Better HHS Planning Needed for National Disaster Medical System

The US Department of Health and Human Services (HHS) needs better strategic planning to ensure it has enough physicians, nurses, and other health care professionals enrolled in the National Disaster Medical System (NDMS), according to a recent report from the US Government Accountability Office (GAO).

The NDMS was established in the 1980s to respond to military casualties but now also assists during events affecting civilians. NDMS personnel have private sector jobs but serve intermittently as federal employees to lead the public health and medical response to natural disasters and national emergencies such as the coronavirus disease 2019 (COVID-19) pandemic. As of March 27, NDMS had deployed 1200 pandemic responders, according to the GAO report. Some helped move potentially infected US residents from cruise ships to quarantine locations in the states.

In 2018, HHS set an enrollment target of 6290 responders for NDMS, but the GAO found it did not follow key principles of strategic workforce planning when it determined that number. For example, the GAO said, HHS failed to identify the critical skills and competencies the NDMS workforce needs. Therefore, the agency can’t be sure its enrollment target would provide an adequate number of responders with the necessary skills for an effective response to national disasters.

Before deployment by the NDMS, responders are required to take web-based training, such as in how to don and doff personal protective equipment. Responders also have in-person training options that cover practices such as how to deliver care in less-than-optimal environments. In-person courses are more beneficial but also more expensive, HHS officials told the GAO.

However, HHS is unable to determine whether NDMS training is effective until responders are deployed, and at that point it might be too late, the GAO said. If HHS could better evaluate the training offered to NDMS responders, the agency would be able to determine which in-person courses should be prioritized or even made mandatory for safe and effective deployment.

Higher Rate of Opioid-Related Stays in Urban Than Rural Hospitals

In most parts of the country, hospitals in metropolitan areas had a higher average rate of opioid-related inpatient stays than hospitals in rural areas, according to a recent analysis of 2016 data by the Healthcare Cost and Utilization Project (HCUP), which is sponsored by the Agency for Healthcare Research and Quality.

The average rate for metropolitan hospitals was 30.8 opioid-related inpatient stays per 1000 stays, the HCUP found. By contrast, the rate for rural hospitals adjacent to urban areas was 20.1 per 1000 and 16.2 per 1000 for remote rural hospitals.

But the rates varied widely across US Census divisions. For example, the rate among remote rural hospitals in the West South Central division was 9.4 per 1000 hospitalizations compared with 34.7 per 1000 in the New England division. Only in New England were rates high in both metropolitan and rural hospitals, the study found.

The analysis included data from 4207 community hospitals in 46 states and the District of Columbia. Hospitals with 25 or fewer beds, regardless of their location, had the lowest rates of opioid-related stays.

NIH Launches Platform to Serve as Depository for COVID-19 Medical Data

The National Institutes of Health (NIH) recently launched the National COVID Cohort Collaborative (N3C) to store and study medical record data from people across the country who have been diagnosed with coronavirus disease 2019 (COVID-19).

By contrast, the rate for rural hospitals adjacent to urban areas was 20.1 per 1000 and 16.2 per 1000 for remote rural hospitals.

The N3C, funded by the NIH’s National Center for Advancing Translational Sciences (NCATS), will create an analytics platform to collect clinical, laboratory, and diagnostic data. The standardized aggregated data will be made available to researchers and clinicians to help them quickly answer questions such as which patients are more likely to need dialysis because of kidney failure or a ventilator because of respiratory failure, according to the NIH.

The data will retain only patients’ zip codes and the dates they received care. NCATS is implementing multiple security and privacy measures to keep the data within a protected cloud infrastructure. Users, who do not have to contribute data, must first register with the N3C to access the data. Interested scientists and clinicians can view an online demonstration of the N3C platform.

Besides accelerating COVID-19 research and clinical care, “we anticipate that [N3C] will serve as the foundation for addressing future public health emergencies,” NCATS Director Christopher Austin, MD, said in a statement. – Rita Rubin, MA

Note: Source references are available through embedded hyperlinks in the article text online.