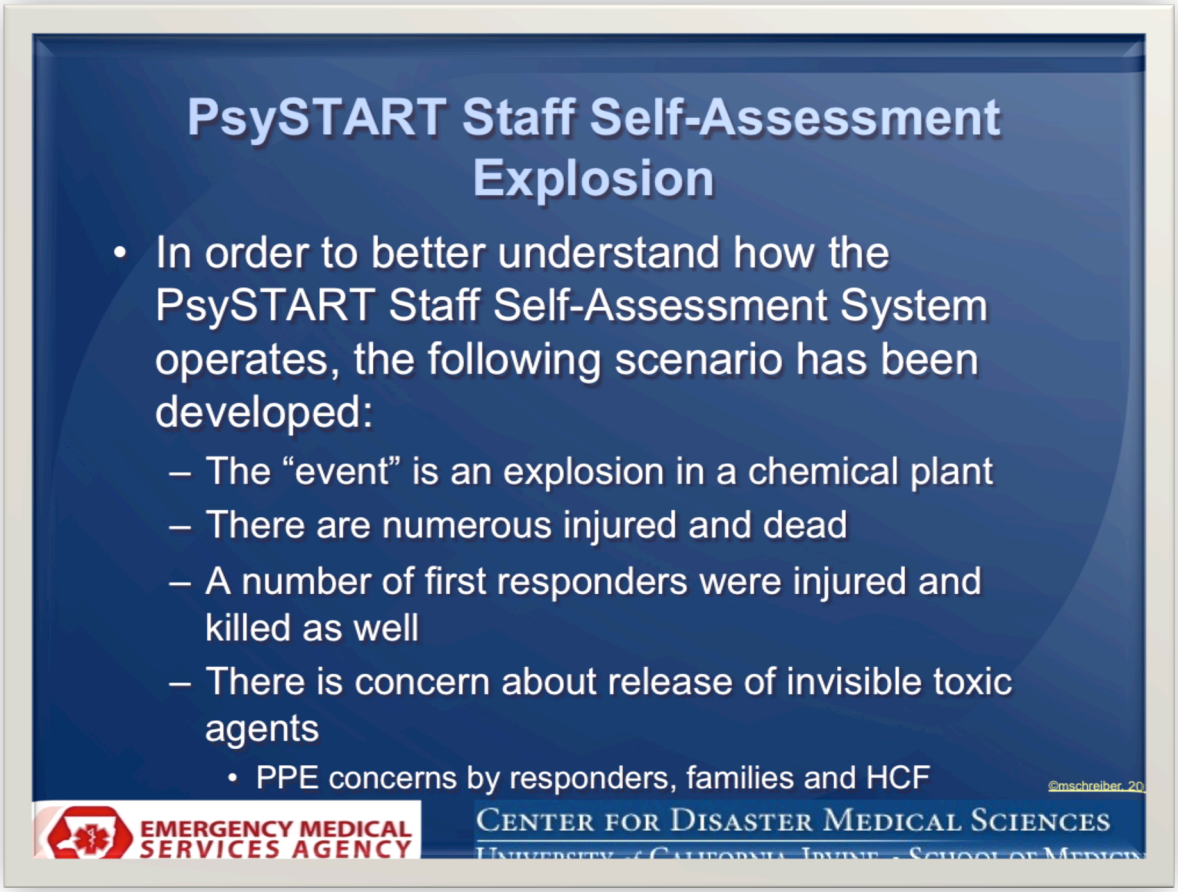

To further understand how this system operates, a scenario based on a local hazard, an earthquake, has been developed as part of this program. The scenario is based on the "ShakeOut" Scenario involving a hypothetical 7.8M earthquake on the Southern San Andreas Fault.

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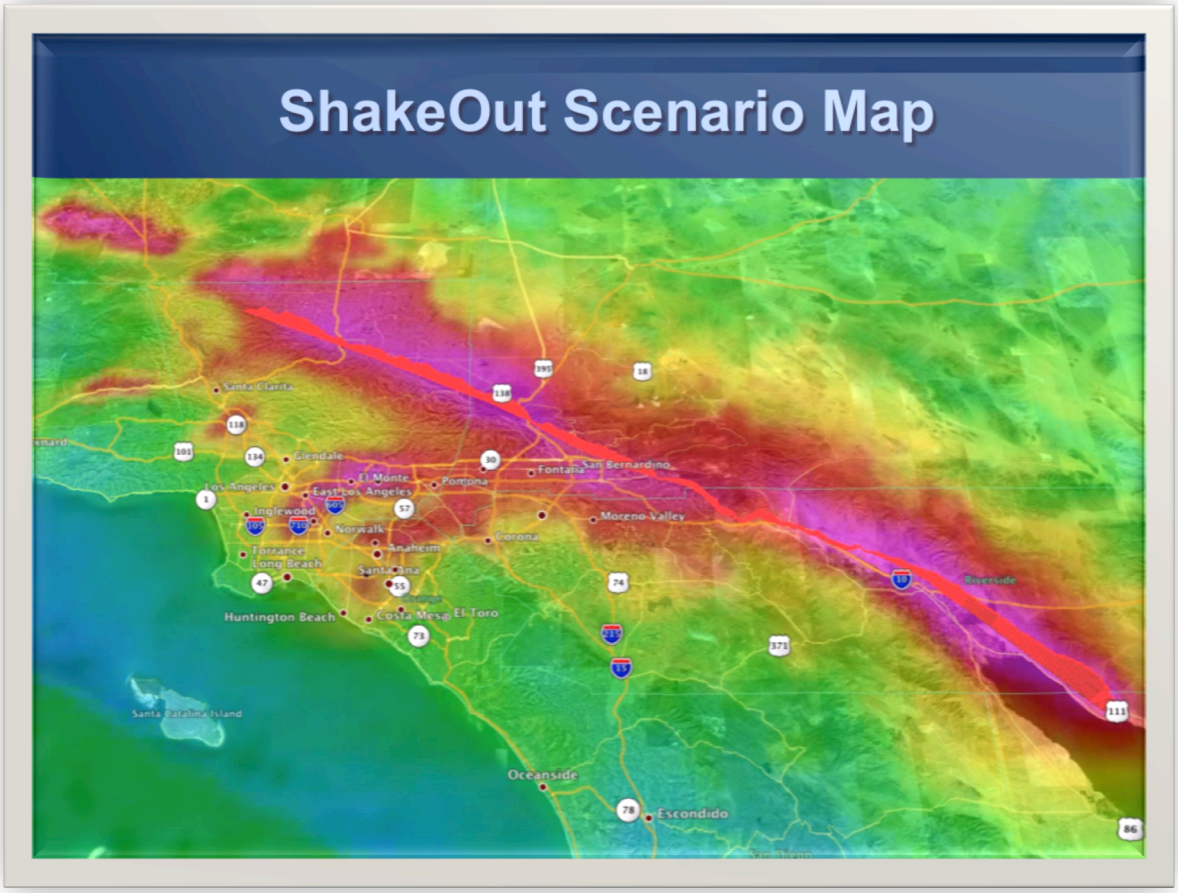

This is a graphic representation of the "ShakeOut" Scenario. In this scenario, the rupture on the San Andreas begins at the Salton Sea area of Riverside County and impacts an eight county area including, notably, Los Angeles County.

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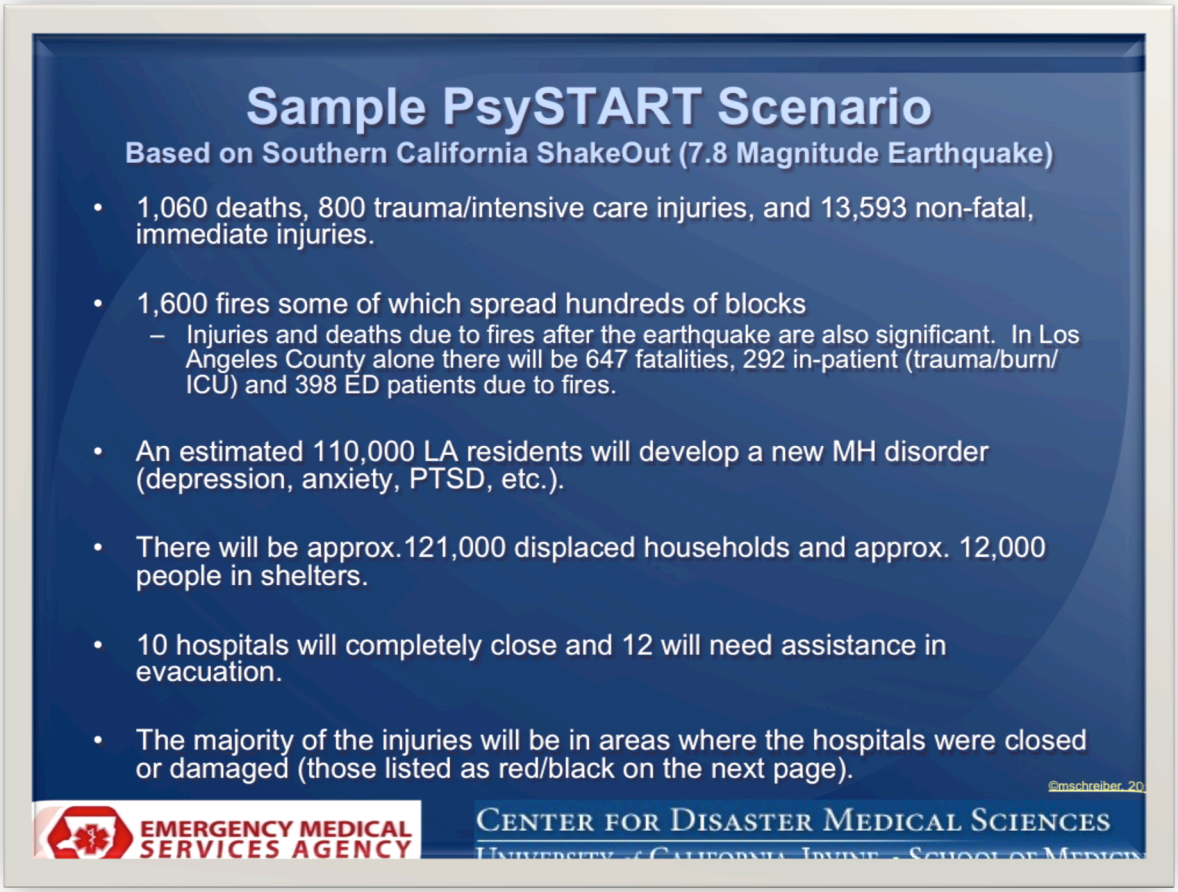

This "Shakeout" scenario commissioned by the US Geological Survey provides casualty projections including an estimate of the health and medical effects as well as effects on hospitals.

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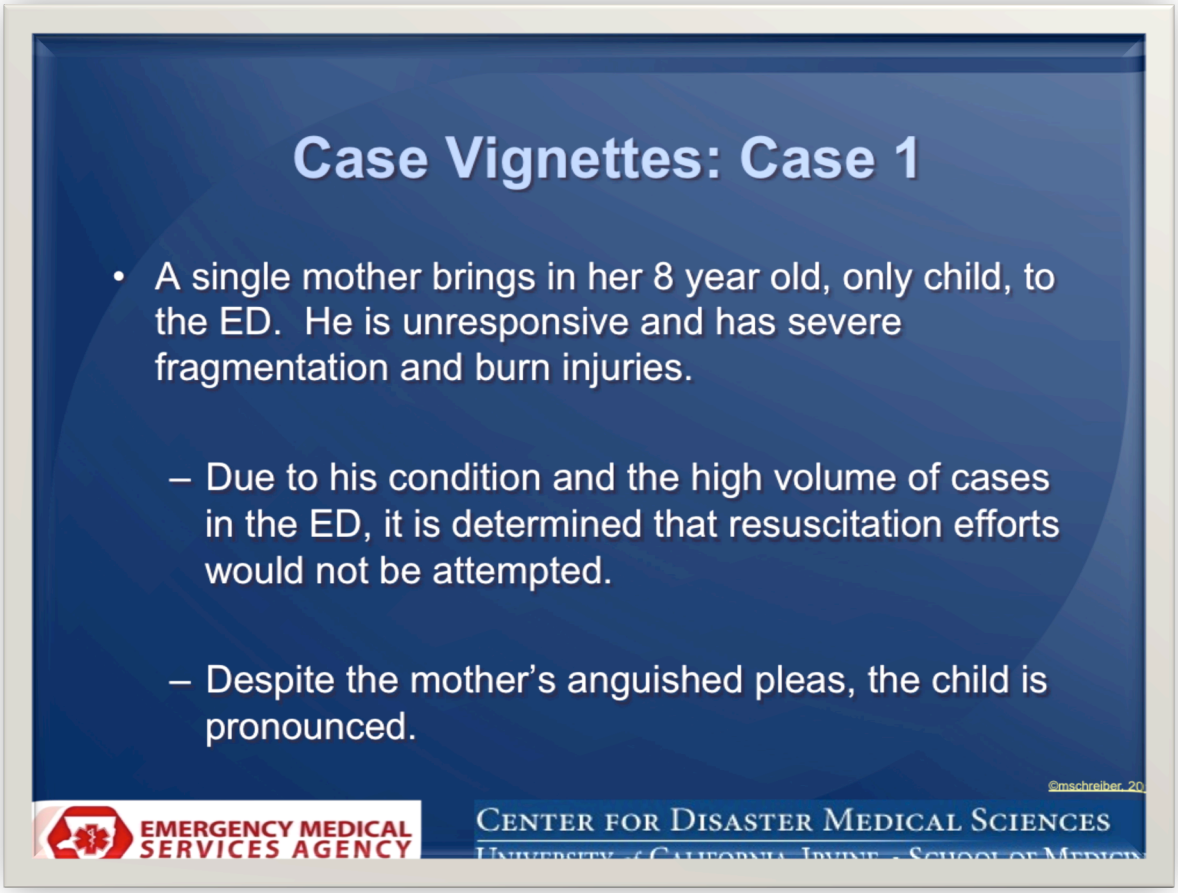

What follows now are several case vignettes designed to approximate some of the stressors that staff might experience during a catastrophic earthquake. These stressors include large numbers of patient injuries, the potential for staff to be direct victims, and having staff work in a "crisis standards of care" context for an extended period of time. After reading through case 1, please use your sample PsySTART Staff Self-Assessment tag, as provided in your training folders, to check the items you feel would be indicated for this staff member's self-assessment form.

Responder Self Triage Answers:
Risk factor 1: Witnessed severe burn and fragmentation injury
Risk factor 2: Unable to meet patient needs
Risk Factor 3: Expectant triage
Risk factor 4: Witnessed pediatric deaths or severe injuries
Risk Factor 5: Direct contact with grieving family members

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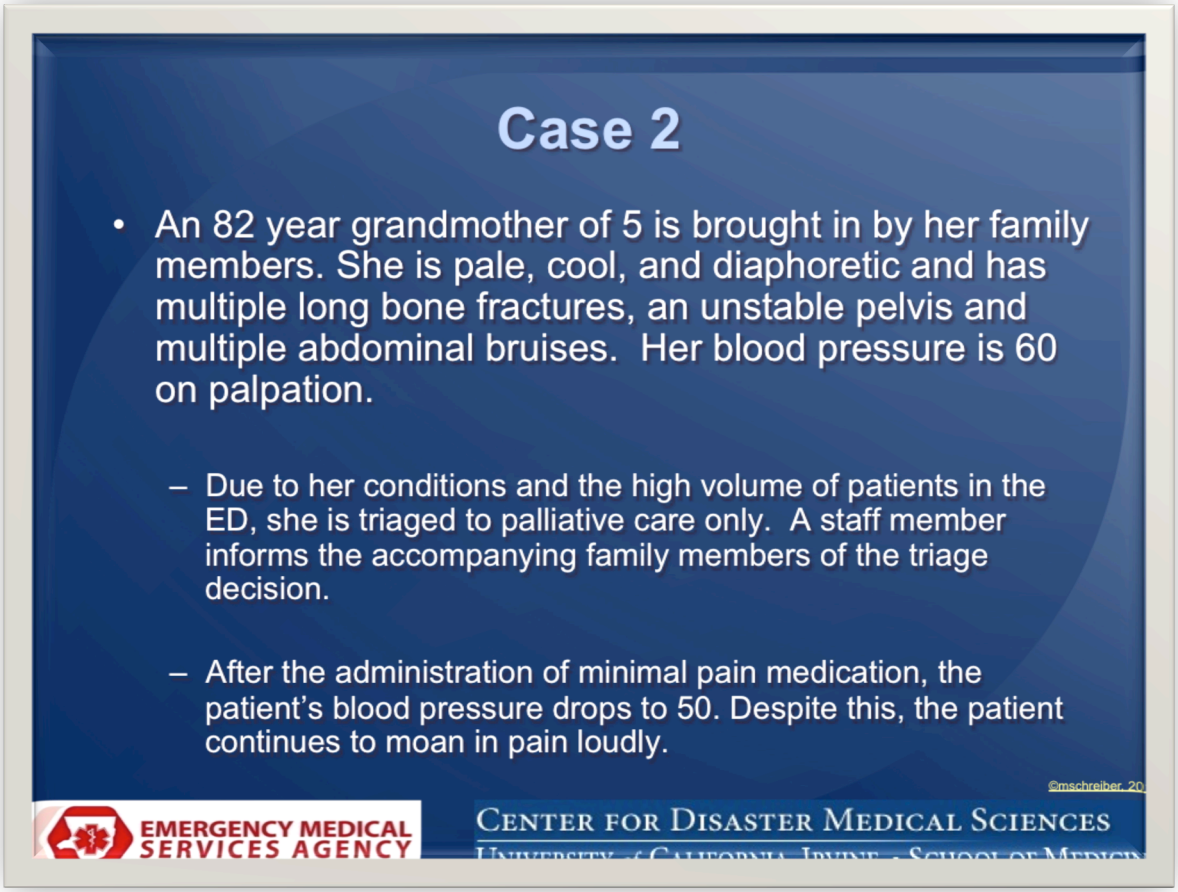

After reading through case 2, please use your sample PsySTART Staff Self-Assessment tag, as provided in your training folders, to check the items you feel would be indicated for this staff member's self-assessment form.

PsySTARTResponder Self Triage Answers:
Risk Factor 1: Unable to meet patient needs
Risk Factor 2: Expectant triage
Risk Factor 3: Direct contact with grieving family members
Risk Factor 4: Patients screaming in pain

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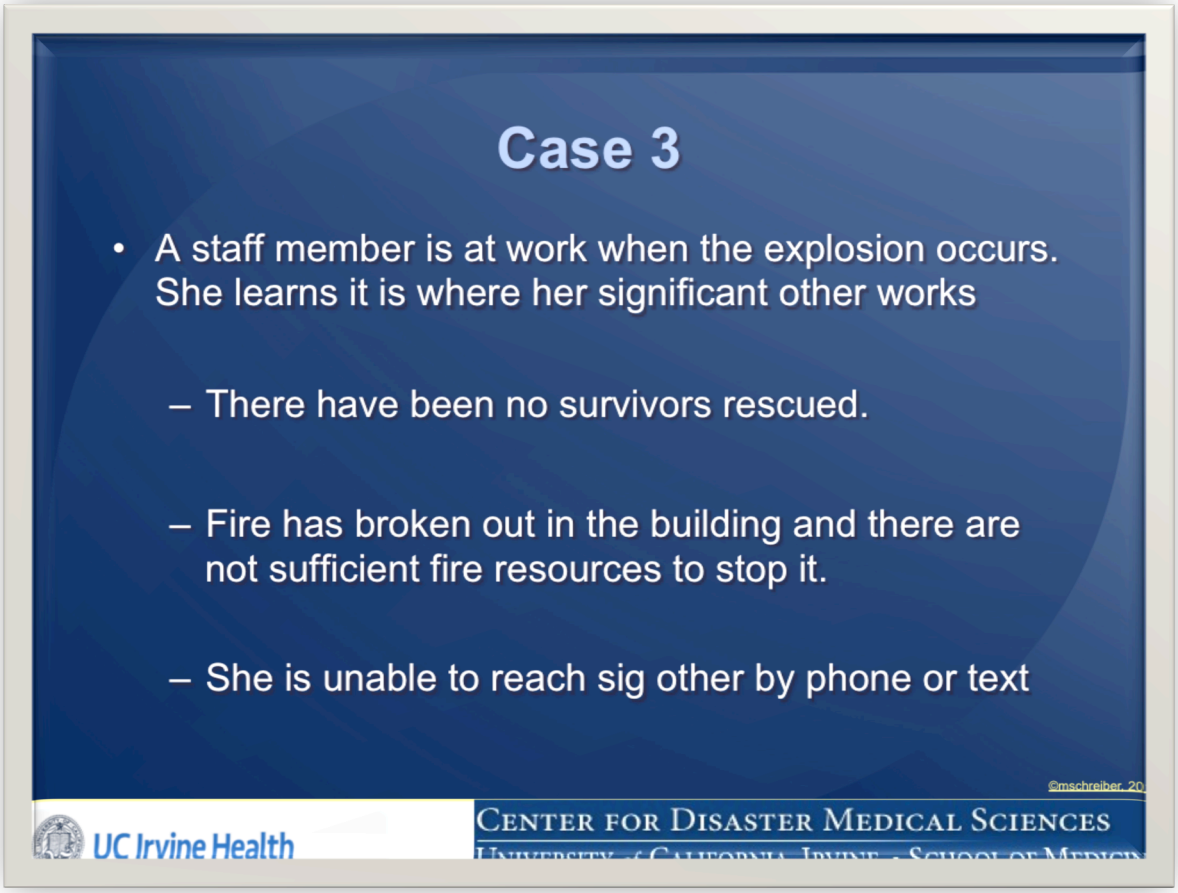

After reading through case 3, please use your sample PsySTART RESPONDER Staff Self-Assessment tag, as provided in your training folders, to check the items you feel would be indicated for this staff member's self-assessment form.

PsySTART Responder Self Triage Answers:
Risk Factor 1: Worried about safety of your family members/significant other
Risk Factor 2: Unable to communicate with family members
Risk Factor 3: Directly impacted by the incident at home (possibly)

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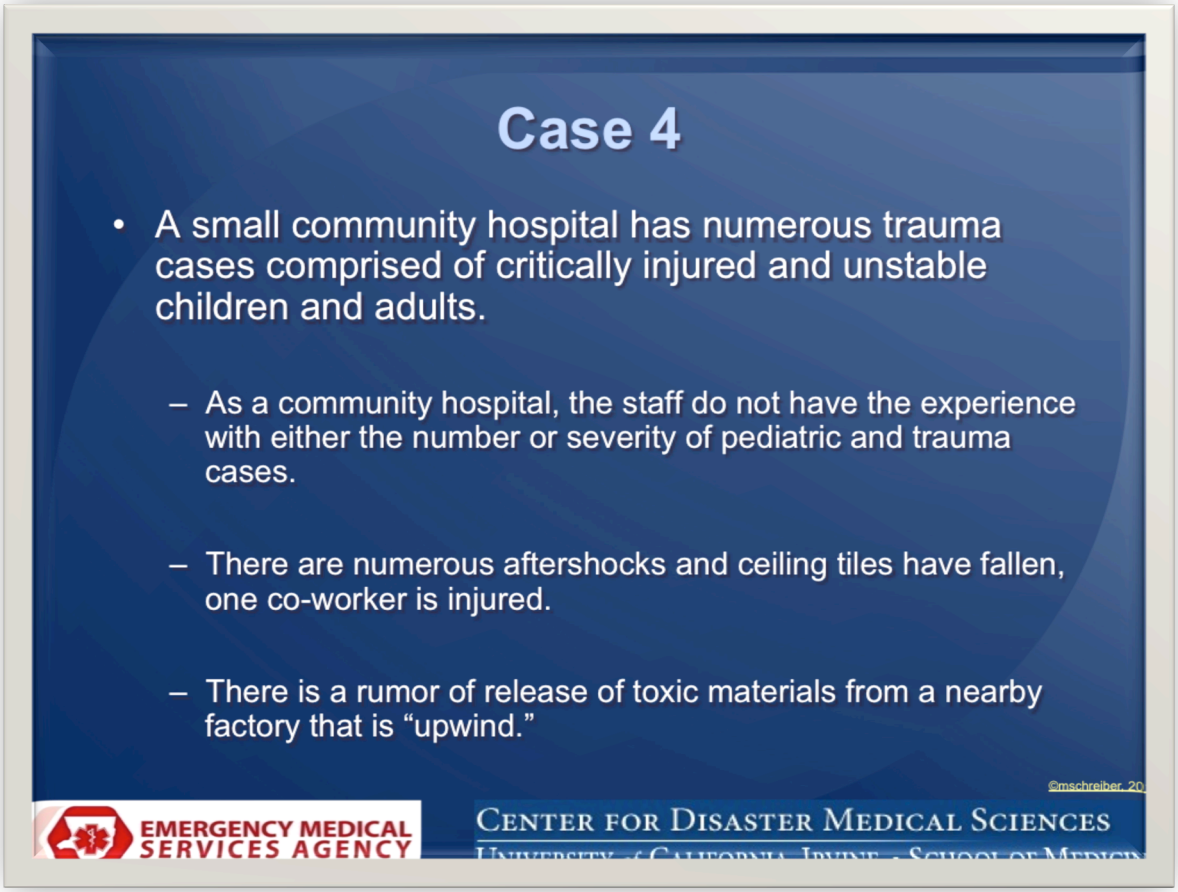

After reading through case 4, please use your sample PsySTART Staff Self-Assessment tag, as provided in your training folders, to check the items you feel would be indicated for this staff member's self-assessment form.

PsySTART Responder Self Triage Answers:
Risk Factor 1: Witnessed severe pediatric injuries
Risk Factor 2: Unable to meet patient needs
Risk Factor 3: Felt as if your life in danger
Risk Factor 4: Injury death or serious illness in coworkers
Risk Factor 5: Experienced hazardous working conditions
Risk Factor 6: Health Concerns about possible agent/toxic exposure

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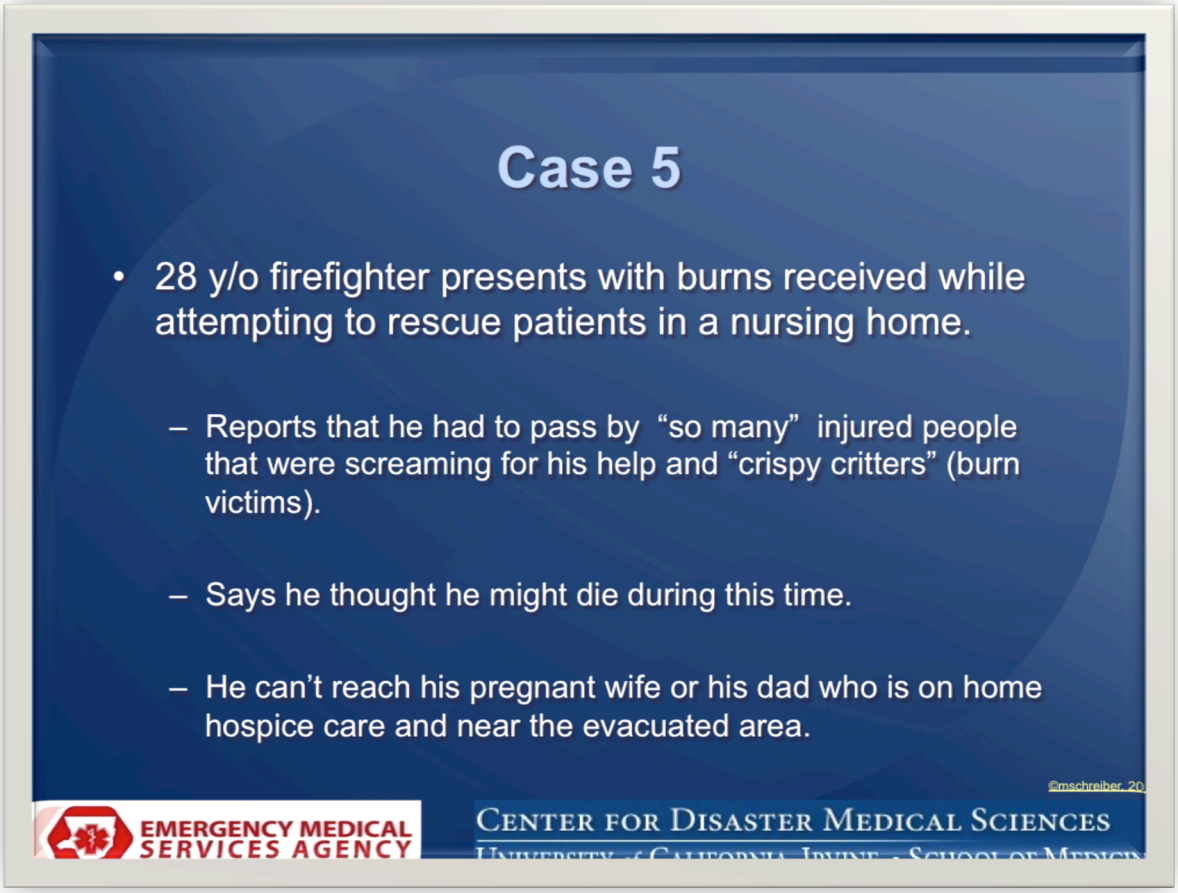

Finally, case 5 is a responder example. This is a 28-year-old firefighter who presents to the emergency department with burns received while attempting to rescue patients in a nursing home. He reports he had to pass by "hundreds and hundreds" of injured people who were screaming for his help and other burn victims. He says he thought he might die during this rescue effort. He can't reach his pregnant wife or his dad who is on home hospice care. Please indicate which PsySTART risk factors you identify for Case 5.

PsySTART Responder Self Triage Answers
Risk Factor 1: Witnessed severe burn
Risk Factor 2: Witnessed patients screaming for help
Risk Factor 3: Unable to meet patient needs
Risk Factor 4: Felt as if life in danger
Risk Factor 5: Unable to communicate with family members/sig others
Risk Factor 6: Worried about safety of family members/sig others/pets

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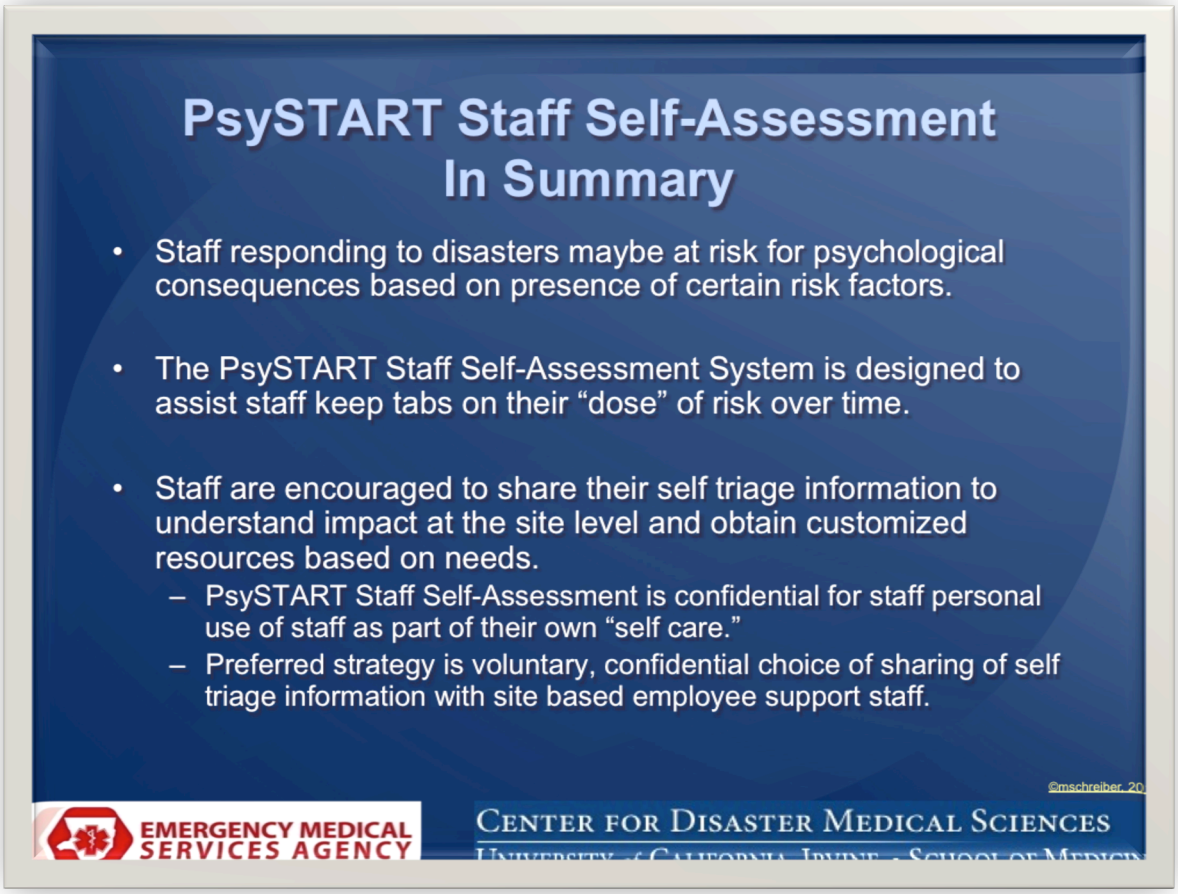

In summary, the PsySTART Response Self-Triage System is designed to be part of a larger, comprehensive approach to managing expectable stress in response to disasters. Staff is likely to be quite resilient, but certain disaster experiences can be stressful. The PsySTART Response Self-Triage System is designed first and foremost to give staff a tool for themselves to help them gauge their exposure to challenging experiences and to help trigger active coping early in response to stress before it becomes "distress." When stress is expected and planned for in advance, early protective actions can be identified to reduce the harmful potential for accumulating stress earlier as opposed to later.

When individual staff self-assessment information is shared with the Employee Health and Well Being Unit Leader, a composite of stress for the entire staff can be estimated. This may help the Employee Health and Well Being Unit Leader with assigning resources, requesting additional supports and facilitating referrals for secondary assessment or assistance for agencies tasked with providing disaster mental health response.
In order to maximize staff comfort with using the system, concerns about confidentiality or individually identifying information are addressed in the form and

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form instructions. The Employee Health and Well Being Unit Leader should make sure to address any potential confidentiality concerns during staff training in this system.

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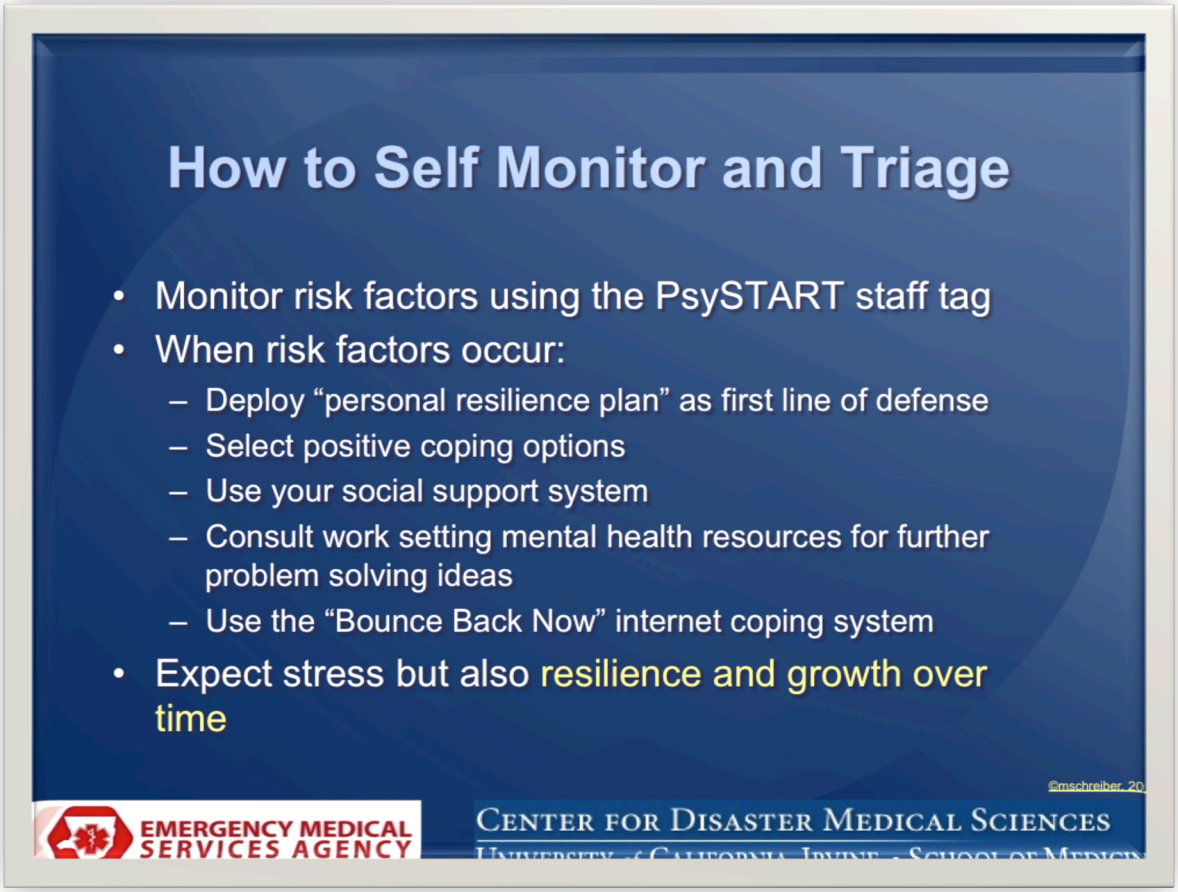

The instructor should review the slide above and include:

- Monitor your daily and multi-day exposures using your PsySTART Responder Self-Triage Information.
- When you detect risk factors, deploy your personal resilience plan like you would don PPE.
- Try your coping plan ideas, seek our social support system and consult with your local resources for more ideas or assistance.
- Try the online "Bounce Back Now" system for additional ideas.
- You can stress but also expect resilience and even growth for your life saving efforts for your community!

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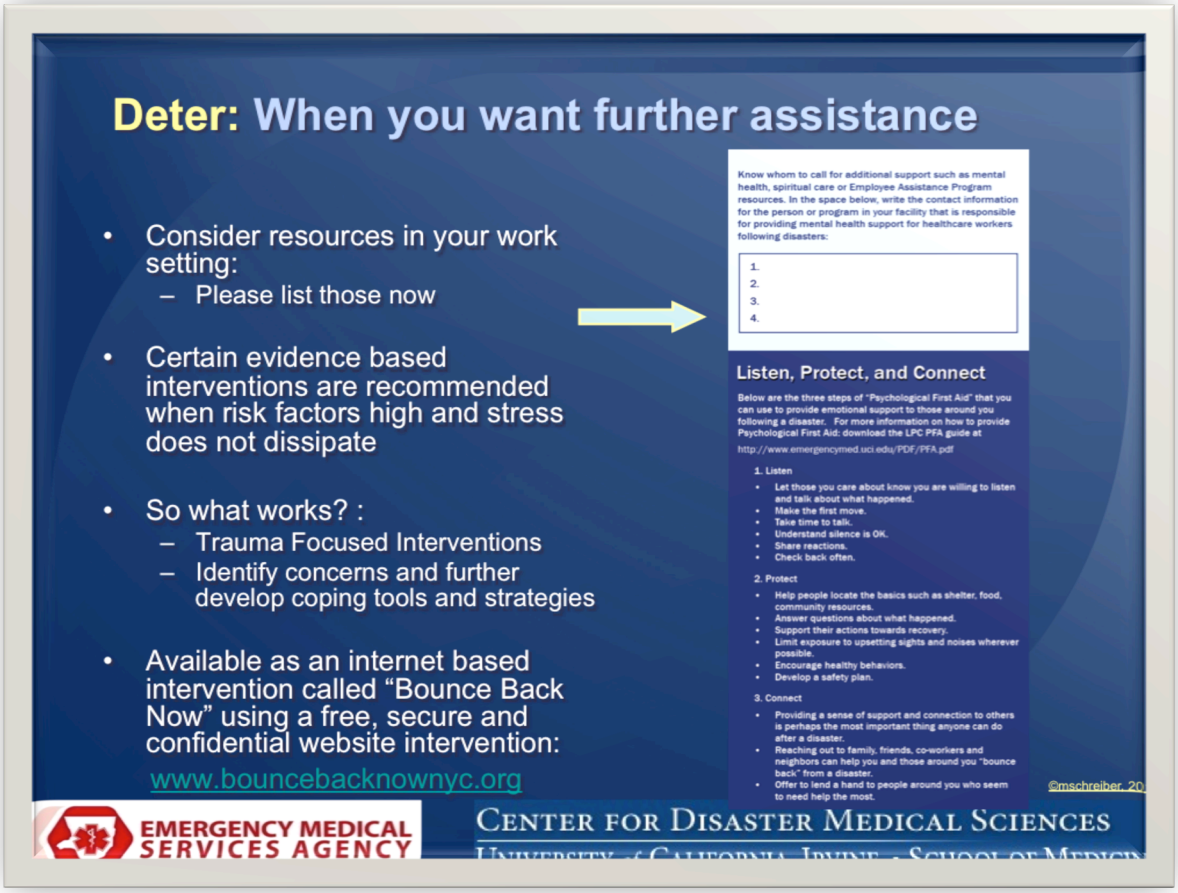

The last part of Deter is knowing when to seek out additional help.

Please list some resources available to you in this box now. This could be your Employee Assistance Program at your work or other mental health and even spiritual care resources you might use if you find yourself having a difficult time following a disaster response.

Also remember you can use the online site "Bounce Back Now"™ described in more detail now.

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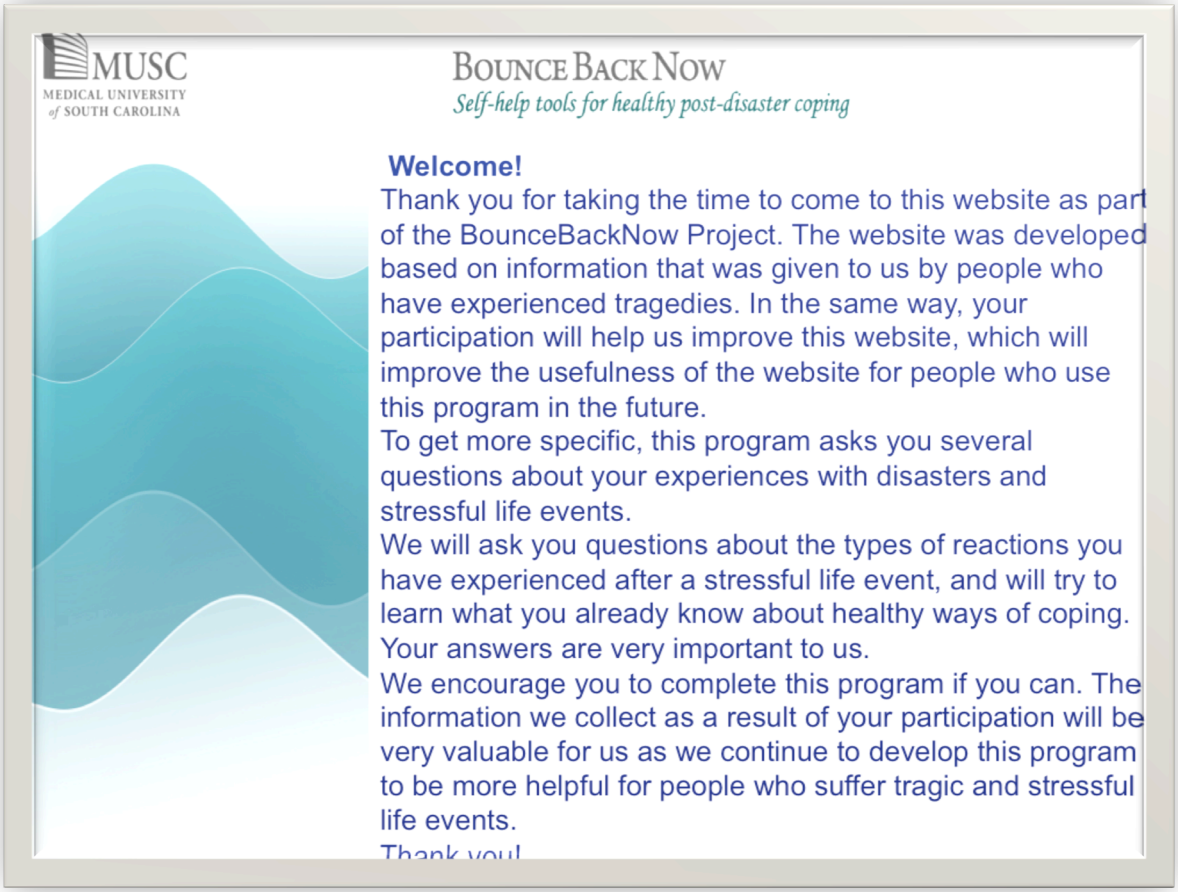

This is what Bounce Back Now looks like:
It is not specific to responders, but because local responders face the "double whammy" of responder and direct victim stress, it is resource that may be helpful.

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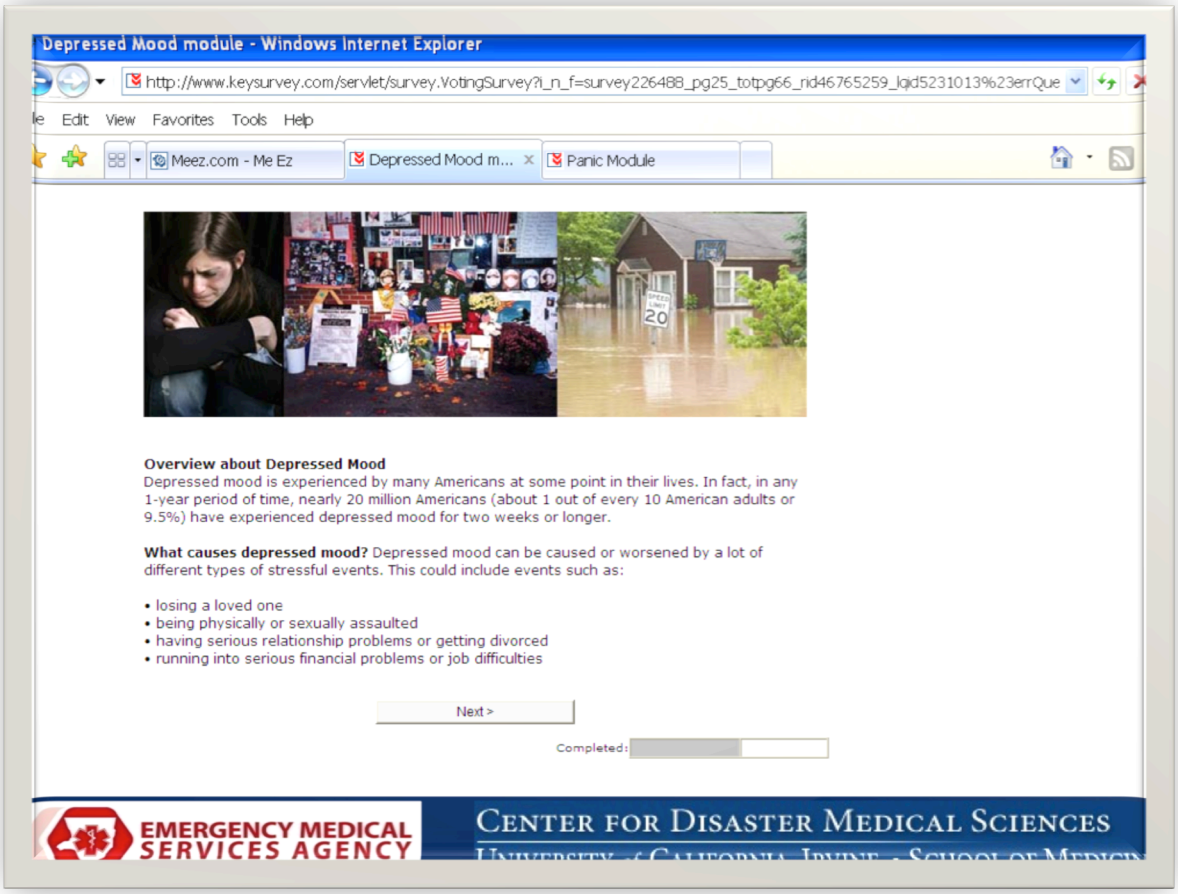

This page from Bounce Back Now helps manage depression that can occur.

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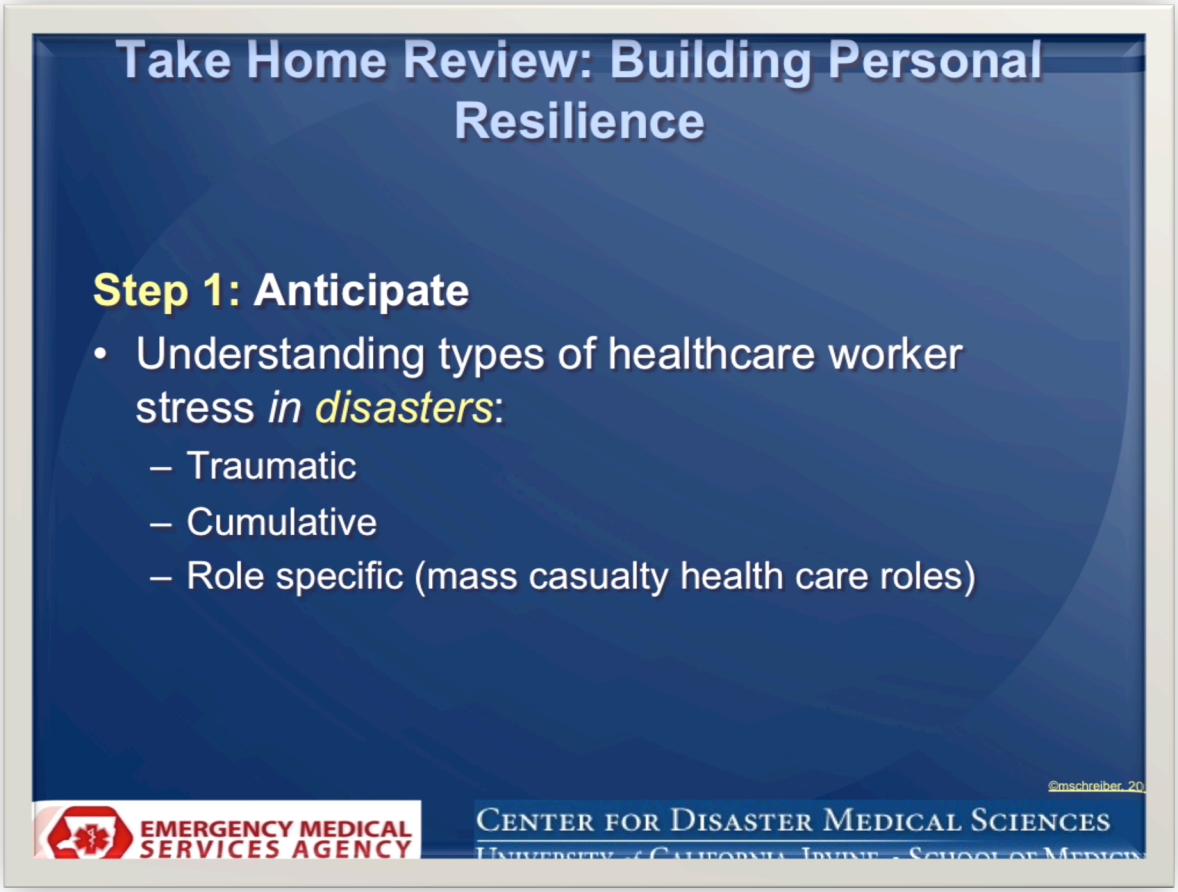

Final APD course review. Please review each key point with group and ask them to address each step and ask any questions now.

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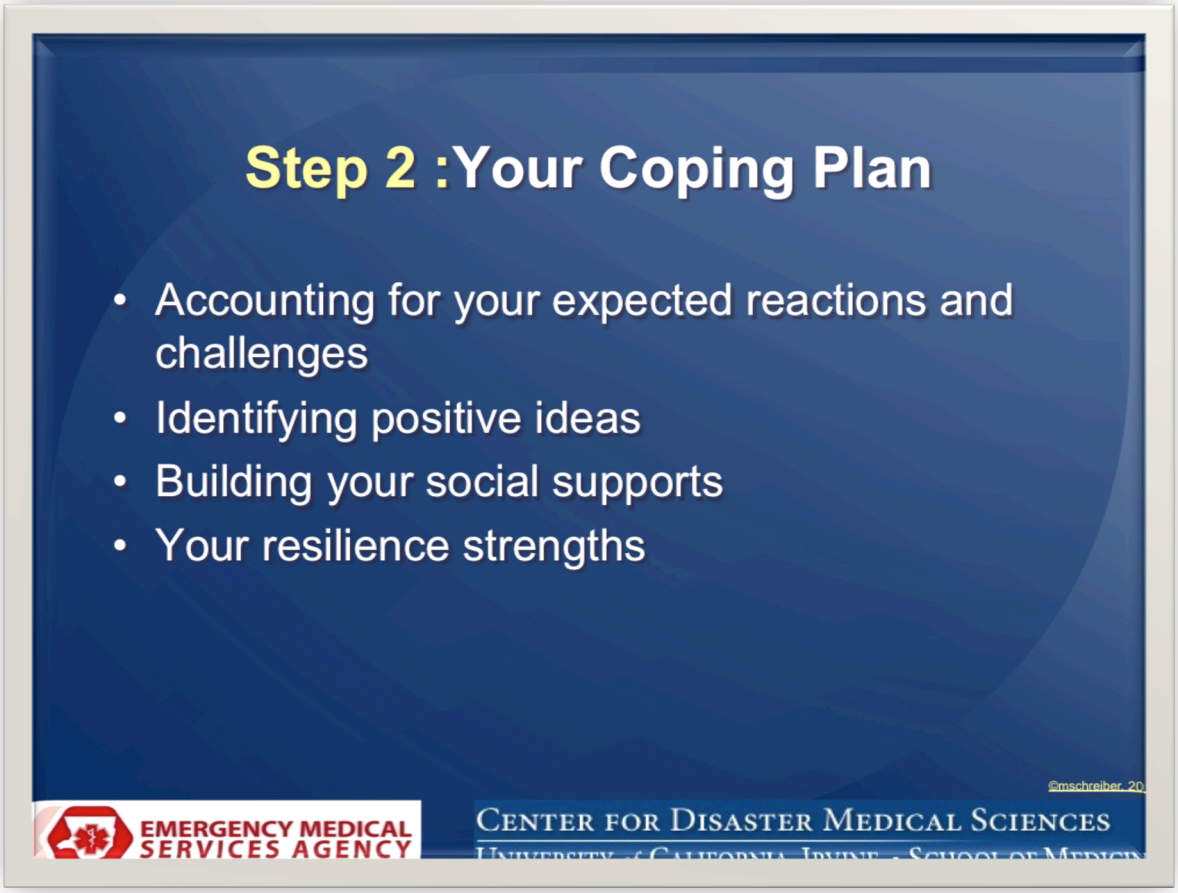

Ask participants to describe these steps and clarify any questions they may have.

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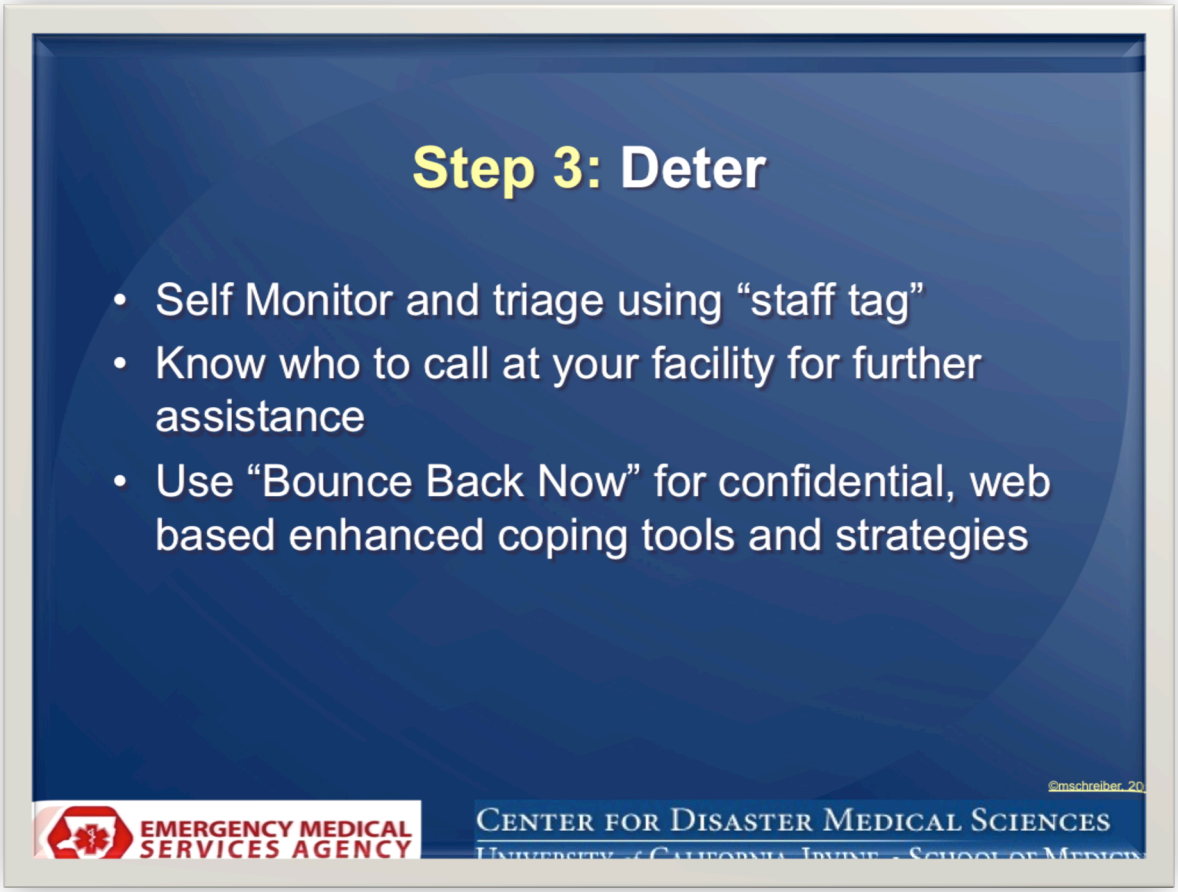

Again ask group members to discuss, review and clarify any questions they may have.

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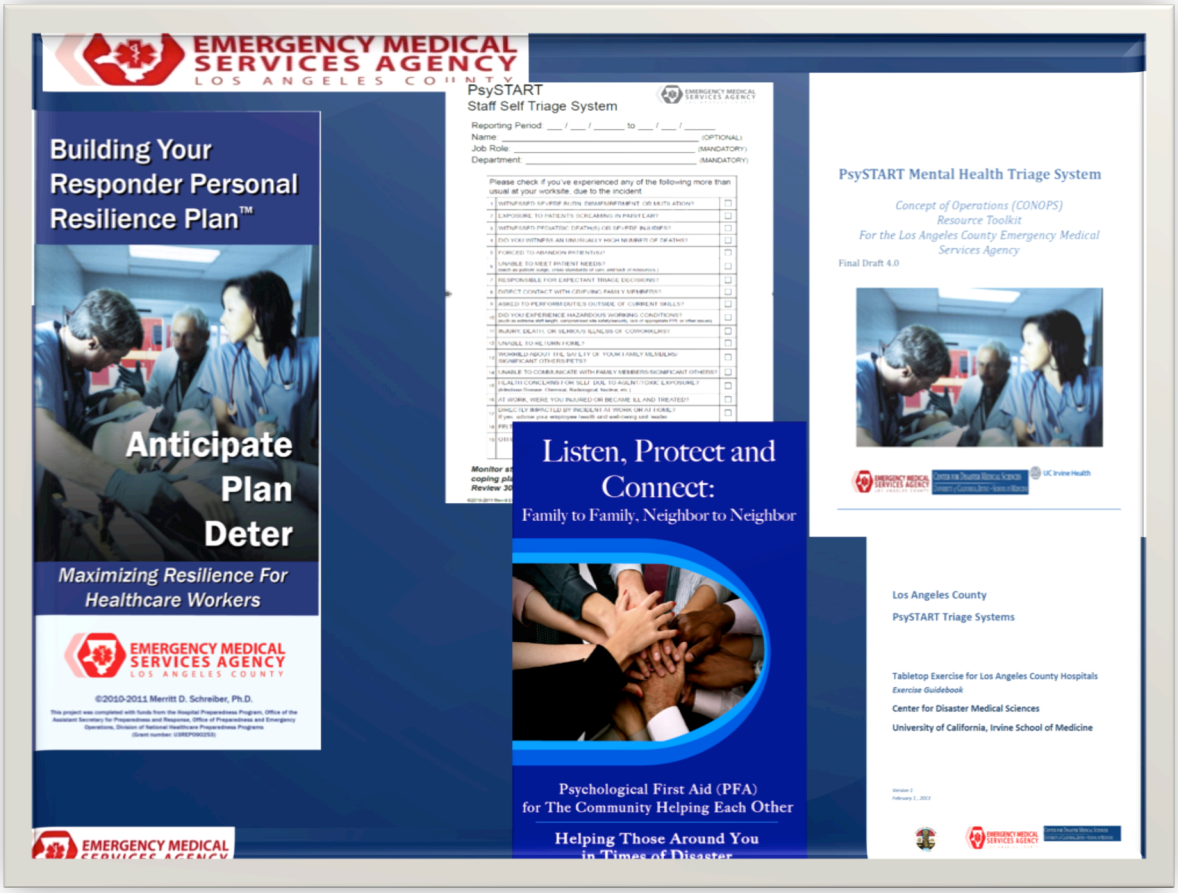

This slide shows all the elements needed for a successful Anticipate.Plan.Deter. Responder resilience training.
All of these elements are located on the LA County EMS Agency Website.

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