Appendixes

Appendix A. Literature Search Strategy

Appendix A. Literature Search Strategy

RAND LIBRARY

SEARCH #1 (RUN 1/21/2011)
DATABASE SEARCH & TIME PERIOD COVERED:
PubMed – 1990-2011

SEARCH STRATEGY:
disasters[mesh] OR disaster*[tiab] OR emergencies OR emergency planning OR emergency preparedness OR mass casualt* OR ((triage[ti] OR triaging[ti]) AND disaster*) OR pandemic[ti]
AND
surge OR scarce OR scarcity OR allocat* OR ration OR mass OR (triage AND (ethic* OR protocol)) OR "emergency medical care" OR (emergency medical care services[mh] AND ration) OR remote consultation[mh] OR "crisis standards" OR "altered care" OR "adapted care" OR "crisis standards of care" OR "altered standards of care"
NOT: Letters, Case Reports, Clinical Trials
NOT: animal*NOT Human*
NOT :("human remains" OR "identifying human bodies" OR autops* OR "end of life planning" OR pig OR pigs OR porcine OR cow OR cows OR bovine OR horse OR horses OR dog OR dogs OR cat OR cats OR mice OR mouse OR hamster OR hamsters OR rat OR rats OR "identification of human bodies" OR epidemiology OR appendectomy OR "dental identification" OR "water insecurity" OR "mass gatherings" OR "dental identification" OR (food AND ration) OR clinicaltrials.gov OR "total hip replacement" OR (mass AND cancer) OR ECMO OR forensic* OR drought OR "abdominal aortic aneurysm" OR (oil AND spill) OR "global warming" OR "partner violence" OR "violence prevention")
OR:
Levin D[au] AND pandemic[ti]

NUMBER OF ITEMS RETRIEVED: 2472

SEARCH #2 (RUN 1/27/2011)
DATABASE SEARCH & TIME PERIOD COVERED:
CINAHL – 1990-2011

Disaster* OR emergencies OR emergency planning OR emergency preparedness OR mass casualt* OR ((TI triage OR TI triaging) AND disaster*) OR TI pandemic
AND
surge OR scarce OR scarcity OR allocat* OR (triage AND (ethic* OR protocol)
OR "emergency medical care" OR ("emergency medical services" AND ration) OR "remote consultation" OR "crisis standards" OR "altered care" OR "adapted care" OR "crisis standards of care" OR "altered standards of care"
And Human
Not Letters

Date of Publication from: 19900101-20111231; Peer Reviewed; Exclude MEDLINE records

NUMBER OF ITEMS RETRIEVED: 83 (AFTER DEDUPING) 76

SEARCH #3 (RUN 1/27/2011)
DATABASE SEARCH & TIME PERIOD COVERED:
Cochrane – 1990-2011

“mass casualt*” OR “disaster preparedness” OR (Triag* AND (disaster OR mass))

NUMBER OF ITEMS RETRIEVED: 56

SEARCH #4 (RUN 1/27/2011)
DATABASE SEARCH & TIME PERIOD COVERED:
Embase – 1990-2011

'mass disaster'/exp OR disaster*:ab,ti OR 'emergencies'/exp OR 'emergency'/exp AND 'planning'/exp OR 'emergency'/exp AND preparedness OR 'mass'/exp AND casualt* OR ((triage:ti OR triaging:ti)AND disaster*) OR pandemic:ti AND [embase]/lim
AND
'emergency medical care'/exp OR ('emergency medical services'/exp AND ration) OR 'remote consultation'/exp OR 'crisis standards' OR 'altered care' OR 'adapted care' OR 'crisis standards of care' OR 'altered standards of care' OR surge OR scarce OR scarcity OR allocat* OR ration OR 'mass'/exp OR ('triage'/exp AND (ethic* OR protocol)) AND [embase]/lim
AND [humans]/lim AND [1990-2011]/py
NOT
pandemic NEAR/3 vaccin*

NUMBER OF ITEMS RETRIEVED: 129 results (before de-duping) 70 (after de-duping & hand removal)

SEARCH #5 (RUN 1/27/2011)
DATABASE SEARCH & TIME PERIOD COVERED:
Web of Science – 1990-2011

TS=disaster* OR TS=emergencies OR TS=emergency planning OR TS=emergency preparedness OR TS=mass casualt* OR (TI=triage OR TI=triaging) AND TS=disaster*) OR TI=pandemic
AND
TS=surge OR TS=scarce OR TS=scarcity OR TS=allocat* OR TS=triage AND TS= (ethic* OR protocol) OR TS="emergency medical care" OR TS= ("emergency medical services" AND ration) OR TS="remote consultation" OR TS="emergency medical care" OR TS= ("emergency medical services" AND ration) OR TS="remote consultation" OR TS="crisis standards" OR TS="altered care" OR TS="adapted care" OR TS="crisis standards of care" OR TS="altered standards of care"
NOT: Letter
NOT :
(TS="human remains" OR TS="identifying human bodies" OR TS=autops* OR TS="end of life planning" OR TS=pig OR TS=pigs OR TS=porcine OR TS=cow OR TS=cows OR TS=bovine OR TS=horse OR TS=horses OR TS=dog OR TS=dogs OR TS=cat OR TS=cats OR TS=mice OR TS=mouse OR TS=hamster OR TS=hamsters OR TS=rat OR TS=rats OR TS="identification of human bodies" OR TS=epidemiology OR TS=appendectomy OR TS= “dental identification” OR TS="water insecurity" OR TS="mass gatherings" OR TS="dental identification" OR TS= (food AND ration) OR TS=clinicaltrials.gov OR TS="total hip replacement" OR TS= (mass AND cancer) OR TS=ECMO OR TS=forensic* OR TS=drought OR TS=“abdominal aortic aneurysm” OR TS= (oil AND spill) OR TS=“global warming” OR TS= “partner violence” OR TS= “violence prevention” OR TS=geological OR TS="clinical trial" OR TS="urban modeling" OR TS="urban simulation" OR)

Refined by: [excluding] Subject Areas=(ENGINEERING, MECHANICAL OR WATER RESOURCES OR ECOLOGY OR CONSTRUCTION & BUILDING TECHNOLOGY OR MATHEMATICS, INTERDISCIPLINARY APPLICATIONS OR ENGINEERING, GEOLOGICAL OR METEOROLOGY & ATMOSPHERIC SCIENCES OR VETERINARY SCIENCES OR ENGINEERING, OCEAN OR MEDICAL INFORMATICS OR OCEANOGRAPHY)

NUMBER OF ITEMS RETRIEVED: 748 (before deduping); 506 after de-duping (and screening)

SEARCH #6 (RUN 2/1/2011)
DATABASE SEARCH & TIME PERIOD COVERED:
Global Health – 1990-2011

1 10670 S DISASTER? OR MASS()CASUALT? OR EMERGENCY(5N)PLAN? OR EMERGENCY(5N)PREPAR? OR EMERGENCY()MEDICAL()CARE OR REMOTE()SERVICES OR EMERGENCIES OR PANDEMIC?

S2 16 S TRIAG?/TI AND DISASTER?

S3 10670 S S1 OR S2

S4 93610 S SURGE OR SCARCE OR SCARCITY OR ALLOCAT? OR RATION OR RATIONED OR RATIONING OR MASS

S5 54 S TRIAGE AND (ETHIC? OR PROTOCOL?)

S6 103284 S S3 OR S4

S7 10670 S S3 AND S6

S8 996 S S3 AND S4

S9 1026 S S8 OR S5

S10 0 S EMERGENCY()MEDICAL()CARE()SERVICE? AND (RATION OR RATIONED OR RATIONING)

S11 1 S EMERGENCY()MEDICAL AND (RATION OR RATIONED OR RATIONING)

S12 21 S REMOTE?(2N)CONSULT?

S13 3 S CRISIS(2N)STANDARD? OR ALTERED()CARE OR ADAPTED()CARE

S14 1048 S S9 OR S11 OR S12 OR S13

S15 974 S S14/ENG

S16 930 S S15/1990:2011

NUMBER OF ITEMS RETRIEVED: 930

SEARCH #7 (RUN 4/16/2011)
DATABASE SEARCH & TIME PERIOD COVERED:
SCOPUS – 1990-2011

TITLE-ABS-KEY(disaster*) OR emergencies OR {emergency planning} OR emergency preparedness OR mass casualt* OR TITLE(triage) OR TITLE(pandemic)
AND
surge OR scarce OR scarcity OR allocat* OR ration OR mass OR (triage AND (ethic* OR protocol)) OR({emergency medical care} OR {remote consultation}) AND ration OR
{crisis standards} OR {altered care} OR {adapted care} OR {crisis standards of care} OR {altered standards of care} OR {crisis care}
AND
PUBYEAR AFT 1989

NOT
{human remains} OR {identifying human bodies} OR autops* OR {end of life planning} OR pig OR pigs OR porcine OR cow OR cows OR bovine OR horse OR horses OR dog OR dogs OR cat OR cats OR mice OR mouse OR hamster OR hamsters OR rat OR rats OR {identification of human bodies} OR epidemiology OR appendectomy OR {dental identification} OR {water insecurity} OR {mass gatherings} OR {dental identification} OR (food AND ration) OR clinicaltrials.gov OR {total hip replacement} OR (mass AND cancer) OR ecmo OR forensic* OR drought OR {abdominal aortic aneurysm} OR (oil AND spill) OR {global warming} OR {partner violence} OR {violence prevention})

NUMBER OF ITEMS RETRIEVED: after deduping 1270 – after weeding 428

SEARCH #8 (RUN 1/28/2011)
DATABASE SEARCH & TIME PERIOD COVERED:
NLMLocatorPlus– 1990-2011

Mass Casualty as a phrase in Title
OR
Disaster in Title
AND
Medicine in Title

NUMBER OF ITEMS RETRIEVED: 141 titles kept 42

SEARCH #9 (RUN 1/31/2011)
DATABASE SEARCH & TIME PERIOD COVERED:
NYAM Grey Literature Report– 1990-2011

Key word: mass casualty OR disaster OR disasters

NUMBER OF ITEMS RETRIEVED: 290

Appendix B. Data Abstraction Tools

Appendix B. Data Abstraction Tools

Short Form

1. Is the language of the article in English?

Yes No (please specify language)

If the language of the article is in a language that you cannot read then please stop.

2. Does this study directly address a KQ?

Yes No (exclude and go to background, soft exclude, and reference mining question)

3. What type of study is this?

A. Proposed Strategy (recommendation)

If proposed strategy then is the proposed strategy based on a rigorous expert consensus process (e.g., expert panel, task force, Delphi process), or data from a real event?

Yes (included) No (exclude and go to background, soft exclude, and reference mining question

B. Tested Strategy (simulation, actual event, etc.)

☐ Prospectively tested in a real event ☐ Prospectively tested using a model, simulation, or exercise ☐ Synthesize results from multiple real events or studies ☐ None (i.e, single event AARs)

C. KQ 3 relevant

If this article contains a tested strategy or is KQ 3 relevant then this article will be **included** and you can proceed to the next article)

D. KQ 4 (only) relevant

KQ4

Is this KQ 4 (only) strategy tested or proposed?

A. KQ 4 Proposed

Is this only KQ 4 (only) proposed strategy based on a rigorous expert consensus process (e.g., national expert panel or task force using Delphi or similar process) or organized review of multiple events?

Yes No (Exclude and go to background, soft exclude, and reference mining questions)

If you answered yes then this article will be **included** and you can proceed to the next article.
If the proposed strategy is not based on a rigorous expert concensus this article will be **excluded**. If you chose to exclude it then please proceed to background, soft exclude, and reference mining questions.

B. KQ 4 Tested Strategy-Training

If the tested strategy is only KQ 4 relevant does it report changes in actual performance outcomes?
Yes No (Exclude and go to background, soft exclude, and reference mining questions)

If you answered yes then this article will be **included** and you can proceed to the next article.
If the tested strategy does not report changes then this article will be **excluded**. If you

chose to exclude it then please proceed to background, soft exclude, and reference mining question

C. KQ 4 Tested Strategy-Other

4. If this study is not being included do we need to separately mine it for references?

Yes No

Please answer the background question if you have **excluded** the article

5. Is this a potential background article?

Yes No

Please only answer the background question if you have **excluded** the article on a previous question.

6. If the study is excluded should it be a soft exclude?

Yes No

Please only answer the soft exclude question if you have **excluded** the article on a previous question.

7. Is this excluded article very high yield? (Use sparingly)

Yes No

Please only answer the high yield question if you have **excluded** the article on a previous question.

Long Form: KQ1 and 2 Tested Strategies

KQ1-2 Long Form

****KQ1-2 Tested Strategy**** Mass Casualty Data Abstraction Form (Long Version)

PAPER ID#

CLASSIFICATION:

I. Key inclusion criteria to be reconciled first

1. Which Key Question(s) are addressed? [Check all that apply – avoid selecting both KQ1, KQ2]

- KQ1: Strategies available to *policy makers* to optimize resource allocation during MCEs
- KQ2: Strategies available to *providers* to optimize resource allocation during MCEs
- KQ3: Public's concerns regarding resource allocation strategies [STOP if KQ3 only. Review separately]
- KQ4: Strategies to engage stakeholders in developing strategies to optimize resource allocation during MCEs [STOP if KQ4 only. Review separately]

Does not address a key question [STOP. Exclude]

Comments

2. Does this study describe a tested or a proposed strategy?

Describes a *tested* strategy (i.e., tested in an actual event, exercise, or simulation. For actual events, the strategy could have been developed ex ante or during an event. Pilot tests qualify as valid tests.) [these items should pop up if "tested strategy"]

- Does the study describe a specific, implementable strategy? [Yes/no] [If no – Stop. EXCLUDE.]
- Does the strategy relate to scarce resources? [Yes/no] [If no – Stop. EXCLUDE.]"
- Does the study report on relevant outcomes (may be qualitative or process measures, but they must be fairly closely related to "hard" outcomes) [Yes/no] [If no – Stop. EXCLUDE.]
- Does the study report outcomes relative to an appropriate standard (e.g., an alternative strategy or of the status quo strategy)? [Yes/no] [If no – Stop. EXCLUDE.]
- If exclude, should this article be considered a high-yield background article? [yes/no]

Describes a *proposed* strategy [these items should pop up if "tested strategy"]

Strategy:

#	Briefly state the strategy [see examples below]	Into which category does this strategy fit? [Use Ringel table of strategies as a guide]	Select stakeholder [check all that apply]	Modulators of the strategy's implementation and/or effectiveness outcomes
1		☐ Reduce/ manage less urgent demand ☐ Optimize use of existing resources ☐ Augment existing resources ☐ Allocation or Reallocation of resources ☐ Other (Describe) ☐ Other (Describe) ☐ Other (Describe)	In-field/On-scene ☐ Health care institution (Hospital) ☐ Health care institution (Non-Hospital)-- eg, nursing home, LTC ☐ Health care (Other) eg, private practice, vaccine clinic, pharmacy ☐ Policy setting/governmental organization (Federal) ☐ Policy setting/governmental organization (State or Local) ☐ Policy setting/governmental organization (Unspecified) ☐ Non-governmental entity ☐ Other [Please specify] ☐ Other	☐ Modulator 1 ☐ Modulator 2 ☐ Modulator 3 ☐ Modulator 4 ☐ Modulator 5

			[Please specify] ☐ Other [Please specify]	
2				
….				

- Examples of individual strategies: Use SOFA score to triage patients; Cancel elective hospital admissions; Request supplemental

STOP HERE to allow reconciliation of these four questions.

II. Study design and characteristics

Where did the study take place?

- US (specify city and state if relevant)
- Canada, Australia, New Zealand
- Western Europe
- Eastern Europe
- Israel
- Asia
- South America
- Not Reported
- Not Relevant (e.g., computer simulation)
- Other – specify (for each "other" entity)

How would you describe the study setting?

- Low population density (e.g., rural)
- Moderate population density (e.g., suburban)
- High population density (e.g., urban)
- Unclear (elaborate if necessary)
- Not relevant
- Not reported

What type of MCE is described? [Check all that apply]

- All-hazards
- Chemical
- Biological
- Radiological
- Nuclear
- Explosive

- Natural disaster – if so, what type?
- Infectious disease (if so, pandemic flu?)
- Other – specify
- Unspecified
- Don’t know

What is the study design?

- Randomized controlled trial
- Observational, pre-post with comparison group [Describe comparison group]
- Observational, pre-post
- Observational, post only with comparison group [Describe comparison group]
- Proof of concept test [outcome of strategy not assessed]
- Systematic Review/Meta-analysis
- Computer Simulations
- Non-systematic Review
- Other, please specify

Where do the data supporting the strategy come from? [Check all that apply]

- Single real event [Give common name if applicable (e.g., Hurricane Katrina; Sarin Gas Attacks)]
- Multiple real events
- Exercise, drill, or training program
- Computer simulation
- Proof of concept test (e.g., alternative oxygen delivery system)
- Survey, focus group
- Other, please specify

III. Outcomes Assessment

Outcomes

#	What are the main results? {These data will be reported directly into the evidence table}	What kind of outcome is it?	To which strategy does this outcome correspond?	What is the effect size (or qualitative result)?	What is the standard error or confidence interval (if reported)?
1		Feasibility Process Health outcome Opinion Ethical Economic Other, please describe Clear Response	Strategy 1 Strategy 2 Strategy 3 Strategy 4 Strategy 5	Effect Size 1 Effect Size 2 Effect Size 3 Effect Size 4 Effect Size 5	SE/CI 1 SE/CI 2 SE/CI 3 SE/CI 4 SE/CI 5
2					

...					
10					

IV. Quality	**TOTAL SCORE:**

What type of study is this?

- Computer Simulations only
- Systematic Reviews only
- Proof of concept study
- All other study-types

Appendix B. Data Abstraction Tools: Long Form for KQ1 and 2 Tested Strategies

For computer simulations only

Evidence supporting assumptions and/or data:

- Weak or no evidence to justify assumptions or data (0)
- Reasonable attempt to justify assumptions or data (1)
- Strong justification of assumptions or data (2)

Description of the strategy:

- Limited description of the strategy is presented (0)
- Comprehensive description of the strategy is presented (i.e., the strategy is presented in enough detail that it can be replicated or is described elsewhere) (1)

Assessment of generalizability of the findings (includes limitations of the strategy)

- No discussion of the generalizability of findings(0)
- At least some discussion of the generalizability of findings (1)
- Thorough discussion of the generalizability of findings (2)

Sensitivity analyses

- No sensitivity analyses performed (0)
- At least some sensitivity analyses performed (1)
- Robust sensitivity analyses of key assumptions performed (2)

Discussion of confounders:

- No discussion of confounders (0)
- At least some discussion of confounders (1)
- Thorough discussion of confounders (2)
- Not Applicable

Appendix B. Data Abstraction Tools: Long Form for KQ1 and 2 Tested Strategies

Systematic Reviews

Was an 'a priori' design provided?

The research question and inclusion criteria should be established before the conduct of the review.

- Yes
- No
- Not Reported
- Not Applicable

Was there duplicate study selection and data extraction?

There should be at least two independent data extractors and a consensus procedure for disagreements should be in place.

- Yes
- No
- Not Reported
- Not Applicable

Was a comprehensive literature search performed?

Appendix B. Data Abstraction Tools: Long Form for KQ1 and 2 Tested Strategies

At least two electronic sources should be searched. The report must include years and databases used (e.g. Central, EMBASE, and MEDLINE). Key words and/or MESH terms must be stated and where feasible the search strategy should be provided. All searches should be supplemented by consulting current contents, reviews, textbooks, specialized registers, or experts in the particular field of study, and by reviewing the references in the studies found.

- Yes
- No
- Not Reported
- Not Applicable

Was the status of publication (i.e. grey literature) used as an inclusion criterion?

The authors should state that they searched for reports regardless of their publication type. The authors should state whether or not they excluded any reports (from the systematic review), based on their publication status, language etc.

- Yes
- No
- Not Reported
- Not Applicable

Was a list of included studies provided?

Appendix B. Data Abstraction Tools: Long Form for KQ1 and 2 Tested Strategies

A list of included and excluded studies should be provided.

- Yes
- No
- Not Reported
- Not Applicable

Were the characteristics of the included studies provided?

In an aggregated form such as a table, data from the original studies should be provided on the participants, interventions and outcomes. The ranges of characteristics in all the studies analyzed e.g. age, race, sex, relevant socioeconomic data, disease status, duration, severity, or other diseases should be reported.

- Yes
- No
- Not Reported
- Not Applicable

Was the scientific quality of the included studies assessed and documented?

'A priori' methods of assessment should be provided (e.g., for effectiveness studies if the author(s) chose to include only randomized, double-blind, placebo controlled studies, or allocation concealment as inclusion criteria); for other types of studies alternative items will be relevant.

Yes

No

Not Reported

Not Applicable

Was the scientific quality of the included studies used appropriately in formulating conclusions?

The results of the methodological rigor and scientific quality should be considered in the analysis and the conclusions of the review, and explicitly stated in formulating recommendations.

Yes

No

Not Reported

Not Applicable

Clear Response

Were the methods used to combine the findings of studies appropriate?

For the pooled results, a test should be done to ensure the studies were combinable, to assess their homogeneity (i.e. Chi-squared test for homogeneity, I^2). If heterogeneity exists a random effects model should be used and/or the clinical appropriateness of combining should be taken into consideration (i.e. is it sensible to combine?).

- Yes
- No
- Not Reported
- Not Applicable

Was the likelihood of publication bias assessed?

An assessment of publication bias should include a combination of graphical aids (e.g., funnel plot, other available tests) and/or statistical tests (e.g., Egger regression test).

- Yes
- No
- Not Reported
- Not Applicable

Was the conflict of interest stated?

Potential sources of support should be clearly acknowledged in both the systematic review and the included studies.

- Yes
- No
- Not Reported
- Not Applicable

Appendix B. Data Abstraction Tools: Long Form for KQ1 and 2 Tested Strategies

Proof of Concept

Data collection:

- Non-systematic data collection (0)
- Systematic, retrospective data collection (1)
- Systematic, prospective data collection (2)

Description of the strategy:

- Limited description of the strategy is presented (0)
- Comprehensive description of the strategy is presented (i.e., the strategy is presented in enough detail that it can be replicated or is described elsewhere) (1)

Assessment of generalizability of the findings (includes limitations of strategy)

- No discussion of the generalizability of findings (0)
- At least some discussion of the generalizability of findings (1)
- Thorough discussion of the generalizability of findings (2)

For all study-types other than computer simulation and systematic reviews:

Data collection:

- Non-systematic data collection (0)
- Systematic, retrospective data collection (1)
- Systematic, prospective data collection (2)

Description of the strategy:

- Limited description of the strategy is presented (0)
- Comprehensive description of the strategy is presented (i.e., the strategy is presented in enough detail that it can be replicated or is described elsewhere) (1)

Fidelity in implementing resource allocation strategy. (Note: fidelity is defined as the degree to which the strategy is implemented consistently throughout the course of the MCE whether or not a formal protocol exists):

- No data on fidelity are reported. (0)
- Quantitative or qualitative data on fidelity are reported. (1)

- Not Applicable

Assessment of generalizability

- No discussion of the generalizability of findings (0)
- At least some discussion of the generalizability of findings (1)
- Thorough discussion of the generalizability of findings (2)

Discussion of confounders:

- No discussion of confounders (0)
- At least some discussion of confounders (1)
- Thorough discussion of confounders (2)
- Not Applicable

V. Applicability

To which geographic scope is this strategy applicable? [Check all that apply]

☐ Local only

☐ Large urban or regional

☐ Multi-regional or larger

☐ Other (specified) ______

Is the strategy unique to the jurisdiction described (in terms of leadership required, populations served, stakeholders included, or availability of resources)? [Check all that apply]

☐ Highly unique

☐ Somewhat unique

☐ Not unique

For strategies tested outside of the U.S., are the strategies applicable in the U.S.? [Check all that apply]

- [ ] Yes
- [ ] No
- [ ] Unclear
- [ ] Not Relevant

How relevant are the outcomes to patients? [Check all that apply]

- [ ] At least somewhat relevant
- [ ] Highly relevant
- [ ] Not Applicable

To what extent is the primary strategy ready for use? [Check all that apply]

- [ ] Not ready for use because the strategy is not effective
- [ ] Not ready for use because the strategy needs additional development/testing
- [ ] Ready for use

☐ Unclear (elaborate if necessary)

VI. General

Are there any references that need to be checked? If so, please indicate the reference number(s).

Has the primary reviewer completed the bottom half of the long form?

◯ Yes

◯ No

Has the secondary reviewer reviewed the bottom half of the form?

◯ Yes

◯ No

Has this article been fully reconciled?

- Yes
- No

Comments on the study

KQ4 Long Form

KQ4 Mass Casualty Data Abstraction Form (Long Version)

PAPER ID#

CLASSIFICATION: EVIDENCE / PROPOSED

I. Key inclusion criteria to be reconciled first

1. Which Key Question(s) are addressed? [Check all that apply – avoid selecting both KQ1, KQ2]
   - KQ1: Strategies available to *policy makers* to optimize resource allocation during MCEs
   - KQ2: Strategies available to *providers* to optimize resource allocation during MCEs
   - KQ3: Public's concerns regarding resource allocation strategies [STOP if KQ3 only. Review separately]
   - KQ4: Strategies to engage stakeholders in developing strategies to optimize resource allocation during MCEs [STOP if KQ4 only. Review separately]

Does not address a key question [STOP. Exclude]

Comments

2. Does this study describe a tested or a proposed strategy?
   - Describes a *tested* strategy (i.e., tested in an actual event, exercise, or simulation. For actual events, the strategy could have been developed ex ante or during an event. Pilot tests qualify as valid tests.) [these items should pop up if "tested strategy"]
   - Does the study describe a specific, implementable strategy? [Yes/no] [If no – Stop. EXCLUDE.]
   - Does the strategy relate to surge capacity? [Yes/no] [If no – Stop. EXCLUDE.]
   - Does the strategy relate to at least one specific strategy (demand, optimize, augment, crisis level) scarce resources? [Yes/no] [If no – Stop. EXCLUDE.]
   - Does the study report on relevant outcomes (***for KQ4 this may also include a tested plan**;* may be qualitative or process measures, but they must be fairly closely related to "hard" outcomes) [Yes/no] [If no – Stop. EXCLUDE.]

If exclude, should this article be considered a high-yield background article?

[yes/no]

- Describes a *proposed* strategy [Stop. Review separately for background section]

Strategy:

#	3.Briefly describe strategy/strategies	4. Into which category does this strategy fit? [see list below]	5a. Stakeholder(s): Who engaged others?	5b. Stakeholders: Who was engaged?	6. Modulators* of strategy implementation or outcome effectiveness
1					
2					
….					

Examples of individual strategies: Use SOFA score to triage patients; Cancel elective hospital admissions; Request supplemental resources from VA hospital.

** Modulators: refers to facilitators and/or barriers*

4. Into what category does this strategy fit?

- STR1 - Reduce/manage less urgent demand
- STR2 - Optimize use of existing resources
- STR3 - Augment existing resources
- STR4 - Allocation or reallocation of resources (crisis level, e.g., triage)
- STR5 - Surge capacity in general (not specifically one or more of the above)
- STR6 - Other – describe:

5a/5b. Select stakeholders: (a) Who engaged others? (b) Who was engaged [indicate all that apply in table above]

- STK1 - In-field / On-scene
- STK2 - Health care institution (hospital)
- STK3 - Health care institution (non-hospital) – e.g., nursing home, LTC
- STK4 - Health care (Other) e.g., private practice, vaccine clinic, pharmacy
- STK5 - Policy setting/govt agency (Federal)
- STK6 - Policy setting/govt organization (State or Local)
- STK7 - Policy setting/govt organization (Unspecified)
- STK8 - Non-governmental entity
- STK9 – Academia
- STK10 – Professional association

- STK11a, b, c, etc. -Other (specify each)

STOP HERE to allow reconciliation of these four questions.

II. Study design and characteristics

8. Where did the study take place?

- US (specify city and state if relevant)
- Canada, Australia, New Zealand
- Western Europe
- Eastern Europe
- Israel
- Not Relevant (e.g., computer simulation)
- Asia
- South America
- Not Reported
- Other – specify (for each "other" entity)

9. How would you describe the study setting?

- Low population density (e.g., rural)
- Moderate population density (e.g., suburban)
- High population density (e.g., urban)
- Unclear (elaborate if necessary)
- Not relevant
- Not reported

10. What type of MCE is described? [Check all that apply]

- All-hazards
- Chemical
- Biological
- Radiological
- Nuclear
- Explosive
- Natural disaster – if so, what type?
- Infectious disease (if so, pandemic flu?)
- Other – specify
- Unspecified
- Don't know

11. What is the study design?

- Randomized controlled trial
- Observational, pre-post with comparison group [Describe comparison group]
- Observational, pre-post
- Observational, post only with comparison group [Describe comparison group]
- Proof of concept test [outcome of strategy not assessed]
- Systematic Review/Meta-analysis
- Non-systematic Review
- Description of planning process
- Description of exercise or real event
- Other, please specify

12. Where do the data supporting the strategy come from? [Check all that apply]

- Single real event [Name if applicable]
- Multiple real events
- Exercise, drill, or training program
- Multi-stakeholder meetings, etc.
- Computer simulation

- Proof of concept test
- Survey, focus group
- Other, please specify

III. Outcomes Assessment

Outcomes

#	13. What is the outcome? [describe briefly]	14. What kind of outcome is it? *[see list below]*	15. To which strategy does this outcome correspond? *[see list below]*	16. What is the effect size (or qualitative result)?	17. Was the outcome tested?
1					
2					
…					
10					

14. What kind of outcome is it?

- OU1 - Feasibility
- OU2 - Process
- OU3 - Health outcome
- OU4- Opinion
- OU5 - Ethical
- OU6 - Economic
- OU7 – Plan or protocol
- OU8 – Surge resources (e.g., staff, space, and/or supplies)
- OU9a, b, c, etc. - Other - specify

15. To which strategy does this outcome fit? [Q3 – strategy number]

IV. Quality	**TOTAL SCORE: ## / 5**

18. Data collection:

- No data collection (0)
- Non-systematic data collection (1)
- Systematic data collection (2)

19. Description of the strategy:

- Limited description of the strategy is presented (0)
- Comprehensive description of the strategy is presented (i.e., the strategy is presented in enough detail that it can be replicated) (1)

20. Fidelity in implementing resource allocation strategy. (Note: fidelity is defined as the degree to which the strategy is implemented consistently throughout the course of the MCE whether or not a formal protocol exists):

- No data on fidelity are reported. (0)
- Quantitative or qualitative data on fidelity are reported. (1)

21. Assessment of generalizability

- No discussion of the generalizability of findings (0)
- Generalizability of findings discussed (1)

V. Applicability

22. To what extent is the strategy/outcome dependent on size/scale of the MCE?

- Not at all
- Somewhat
- Moderately
- Very much
- Unclear

23. Is the strategy unique to the jurisdiction described (in terms of leadership required, populations served, stakeholders included, or availability of resources)?

- highly unique
- somewhat unique
- not unique

24. For strategies tested outside of the U.S., are comparable resources available in the U.S.?

- Yes
- No
- Unclear
- Not relevant

25. How relevant are the outcomes to patients? [check all that apply]

- At least somewhat relevant
- Highly relevant
- Not applicable

26. To what extent is each strategy or outcome ready for use? [indicate for each]

Strategy or Outcome #	Strategy or Outcome	Not ready for use (e.g., needs more detail or testing before possible to use)	Ready for use	Unclear

VI. General

Are there any references that need to be checked? If so, please indicate the reference number(s)

Comments on the study

Appendix C. Evidence Tables

Appendix Table C-1a. Tested strategies to reduce or manage less urgent demand (KQ1)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Ablah, 2010[26]	Biological counter-measures	Nassau Co, NY	Exercise, drill, or training program	Post only with comparison group: Hybrid POD model	Biological, Infectious disease: Anthrax	Use of centralized POD model, as compared with a hybrid POD model.	Centralized POD model had slightly faster processing time than the hybrid model. Centralized and hybrid models had similar quality control outcomes overall. However, hybrid models were more likely to follow the individual steps in the protocol designed to reduce medication error. Centralized PODs were slightly more accurate in dispensing the correct medication. Centralized POD processed 0.75 patients/minute, compared with 0.48 patients per minute.	This only looked at 1st responder/receivers and family, not general population.	6/8

Appendix Table C-1a. Tested Strategies to reduce or manage less urgent demand (KQ1)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Arora, 2010[28]	Biological counter-measures	Not relevant	Computer simulation	N/A	Infectious disease: Influenza	1) Determine what proportion of CDC stockpile to preallocate in response to pandemic flu outbreak. 2) Implement mutual aid agreements that allow transshipment of antivirals between counties. 3) Allocate CDC stockpile according to age group, gross attack rate, or population only. 4) Determine what proportion of CDC stockpile to use for prophylaxis vs. treatment for pandemic flu outbreak.	Postponing allocation is optimal by allowing allocation according to the infected population rather than the susceptible population. Transshipment through mutual aid agreements is an optimal policy when infection rates vary across counties and counties with small populations are affected. Allocate CDC antiviral stockpile according to gross attack rates rather than population is the optimal strategy. Age-based allocation may also be optimal. Limit use of CDC antiviral stockpile for prophylaxis when supplies are limited and focus on treatment instead.	Vaccine effectiveness is lower among the elderly	4/7

Appendix Table C-1a. Tested Strategies to reduce or manage less urgent demand (KQ1)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Zenihana, 2010[32]	Biological counter-measures	Not relevant	Computer simulation	N/A	Biological, Infectious disease: Smallpox	A combination of mass vaccination, contact tracing and vaccination, and school closure as countermeasures to a smallpox bioterrorism attack	A combination of mass vaccination and contact tracing and vaccination can lead to lower mortality, quicker eradication, and less vaccine use than either strategy separately. School closure potentiates the effect of all strategies.	Time required to trace contacts Number of days between index patient and start of countermeasures 1-day vs. 2-day mass vaccination periods	3/7
Medlock, 2009[29]	Biological counter-measures	Not relevant	Computer simulation Analysis of multiple real events	N/A	Infectious disease: Influenza	Model to determine optimal vaccine allocation strategy for mass prophylaxis to a novel virus	Mortality (relative to status quo strategy) and other outcomes were usually most reduced by vaccinating children 5-19 years old (highest transmission group) and child-rearing aged adults (30-39 years), but reduced mortality by 20-40% relative to current CDC recommendations.	Optimal strategy depends on which outcome gets priority (deaths averted, life years saved, etc.) Outcome depends on age-group related transmission rate Outcome depends on age-specific mortality Outcome depends on age-specific vaccine efficacy	5/9

Appendix Table C-1a. Tested Strategies to reduce or manage less urgent demand (KQ1)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Koh, 2008[25]	Biological counter-measures	Boston, MA	Exercise, drill, or training program	Post only with comparison group: Implicit benchmark standard	Biological	1) A streamlined Point of Dispensing (POD) strategy for mass distribution of antibiotics within 48 hours after an Anthrax release. 2) A push method of dispensing (via U.S. Postal Service mail carriers) for mass distribution of antibiotics within 48 hours after an Anthrax attack	Number of people served per hour via POD (relative to benchmark standard)- 1988 person/hour (about 33/hour/staff person) Number of people served per hour via mail carrier - 23,000 persons in 6 hours (120 people/hour/carrier)	Heads of household can pick up meds for all No identification requirement to register Preregistered/trained staff insufficient for probable demand Innovation in training: online and tailored to background (clinical/nonclinical) and commitment (response/leadership Neighborhood-centric strategy for selecting PODs was seen as important	6/8
McCaw, 2008[27]	Biological counter-measures	Not relevant	Computer simulation Analysis of multiple real events	N/A	Infectious disease: Influenza	Optimal strategy for allocation of antivirals from the Strategic National Stockpile (SNS) during an influenza pandemic (if there ARE two effective drugs)	The two drug strategy (give a different drug to Cases versus their Contacts – i.e. use a different drug for treatment versus prophylaxis) is superior to other strategies because it produces greater delays in: a) propagation of the epidemic and b) the emergence of drug resistance (including multi-drug resistance), but when resistance does emerge, it is more likely to be multi-drug resistance.	The implications of multidrug resistance are strongly dependent on the relative fitness of mutant strains, with the potential for either reduced or extended delays to an uncontrolled outbreak. Strategies that allocate different drugs to treated cases and their close contacts are likely to be most effective at constraining the rate of resistance emergence	7/9

Appendix Table C-1a. Tested Strategies to reduce or manage less urgent demand (KQ1)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Zaric, 2008[31]	Biological counter-measures	Not relevant	Computer simulation	N/A	Infectious disease: Anthrax	Develop a model to optimize the logistical response to a bioterrorism event.	The demonstration model provides the following insights: (1) communities should focus on dispensing capacity rather than stockpiling of supplies. (2) improved surveillance can reduce mortality if adequate dispensing capacity exists. (3) the mortality from an attack is significantly affected by the number of unexposed individuals who seek prophylaxis and treatment.	N/A	3/9

Appendix Table C-1a. Tested Strategies to reduce or manage less urgent demand (KQ1)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Lee, 2006[24]	Biological counter-measures	Atlanta, Georgia	Exercise, drill, or training program	Post only with comparison group: 7 counties not using decision support software	Biological, Infectious disease: Anthrax	Use of integrated simulation and decision-support software (RealOpt) to determine appropriate staffing for point of dispensing medical countermeasure following Anthrax release.	DeKalb County, the only county participating in the point of dispensing exercise that used RealOpt, achieved the highest throughput compared to all other participating counties. DeKalb was the only county to exceed 450 targeted households; its throughput was 50% higher than the next highest county (which processed only 71% of target households). External evaluators reported that DeKalb County produced the most efficient floor plan (with no path crossing), the most cost-effective dispensing (lowest labor/throughput value), and the smoothest operations (shortest average wait time, average queue length, and equalized utilization rate). No quantitative measures were reported for these parameters.	Computation time for a simulation required <1 minuted CPU time, compared to 5-10 hours for existing commercial software. Combined computation time (using RealOpt) for total 860,000 households was 30 minutes.	4/8

Appendix Table C-1a. Tested Strategies to reduce or manage less urgent demand (KQ1)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Wein, 2003[30]	Biological counter-measures (POD) *Also in Augment resources	Not relevant	Computer simulation	N/A	Biological, Infectious disease: Anthrax	1) Aggressive and rapid antibiotic distribution post Anthrax mass attack detection 2) Dramatically expanded POD & hospital surge capacity (for example by cross training, and using non-hospital volunteers to extend trained personnel, and mobile servers from other federal agencies to provide hospital surge capacity)	The Number of Deaths (relative to base case strategy of no or very delayed treatment) is a function of the speed of distribution - Mass antibiotic distribution reduces deaths to 123,000 (8.3% of base case) versus 660,000 deaths (44% of base case) if only symptomatic patients are treated Number of Deaths (relative to base case strategy) - function of hospital capacity - dramatically decreased with sufficient personnel - ten-fold or more, and mobile servers (e.g., from other federal agencies)	Antibiotic Efficacy Adherence to prophylactic regimen Adding mobile servers (to provide surge hospital care) is more effective than adding local servers because the former are typically less busy and therefore more available.	5/9

Appendix Table C-1a. Tested Strategies to reduce or manage less urgent demand (KQ1)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Savoia, 2009[173]	Non-biological counter-measures	US	Exercise, drill, or training program	Pre-post	Infectious disease	Tabletop Exercise (and didactic session) to train Public Health officials in what steps they can legally take to limit spread in response to a pandemic	After participating in the course there was a statistically significant increase in most participants' knowledge of and level of confidence in their legal authority to take specific response actions (such as imposing quarantine) to limit pandemic spread.	Legal authority may be present, but procedures to implement that authority may still be lacking... Legal professionals gained somewhat more knowledge	4/7

Appendix Table C-1a. Tested Strategies to reduce or manage less urgent demand (KQ1)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Cahill, 2008[33]	Non-biological counter-measures	Not relevant	Computer simulation Analysis of multiple real events	N/A	Infectious disease: Influenza	Distribute surgical masks or N95 respirators to the public to limit the spread of pandemic influenza (both droplet and airborne transmission).	Use of N95 respirators lowers the probability of infection and the percentage of the population infected compared to surgical masks. Estimated outpatient visits for the N95 mask (100% compliance) were 14,330, as compared to the surgical mask (100% compliance) with 56,200 outpatient visits. However, at 60% compliance, this range narrows to 126,640-128,070. Use of N95 respirators reduces use of hospital beds, ICU beds, and ventilators compared to surgical masks. Estimated hospitalizations for the N95 mask (100% compliance) were 300, as compared to the surgical mask (100% compliance) with 1,190 hospitalizations. However, at 60% compliance, this range narrows to 580-590. N95 respirators and surgical masks had comparable impacts on workdays lost and total economic losses at compliance levels of 60%, but respirators were superior when compliance levels were 100%.	Optimal strategy depends on attack rate and level of compliance wearing masks. Protective efficiency of mask types is based on theoretical calculations involving droplet size, not empiric evidence	2/9

Appendix Table C-1b. Tested Strategies to optimize use of existing resources (KQ1)

Appendix Table C-1b. Tested Strategies to optimize use of existing resources (KQ1)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Simon, 2001[34]	Load sharing	NYC	Analysis of single real event	Post only with comparison group: Qualitatively compared against counterfactual	Explosive, Terrorism	1) Control the distribution of urgent patients through scene or central command to limit overwhelming the nearest hospital. 2) Site emergency management centers in a low vulnerability location. 3) Use robust and interoperable emergency communications systems.	No enforced patient distribution system led to moderate and critical patients swamping the two nearest trauma centers, while a 3rd trauma center 3 miles from scene sat idle Attack damage to Office of Emergency Management (OEM) dramatically exacerbated communication and coordination efforts including patient distribution Cell phone and radio disruptions (from attack damage and post-attack overload) prevented response coordination - most patient distribution was blind to hospital resource availability	N/A	2/8

Appendix Table C-1c. Tested Strategies to augment existing resources (KQ1)

Appendix Table C-1c. Tested Strategies to augment existing resources (KQ1)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Epley, 2006[35]	Load sharing	Southwest Texas	Analysis of multiple real events	Pre-post with comparison group: Routine trauma system (pre-/post-) and disaster trauma system	All-hazards, Natural Disaster: Hurricane	Use of comparable coordinated regional trauma systems for routine (Medcom) and disaster (Regional Medical Operations Center) operations to facilitate the rapid transfer of hospitalized and special needs patients following small-scale trauma events and disasters.	Pre-post- analysis of Medcom: • Pre-Medcom (10 mos.): Transfer decision time 115 +/-3 min; transfer accept time 30.5min; total transfer time 145+/-12min. • Post-Medcom (10 yrs): Transfer decision time 80+/-1min, transfer accept time 10 +/-2 min, total transfer time 91 +/-1 min Regional Medical Operations Center (RMOC) : • Post-Hurricane Katrina- transferred 6 patients/hour & 170 patients/hour from 2 incoming transports • Pre-Hurricane Rita: transferred 20 patients/hour	Medcom (routine) and RMOC (disaster) regional trauma systems are comparable, inter-related and symbiotic. Medcom is practical small-scale rehearsal for major disasters. Authors unaware of comparative data between trauma system; benchmarks would be useful.	4/8
Blackwell, 2007[36]	Temporary facility	US	Analysis of single real event	Post only with comparison group: Qualitatively compared to implied standard of limited or no care available.	Natural Disaster: Hurricane	Deploy a mobile field hospital	7,400 patients were evaluated and treated over a 6-week period.	N/A	3/5

Appendix Table C-1c. Tested Strategies to augment existing resources (KQ1)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Eastman, 2007[37]	Temporary facility	Dallas, TX	Analysis of single real event	Pre-post	Natural Disaster: Hurricane	Implement alternate-site surge capacity facility during a mass casualty event	All other trauma centers/EDs in Dallas had no statistically significant increases in visit rates during the two-week period in which the alternate care site was operational compared to visit rates in the prior year. There were no incidents of safety or contamination breaches during operation of the alternate care site.	Leadership team for the alternate care site also served as medical direction team for the City of Dallas Emergency Medical Services and enhanced effectiveness through greater coordination with other agencies. Availability of space and physical structure (especially climate-controlled) Level I centers were required to provide staff and resources, and took nearly 7 days to obtain necessary equipment. Limited capabilities for surgical intervention.	4/7

Appendix Table C-1c. Tested Strategies to augment existing resources (KQ1)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Wein, 2003[30]	Temporary facility *Also in Reduce demand	Not relevant	Computer simulation	N/A	Biological, Infectious disease: Anthrax	1) Aggressive and rapid antibiotic distribution post Anthrax mass attack detection 2) Dramatically expanded POD & hospital surge capacity (for example by cross training, and using non-hospital volunteers to extend trained personnel, and mobile servers from other federal agencies to provide hospital surge capacity)	The Number of Deaths (relative to base case strategy of no or very delayed treatment) is a function of the speed of distribution - Mass antibiotic distribution reduces deaths to 123,000 (8.3% of base case) versus 660,000 deaths (44% of base case) if only symptomatic patients are treated Number of Deaths (relative to base case strategy) - function of hospital capacity - dramatically decreased with sufficient personnel - ten-fold or more, and mobile servers (e.g., from other federal agencies)	Antibiotic Efficacy Adherence to prophylactic regimen Adding mobile servers (to provide surge hospital care) is more effective than adding local servers because the former are typically less busy and therefore more available.	5/9

Appendix Table C-2. Tested Strategies lacking comparison groups (KQ1)

Appendix Table C-2. Tested Strategies lacking comparison groups (KQ1)

Author, Year	Strategy	Mass Casualty Context	Innovation	Description	Results
Balch, 2004 [174]	Augment resources	All-hazards	Community readiness	Conducted an exercise to demonstrate community readiness and medical response to a MCE	Shadow Bowl earthquake scenario demonstrated significant strain on the healthcare system.
Irvin, 2007 [43]	Augment resources	Hurricane	Surge, alternate care site-real event	Description of a multidisciplinary Hurricane Katrina Evacuation Center	Successful non-ED alternative to address non-emergent medical concerns
van Asten, 2009 [39]	Augment resources	Infectious Disease	Load sharing	Strengthening national lab surge capacity with regard to diagnostic demand	National network of laboratories has capacity to handle diagnostic requests from hospitals, but probably insufficient for a surge generated in the non-hospitalized population (Netherlands)
Weddle, 2000 [175]	Augment resources	Hurricane	Readiness	Improve the efficiency of deployable military hospitals to supplement surviving local health care capabilities after disasters	Improve communications while requesting resources, broaden the range of available health assets, position resources regionally or in the civilian sector, and create clear indications for full-scale deployable hospitals when they are required.
Etienne, 2010 [42]	Crisis standards of care	Earthquake	Ethics committee	Multidisciplinary Healthcare Ethics Committee to determine allocation of resources	Describe guiding ethics principles for allocation of resources
Kellermann, 2010 [41]	Reduce demand	Infectious Disease	Web-based self triage	Deployment of clinical algorithm during 2009 H1N1 enabled adults with influenza-like illness to self assess need for ED versus clinic or self care	Two websites deployed and used during 2009 H1N1 pandemic; one via flu.gov. Approximately 800,000 visits nationwide, no reports of adverse outcomes. Unable to measure impact due to no follow up

Appendix Table C-2. Tested Strategies lacking comparison groups (KQ1)

Zerwekh, 2007 [38]	Reduce demand	All-hazards	Biological countermeasure	Drive-thru clinic model for dispensing SNS medication	Timely dispensing of prophylactic medications with high accuracy and minimal human to human contact

Appendix Table C-3. Proposed strategies to allocation scarce resources during mass casualty events (KQ1)

Appendix Table C-3. Proposed strategies to allocation scarce resources during mass casualty events (KQ1)

Author, Year	Organization, Task Force, or Panel	Title of Report or Article	Proposed Strategy
No Author, [44]	U.S. Department of Health and Human Services; U.S. Department of Homeland Security	Guidance on Allocating and Targeting Pandemic Influenza Vaccine	Guidance on the allocation and targeting of influenza vaccines during influenza pandemics for Federal, State, local and tribal governments, communities, and the private sector. According to the recommendation, pandemic vaccination target groups are prioritized into four categories by order of importance: homeland and national security, health care and community support services, critical infrastructures, and the general population. These target groups are further prioritized into tiers within each category, and prioritization by tier depends on the severity of the pandemic. For example, in the general population, highest risk groups include pregnant women then infant and toddlers whereas the lowest risk groups include healthy adults 19-64 years old. A detailed rationale for prioritization is provided.

Appendix Table C-4a. Tested Strategies to reduce or manage less urgent demand

Appendix Table C-4a. Tested Strategies to reduce or manage less urgent demand (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Erwin, 2009[45]	Biological counter-measures	US	Analysis of single real event	Post only with comparison group: Benchmark	Biological, Infectious disease: Smallpox	Use CDC smallpox post-exposure clinic guidelines to establish an emergency mass clinic. (The guidelines were implemented during a Hepatitis A outbreak.)	Time per patient - mean: 10 minutes for individuals and mean: 3.5 minutes for groups Immunizations (actual demand) per staff-hour - 1.45 immunizations per staff-hour (versus CDC benchmark of 1.58 immunizations per staff-hour)		4/8

Appendix Table C-4a. Tested Strategies to reduce or manage less urgent demand

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Hupert, 2009[46]	Biological counter-measures	Not relevant	Computer simulation	N/A	Infectious disease: Anthrax	Account for temporal variability in patient arrivals by dynamically adjusting staffing to meet demand in point-of-dispensing stations for mass prophylaxis using Dynamic POD Simulator	For a given number of staff hours, dynamic changes in staffing in response to demand can increase the capacity (number of patients treated) of a POD station.	Ability to accurately forecast future arrivals based upon current demand might be limited	2/7
Xiong, 2010[47]	Telemedicine *Also in Optimize resources	Not relevant	Computer simulation	N/A	Natural Disaster: Earthquake	Implement regional telemedicine hub to support delivery of specialty care during MCE	Use of the telemedicine hub reduced the number of deaths by 5.4%, 36.5% and 27.3% for the major, medium and minor scale earthquake scenarios respectively. Use of the telemedicine hub reduced local ED bed usage and local trauma specialist usage for medium and minor earthquakes. Use of the telemedicine hub lowered average wait times for ED beds and specialists.	Rapid availability of specialists external to the event are required Local ED resources may serve as a bottleneck and require higher rates of transfer even when the telemedicine hub is operational	2/7

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Einav, 2009[65]	Case managers	Israel	Analysis of multiple real events	Pre-post	Explosive	Use of case managers in supervising patient care and transfer of care throughout an MCE.	Using case managers improved patient management and flow with similar staff and no additional resources. Reductions were observed in: the number of x-rays/patient/1st 24-hour ($P < 0.001$), time to performance of first chest x-ray ($P = 0.015$), time from first chest x-ray to arrival at the next diagnostic/treatment location ($P = 0.016$), time from ED arrival to surgery ($P = 0.022$) and hospital lengths of stay for critically injured casualties (37.1 +/- 24.7 versus 12 +/- 4.4 days, $P = 0.016$ for ISS > or = 25). Using case managers had no adverse impact on the health outcomes of critically injured patients. Mortality rates were similar for critically injured patients.		3/8

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Amlot, 2010[66]	Decontamination	Western Europe	Exercise, drill, or training program	Randomized controlled trial	Chemical, Biological, Radiological, Nuclear	Use of instructions, washcloth and/or shower duration to increase decontamination effectiveness	Any form of showering is more effective than not showering; however, the use of a washcloth significantly improved results over showering alone, showering with instructions or showering for longer. Washcloth use led to 20% less contamination, compared to other interventions.	Showering instructions were provided before the shower, and were not available during the shower, which may have reduced effectiveness.	3/6

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Gao, 2007[69]	Health info technology	US	Exercise, drill, or training program	Post only with comparison group: Paper triage tags	Unspecified	Use electronic triage tags (Advanced Health and Disaster Aid Network, AID-N) to monitor vital signs and transmit information to first responders.	Time required for triage was similar in both electronic and paper triage groups. Electronic triage tags allowed first responders to re-triage patients three times more often as first responders who used paper triage tags.	Triage status indicator used LEDs that were difficult to see from a distance under bright sunlight and when the triage tag was flipped over on the patient. Patients might wander out of range or vehicles (e.g., fire trucks) might block data transmissions. Pulse oximeter readings have limited accuracy in the presence of methemoglobin, carboxyhemoglobin, nail polish, nail fungus, fluorescent light, and motion. Tags used at least eight times less energy than existing, similar devices	5/8

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Beck-Razi, 2007[67]	Imaging	Israel	Analysis of single real event Validation study	Medical record review	Explosive, Trauma: War	Use of focused assessment of sonography for trauma (FAST) in for MCE triage.	FAST results were generally consistent with the results of CT scans, laparotomy and clinical observation. Overall accuracy of FAST (compared to other methods) was 93.1% (sensitivity: 75.0%, specificity: 97.6%).	Sonography in this study was performed and interpreted by radiologists, not emergency medicine physicians/providers Type of injury varied between soldiers (open wounds and fractures) versus civilians (blast/shrapnel injuries) FAST only can detect fluid/air so can diagnose bleeding, but cannot exclude all clinically important types of abdominal injury	6/8

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Korner, 2006[64]	Imaging *Also in Altered standards	Western Europe	Exercise, drill, or training program	Pre-post with comparison group: Individually admitted patients after multiple trauma (historical)	Unspecified	Implement accelerated whole body multislice computed tomography protocol (Triage MSCT)	Use of the triage MSCT protocol allowed a throughput of 6.7 patients per hour compared to 2.4 patients per hour for the standard protocol. Triage MSCT protocol produced an average of 201 images per patient compared with 1031 images per patient for the standard protocol.	Triage MSCT patients were assumed to undergo preparation at the site of the MCE or during transport, did not undergo focused abdominal ultrasound, and were transferred directly to the CT exam room. This accounted for most of the throughput gain. To decrease image number and image calculation time, no high-resolution reformations and multiplanar reformations were calculated in the Triage MSCT group. Tube cooling problem were encountered when using the Triage MSCT protocol that required a reduction in dose for each scan and consequently the potential for lower image quality. This issue may be avoided by using newer scanners. Staff participating in the study were instructed before the simulation on how to operate the CT console with the new MSCT protocol.	5/7

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Sarkisian, 1991[68]	Imaging	Eastern Europe	Analysis of single real event	Retrospective case review	Natural Disaster: Earthquake	Sonographic screening for abdominal/pelvic injury or bleeding to triage earthquake MCE casualties and screen for occult injuries	False positive rate of 0/345 (0%) among patients without true abdominal trauma. (Reviewers' calculation) False negative rate of 4/55 (7.2%) among patients with true abdominal trauma. (Reviewers' calculation) Mean exam time of 4 minutes (Range: 1-10 minutes)		4/8
Raiter, 2008[70]	Load sharing	Israel	Analysis of single real event	Post only with comparison group: Benchmark (implied)	Explosive	1) Central Incident Command System (ICS) which gathers data and assigns patients to receiving hospitals 2) Robust redundant communications channels between Command Center, Responders, and Receiving Hospitals	Optimal allocation of resources (patients to hospitals) - no overload of capacity - nearest Level I got 5/9 severe patients, Level II got 4/9, 59 mildly injured patients distributed amongst 5 hospitals Effective communication between responding entities - cell phone service overloaded/failed, radio, beeper & internet channels functioned smoothly		3/8

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Kanter, 2007[72]	Load sharing *Also in Altered standards	Not relevant	Computer simulation	N/A	Unspecified	1) Control distribution of pediatric disaster victims to avoid overcrowding near scene 2) Expand hospital capacity by altering standards of care to provide only "essential interventions"	Simulated mortality was reduced both by controlling the distribution of disaster victims and by relaxing standards of care. The greatest reduction was achieved by employing both strategies together.	Findings are based upon a variety of untested and extrapolated assumptions. Thus, "the reported results are not intended to recommend particular response strategies." A large urban center is modeled; the applicability to rural or suburban environments is unclear.	3/9
Leiba, 2006[71]	Load sharing	Israel	Analysis of single real event	Post only with comparison group: Benchmark (implied)	Explosive	1) Central allocation of patients to hospitals based on available resources 2) Central information system and local hospital information offices remote from care areas 3) Simplified field triage system - urgent (P1 & P2), non-urgent (P3), and expectant (P4) to speed scene clearance	Avoidance of individual hospital overload - 5/13, 5/13 and 3/13 urgent patients triaged to three nearest Level I trauma centers Limited diversion of medical care personnel to family/media information needs Speed of scene clearance - all 21 urgent (and 2 DOA) casualties evacuated in 25 minutes. All ambulance patients cleared within 35 minutes		2/8

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Gunal, 2004[74]	Medical care	Asia	Analysis of single real event	Post only with comparison group: Benchmark (historical comparison)	Natural Disaster: Earthquake	An organized, on-site medical intervention for the prevention of acute renal failure in crush victims after a catastrophic earthquake.	Only 4 of 16 patients with rhabdomyolysis required hemodialysis. All 16 survived. This is compared to dialysis rates of 60.8% and 77% for comparable patients in two recent earthquakes, and to other reported mortality rates of 15%-40% for patients who require hemodialysis.		6/8
Vardi, 2004[75]	Medical care	Israel	Exercise, drill, or training program	Randomized controlled trial	Chemical	Spring-driven intraosseous infusion device to replace IV insertion in a chemical MCE where providers are in full protective gear.	Simulated survival with/without IO device use - 73.4% survival versus 3.3% survival (under the simulation rules) Total average casualty treatment time with/without device - 207 seconds versus 590 seconds	Anesthesiologists performed faster in both treatment and control groups	6/8
Adini, 2010[73]	Public information	Israel	Analysis of multiple real events	Pre-post	All-hazards	Use a standardized, automated central information distribution system for hospitals to help family members locate and identify MCE victims	Overload of hospital communication lines occurred frequently during MCEs, prior to deploying the central information system, but has never happened since implementing the system		4/8

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Xiong, 2010[47]	Telemedicine *Also in Reduce demand	Not relevant	Computer simulation	N/A	Natural Disaster: Earthquake	Implement regional telemedicine hub to support delivery of specialty care during MCE	Use of the telemedicine hub reduced the number of deaths by 5.4%, 36.5% and 27.3% for the major, medium and minor scale earthquake scenarios respectively. Use of the telemedicine hub reduced local ED bed usage and local trauma specialist usage for medium and minor earthquakes. Use of the telemedicine hub lowered average wait times for ED beds and specialists.	Rapid availability of specialists external to the event are required Local ED resources may serve as a bottleneck and require higher rates of transfer even when the telemedicine hub is operational	2/7

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Hsu, 2004[76]	Training: exercises	US, Western Europe, Eastern Europe, Asia	Systematic Review/Meta-analysis	N/A	All-hazards, Chemical, Biological, Radiological, Nuclear, Explosive, Transportation accident	1) Conduct hospital disaster drills to train hospital staff to respond to a mass casualty event 2) Use computer simulations to train hospital staff to respond to a mass casualty event 3) Conduct tabletop or other exercises to train hospital staff to respond to a mass casualty event	Disaster drills have the potential to identify problems with incident command, communications, triage, patient flow, materials and resources, security, and decontamination. Disaster drills usually were not designed to evaluate the effectiveness of patient care. Computer simulation was able to identify bottlenecks in patient care, electromechanical failures, crowd control issues and other security problems, and resource deficiencies. Evidence is insufficient to reach definitive conclusions regarding the effectiveness of computer simulations or tabletop exercises.		7/10
Andreatta, 2010[79]	Training: triage	Ann Arbor, MI	Exercise, drill, or training program	Randomized controlled trial	Explosive	Use virtual reality to teach START triage	Virtual reality-based triage performance did not lead to improved performance compared to (traditional) standardized patient triage training.	Higher up-front costs for VR development	6/6

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Jarvis, 2009[77]	Training: triage	Western Europe	Exercise, drill, or training program	Randomized controlled trial	Unspecified	Use computer game method of triage training	Computer game participants achieved higher triage tagging accuracy (compared to participants in a tabletop exercise)	Providing interim feedback improves step accuracy but not accuracy of triage classification.	4/8
Vincent, 2009[80]	Training: triage	US	Exercise, drill, or training program	Pre-post	Explosive	Teach triage skills using podcasts and iterative multi-manikin simulations	Accuracy of triage, choice of intervention, and rapidity of triage all improved with training.	Performance may vary with mechanism of injury Improvement might have resulted from technical familiarity with manikins rather than improvement in triage skills.	3/5
Vincent, 2008[78]	Training: triage	US	Exercise, drill, or training program	Pre-post	Unspecified	Teach mass casualty triage skills using an immersive 3D Virtual Reality environment.	Triage accuracy and intervention scores improved significantly after one iteration of training. Time to complete the scenario improved with each iteration.	There may have been a selection bias, with more technologically savvy learners signing up to participate in this trial Apparent performance gains could reflect familiarity with VR equipment rather than improved triage knowledge	4/7

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Sanddal, 2004[81]	Training: triage	US	Exercise, drill, or training program	Pre-post	Explosive, Transportation accident	A 1 hour training program to improve pediatric triage performance ("JumpSTART")	The training session improved triage performance and that improvement was sustained at 3 months.	Motivation and abilities of trainees The generalizability of performance improvement to other scenarios (or to any non-drill situation) is unknown. The sustainability of performance improvement beyond 3 months is unknown. Using triage tags rather than simulating them was found to be helpful	6/8
Adeniji, 2011[176]	Triage	Western Europe	Validation study	Retrospective case review	Infectious disease: Influenza	STSS (Simple Triage Scoring System) to help triage critical care admissions during influenza pandemic	STSS had superior accuracy in predicting ICU need relative to SOFA score - the Area Under the Curve (AUC) of the Receiver Operator Characteristic (ROC) was 0.88 versus 0.77 STSS had superior accuracy in predicting need for mechanical ventilation relative to SOFA score - the Area Under the Curve (AUC) of the Receiver Operator Characteristic (ROC) was 0.91 versus 0.87	Low mortality of H1N1 patients prevented evaluation of predictive accuracy for mortality	3/6

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Romm, 2011[56]	Triage	US, Canada/ Australia/ New Zealand, Western Europe, Asia	Laboratory test	N/A	Radiological, Nuclear	Use fewer metaphase spreads when using the dicentric chromosome assay method of biodosimetry for mass radiological incidents.	Analyzing 50 metaphases gives reliable and accurate individual dose estimations over the dose range of 0.75 to 4.5 Gy. Most of these dose estimations are within 20% of the actual doses. Dose estimations based on analysis of only 20–30 metaphases allowed an accurate evaluation in the higher dose ranges. (Routine standard is 500-1000 metaphases)	Range of exposure doses and uniformity of exposure will impact effectiveness of strategy.	5/5
Cryer, 2010[57]	Triage	Los Angeles County, CA	Analysis of multiple real events	Pre-post	Transportation accident	1) Use a trauma system performance improvement program to evaluate MCE response, identify shortcomings, and change policy based upon the findings. 2) Use air transport to facilitate distribution of "immediate" patients evenly to area trauma centers. 3) Encourage EMS to distribute all victims meeting "trauma center criteria" to trauma centers rather than to non-trauma community hospitals.	Regional EMS quality improvement plan can improve the distribution of patients to appropriately resourced hospitals in mass casualty events. In the 2005 train crash only 44% (11/25) of "immediate" patients were taken to trauma centers, as compared to 89% (55/62) in 2008. In the 2005 crash, only 2 patients were transported by air; in 2008, 34 were transported by air.		5/8

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Hirshberg, 2010[54]	Triage	Not relevant	Computer simulation	N/A	Explosive	1) Use a 2-stage triage system for large-scale MCEs 2) Use most experienced physician for the first step of triage	Single-step triage works well for small-scale incidents. When resources are overwhelmed, 2-stage triage substantially increases the "time to saturation" (point at which ED is at full capacity). If two triage providers have 70% and 90% accuracy, assigning the better provider to the first step of a sequential triage increases time to saturation by approximately 50%.	Value of 2-step procedure varies with the ratio of casualties to provider teams Model does not deal well with the possibility of under-triage in two-step process	6/9
Kilner, 2010[48]	Triage	Not relevant	Systematic Review/Meta-analysis	N/A	Explosive, Natural Disaster	Field triage tools for victims of "big bang" incidents (sudden onset MCEs rather than slowly emerging MCEs).	There is limited evidence for the validity of existing triage tools. The authors identify the Sacco triage system as "the most promising" but state that further evaluation of this tool is required.		8/8

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Lerner, 2010[63]	Triage	Augusta, GA & Milwaukee, WI	Exercise, drill, or training program	Post only with comparison group: Benchmark (START protocol)	Explosive	Use of the Sort- Assess- Lifesaving Interventions- Treatment/transport (SALT) triage protocol	Performance using the SALT protocol was comparable to other studies using the START triage protocol. Final triage was correct 83% of the time (CI: 78-88%), compared to START studies (48-75%). 6% were overtriaged and 10% were undertriaged. Timing using the SALT protocol was comparable to other studies using the START triage protocol. Mean triage time was 28 seconds (Std dev: 22 sec), compared to 30 seconds for START. Further, this study used simulated 'patient' interference, which may have increased triage times.		5/8
Nie, 2010[55]	Triage	Asia	Analysis of single real event	Post only with comparison group: Benchmark (START protocol)	Natural Disaster: Earthquake	Use field triage method that accounts for resources at the accepting institution. In this instance, a 'resuscitation' category was added.	The addition of a resuscitation group to standard (START) protocols led to lives saved within that group. 4 of 6 patients in the resuscitation group survived to discharge. These patients would have been classified as 'expectant' under START.	Strategy depends heavily on local decisions. Accuracy of triage may depend on specialty of physician who conducts initial triage.	2/8

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Rehn, 2010[52]	Triage	Western Europe	Exercise, drill, or training program	Pre-post	Transportation accident	TAS Triage Method for bus crash type MCE (combines triage Sieve for adults and trauma tape for pediatric patients)	Overtriage rate before implementation of TAS: 9/74 (12.2%), versus 0/74 (0%) after implementation of TAS Undertriage rate before implementation of TAS: 9/24 (12.2%) , versus 0/24 (0%0 after implementation of TAS Scene clearance rate - mean: 22 minutes (range 15-32) before implementation of TAS, versus mean: 10 minutes (range 5-21) after implementation of TAS	Need TAS Training Need TAS Equipment Probably easier to collect accurate input data under simulation conditions than in real MCE	6/8
Rodriguez-Noriega, 2010[60]	Triage	Mexico	Analysis of single real event	Prospective case series	Infectious disease: Influenza	Use Influenza-Like Illness Scoring System to triage adults seeking care at an ED during an influenza pandemic. Patients with high scores are admitted and treated with oseltamivir. Those with intermediate scores are sent home with oseltamivir and followed up by phone daily for 10 days. Those with low scores are discharged home without treatment.	Of 1324 ambulatory patients who were discharged without receiving oseltamivir, 14 (0.8%) returned after their initial visit. Three of these patients were hospitalized and treated with oseltamivir (two of them tested positive for H1N1).		5/8

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Cone, 2009[53]	Triage	US	Exercise, drill, or training program	Post only with comparison group: Benchmark	All-hazards	Use of the Sort- Assess-Lifesaving Interventions-Treatment/transport (SALT) triage protocol.	Study participants (paramedics) using SALT had a 78.8% accuracy rate. The overtriage rate was 13.5% and the undertriage rate was 3.8%. The undertriage rate is lower than the 5% the authors assert is standard in the literature. Average triage time was 15 seconds (median: 11.5 seconds; range 5-57 seconds).	Time elapsed between training on triage method and application of methodology. Training level and experience of triage provider (EMT, Paramedic, MD, etc.) may also influence accuracy	5/8
Navin, 2009[177]	Triage	Not relevant	Computer simulation	N/A	Unspecified	Use Sacco triage method (vs. START triage) for patients of military age with blunt, penetrating, and blast injuries.	Simulated survivorship improves by 20-300% depending upon the distribution of injuries and resource constraints.		3/7
Cancio, 2008[49]	Triage	Iraq	Validation study	Medical record review	Military/Combat	The use of the Field Triage Score (FTS07) compared to the Revised Trauma Score (RTS) in predicting mortality and massive transfusion.	FTS predicted mortality and massive transfusion nearly as well as the Revised Trauma Score (RTS), but can be calculated without computing assistance in the field.	Often, study patients already had field interventions (such as intubation) performed prior to RTS/FTS assessment	4/6

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Cone, 2008[59]	Triage	New Haven, CT	Exercise, drill, or training program	Post only with comparison group: Gold standard triage category	Chemical	Use combined trauma/CBRN-specific triage method during an MCE.	Overtriage rate (1.8%, 1/56 patients) Undertriage rate (10.8%, 6/56 patients) Triage speed - 19 seconds per patient	Inaccuracy in triage mostly due to missing signs of chemical toxidrome	6/8
Kuniak, 2008[62]	Triage	US	Exercise, drill, or training program	Post only with comparison group: Gold standard disposition categories	Radiological	Use Radiation Injury Severity Classification (RISC) for early triage of radiation MCE casualties when dosimetry data are unavailable	Accuracy of raters' classification was approximately 95%.	Trend towards training level affecting triage accuracy (MD>RN>EMT) Hematologic component proved most difficult to score System allows for the rapid assessment of ARS severity without the availability of dose information Less complex than other systems (e.g., METROPOL) and is amenable to self-education.	6/8
Zoraster, 2007[50]	Triage	Los Angeles, CA	Analysis of single real event	Retrospective case review	Transportation accident	Use of START triage by a regional trauma network to prioritize transport of MCE patients and to distribute them among area hospitals.	Trauma centers were underutilized and community hospitals received critical patients that they were poorly equipped to handle.	Hospital capacity self-report was inaccurate START categorization scheme was imperfectly understood START triage categories differ from trauma center criteria, causing confusion	4/6

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Aylwin, 2006[61]	Triage *Also in Altered standards	Western Europe	Analysis of single real event	Retrospective case review	Explosive	1) Trained/experienced triage at scene 2) Simplified on-scene triage (urgent (P1 & P2), not urgent (P3), expectant 3) Re-triage at every stage, directed by trained/experienced providers with explicitly designated authority 4) Damage Control approach (minimize use of all critical hospital resources)	Accuracy of on-scene triage was much higher for locations where fully trained responders (versus by medically trained bystanders) performed triage (33% overtriage versus 82% overtriage of critical patients) Speed of scene clearance - Average of 27 P1 & P2 (most seriously wounded) patients per hour (= 2.2 minutes per patient) Second stage screening (at the ED Door) reduced the surge demand (by screening out over-triage and identifying under-triaged/deteriorating patients) reducing initial overtriage to 0% and undertriage to 20% of critical patients. Increase available surge capacity - created 10 ICU bed spaces and made all ORs available within 2 hours		5/8

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Schenker, 2006[51]	Triage	New York, NY	Exercise, drill, or training program	Post only with comparison group: Benchmark	Chemical, Explosive, Transportation accident	Implement START triage algorithm during mass casualty event	A total of 88/121 patients (70%) were triaged accurately. A total of 29 of 47 patients (62%) were managed appropriately when their clinical status was altered as part of the exercise. Six patients who underwent status changes indicating a possible myocardial infarction or asthma attack were classified as over-triaged according to START but were judged to be managed appropriately by exercise staff.		6/8

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Janousek, 1999[178]	Triage	US	Performance evaluation (direct assessment)	Post only with comparison group: Provider groups compared against each other.	Chemical, Biological, Nuclear, Trauma: War	The use of various providers types in doing MCE triage.	Physicians had higher triage accuracy scores than other military healthcare providers (nurses, dentists and medics, using the NATO triage classification system (mean score of 54, compared to 50--denominator could not be determined). There were no statistically significant differences between emergency physicians, surgeons and general medical officers. Likewise, there were no differences between medics, nurses and dentists.		3/7

Appendix Table C-4b. Tested Strategies to optimize use of existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Cohen, 1998[58]	Triage	Israel	Analysis of multiple real events Validation study	Retrospective case review	Explosive	Use American College of Surgeons Committee on Trauma criteria during field triage for blast MCE injuries.	Field undertriage rate - 0/26 (0%) critical patients, 4/28 (14%) severely injured, and 19/143 (13%) moderately injured patients initially classified as less severe Field overtriage rate - 12/36 (33%) minor injury patients initially classified as more severe	Experience of field triage providers	4/8
Beyersdorf, 1996[179]	Triage	Spokane, WA	Analysis of single real event	Post only with comparison group: Benchmark (implied)	Mass shooting	Preexisting/pre-tested MCE response plan incorporating interagency cooperation, unified communications and incident command, on-scene provider triage, and allocation of casualties based on hospital resources.	A total of 2/19 patients (11%) were over-triaged and 2/19 (11%) were under-triaged. 100% survival.	Pre-hospital vehicles contained job descriptions and duties printed on small cards, and were utilized to establish a command center and chain of command at the scene Designation of a regional disaster control hospital allowed for minute-by-minute knowledge of the capabilities of area hospitals and efficient dispersion of the victims to appropriate facilities. Surgical specialists were preassigned to specific facilities thereby avoiding confusion.	2/6

Appendix Table C-4c. Tested Strategies to augment existing resources (KQ1)

Appendix Table C-4c. Tested Strategies to augment existing resources (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Loeb, 2009[83]	Reduce HCW attrition	Canada/ Australia/ New Zealand	Analysis of single real event	Randomized controlled trial	Infectious disease: Influenza	The use of surgical masks in place of N95 respirators to protect healthcare workers against influenza.	Surgical masks were deemed noninferior to N95 respirators. The lower end of the 95% confidence interval for the reduction in incidence of influenza (N95-surgical) was greater than the established noninferiority limit of -9%.	N/A	5/6
Corvino, 2006[84]	Resource conversion	US	Laboratory experiment	N/A	Chemical	Convert Pralidoxime (2-PAM) in autoinjectors into IV form if needed to respond to nerve agent MCE	Resulting formulation is potent and stable - Greater than 90% potency at 28 day post-preparation, with no bacterial contamination or detected physical changes	N/A	6/7
Satterthwaite, 2010[82]	Reverse triage	Canada/ Australia/ New Zealand	Analysis of single real event	Retrospective case review	Explosive, Transportation accident	Use reverse triage to create surge capacity, including: suspension of normal elective activity, discharging patients earlier in the day, and increasing use of community care options such as respite nursing home beds and community nursing services)	Nineteen patients were discharged early (and would not have been discharged early under normal conditions). Seven patients were ultimately readmitted, however, early discharge did not increase clinical risk.	N/A	2/7

Appendix Table C-4d. Tested Strategies for altered standards (KQ2)

Appendix Table C-4d. Tested Strategies for altered standards (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Merin, 2010[85]	General	Haiti	Analysis of single real event	Post only with comparison group: Standard care (implied)	Natural Disaster: Earthquake	Altered standards of care, and allocation of resources towards patients most likely to benefit.	Authors assert that they treated more patients than they would have if they had not relaxed standards of care or had they not allocated resources with the goal of maximizing the number of lives saved.		1/6

Appendix Table C-4d. Tested Strategies for altered standards (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Korner, 2006[64]	Imaging *Also in Optimize resources	Western Europe	Exercise, drill, or training program	Pre-post with comparison group: Individually admitted patients after multiple trauma (historical)	Unspecified	Implement accelerated whole body multislice computed tomography protocol (Triage MSCT)	Use of the triage MSCT protocol allowed a throughput of 6.7 patients per hour compared to 2.4 patients per hour for the standard protocol. Triage MSCT protocol produced an average of 201 images per patient compared with 1031 images per patient for the standard protocol.	Triage MSCT patients were assumed to undergo preparation at the site of the MCE or during transport, did not undergo focused abdominal ultrasound, and were transferred directly to the CT exam room. This accounted for most of the throughput gain. To decrease image number and image calculation time, no high-resolution reformations and multiplanar reformations were calculated in the Triage MSCT group. Tube cooling problem were encountered when using the Triage MSCT protocol that required a reduction in dose for each scan and consequently the potential for lower image quality. This issue may be avoided by using newer scanners. Staff participating in the study were instructed before the simulation on how to operate the CT console with the new MSCT protocol.	5/7

Appendix Table C-4d. Tested Strategies for altered standards (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Labeeu, 1996[87]	Orthopedics	Rwanda	Analysis of single real event	Post only with comparison group: Standard care (implied)	Trauma: War	External fixation of fractures rather than definitive orthopedic care	External fixation used for 1,129 fractures. Average time of placement was 30 minutes. Numerous complications, not quantified. Authors consider this to be the best compromise between nonoperative methods and definitive care.		1/6
Kanter, 2007[72]	Pediatrics *Also in Optimize resources	Not relevant	Computer simulation	N/A	Unspecified	1) Control distribution of pediatric disaster victims to avoid overcrowding near scene 2) Expand hospital capacity by altering standards of care to provide only "essential interventions"	Simulated mortality was reduced both by controlling the distribution of disaster victims and by relaxing standards of care. The greatest reduction was achieved by employing both strategies together.	Findings are based upon a variety of untested and extrapolated assumptions. Thus, "the reported results are not intended to recommend particular response strategies." A large urban center is modeled; the applicability to rural or suburban environments is unclear.	3/9

Appendix Table C-4d. Tested Strategies for altered standards (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Dhar, 2008[86]	Trauma surgery	Asia	Analysis of single real event	Post only with comparison group: Comprehensive care (implied)	Natural Disaster: Earthquake	"Damage control" surgery for the orthopedic injuries of MCE polytrauma patients if referral to hospital is delayed or comprehensive care resources unavailable	Acceptable outcome at 1 year compared with comprehensive care = 49/62 (79%) "excellent" or "good" outcomes; only 3 non-unions (unhealed fractures) Mortality - 0% Operating Room Time (relative to definitive repair) - mean: 38.5 minutes for external fixation (37% of internal fixation time)	Results inferior for intra-articular (joint involved) fractures	5/8

Appendix Table C-4d. Tested Strategies for altered standards (KQ2)

Author, Year	Sub-category	Study Location	Study Type	Study Design	Relevant type of mass casualty event	Strategy	Findings	Outcome Modulators	Quality score
Aylwin, 2006[61]	Trauma surgery *Also in Optimize resources	Western Europe	Analysis of single real event	Retrospective case review	Explosive	1) Trained/experienced triage at scene 2) Simplified on-scene triage (urgent (P1 & P2), not urgent (P3), expectant 3) Re-triage at every stage, directed by trained/experienced providers with explicitly designated authority 4) Damage Control approach (minimize use of all critical hospital resources)	Accuracy of on-scene triage was much higher for locations where fully trained responders (versus by medically trained bystanders) performed triage (33% overtriage versus 82% overtriage of critical patients) Speed of scene clearance - Average of 27 P1 & P2 (most seriously wounded) patients per hour (= 2.2 minutes per patient) Second stage screening (at the ED Door) reduced the surge demand (by screening out over-triage and identifying under-triaged/deteriorating patients) reducing initial overtriage to 0% and undertriage to 20% of critical patients. Increase available surge capacity - created 10 ICU bed spaces and made all ORs available within 2 hours		5/8

Appendix Table C-5. Tested Strategies Lacking Comparisons Groups (KQ2)

Author, Year	Strategy	Mass Casualty Context	Innovation	Description	Results
Albanese, 2007[126]	Augment resources	Radiological	Load sharing	Establisment of a Biodosimetry Laboratory in Connecticut for surge capacity	Identified 30 of 32 labs qualified and willing to perform initial biodosimetry processing. Additionally a functional exercise involving a subset of these labs and their technicians was conducted with promising feedback.
Baldwin, 2006[116]	Augment resources	Hurricane	Mass transfer	Can the mass interstate transfer of pediatric patients be accomplished during a hurricane? (acutal event)	Despite successful interstate transfer of pediatric patients, there remains a need for planned regionalization of children's services.
Barillo, 2010[111]	Augment resources	Burns	Response teams	Use of Special Medical Augmentation Response Teams-Burn for rapid ICU expansion (actual event)	Description of a method for and lessons learned from creating a temporary burn center
Björnsson, 2008[113]	Augment resources	Tsunami	Mass transfer	Conversion of a charter plane to mass transport patients (actual event)	Alterations of a Boeing 757-300 in 2 days to accommodate 18 patients on stretchers and 78 seated passengers was deemed a success with regard to safe transport from Thailand to Sweden.
Chen, 2009[114]	Augment resources	Earthquake	Mass transfer	Trans-province transfer of patients (China - actual event)	Successful trans-province transfer of 10,373 patients (no casualties)
Cryer, 2009[117]	Augment resources	All-hazards	Load sharing	Use of a trauma system structure during multicasualty events (actual events)	The Medical Alert Center for Los Angeles County can coordinate the distribution of casualties among the hospitals serving the region (e.g. most critical patients triaged to level 1 centers)
ECRI Institute, 2009[106]	Augment resources	All-hazards	Mechanical ventilation	Use of automatic gas-powered resuscitators (AGPRs) for respiratory support in MCI as an alternative to ventilators	AGPRs do not have all features needed for full respiratory support. Usefulness and limitations of APGRS discussed
ECRI	Augment resources	All-hazards	Mechanical	Use of automatic gas-powered resuscitators (AGPRs)for	Conclude that the respiratory needs of most pt in a MCI will exceed what

Appendix Table C-5. Tested Strategies Lacking Comparisons Groups (KQ2)

Author, Year	Strategy	Mass Casualty Context	Innovation	Description	Results
Institute,2008[107]			ventilation	respiratory support in MCI as an alternative to ventilators (simulation)	AGPRs can provide.
Epstein, 2010[124]	Augment resources	All-hazards	Communications	Text messages for staff recall (simulation)	Successful test of system to rapidly mobilize staff. Text messaging is simple, inexpensive, and easy to implement
Fuzak, 2010[115]	Augment resources	All-hazards	Mass transfer	Mass inpatient pediatric transfer using parallel circuits - actual event (nondisaster)	Successful transfer of 111 pediatric pts (64 critical) with no adverse outcomes. Describe pediatric considerations and equipment, lessons learned
Gao, 2008[122]	Augment resources	All-hazards	Information technology	Use of miTag (medical information tag) to track patients throughout the disaster response process (simulation)	Two separate pilots demonstrated feasibility of the miTag in terms of increasing patient care capacity in the field as well as successful transfer of information within radio-interference-rich settings.
Hamilton, 2003[119]	Augment resources	All-hazards	Information technology	Institute a Web based tool - a mass casualty tracking system- to help reduce the amount of confusion at a MCI (simulation)	The alpha test of the Emergency Patient Tracking System (EPTS) demonstrated that it is possible to coordinate efforts and reduce confusion during MCIs.
Hammer, 1996[127]	Augment resources	All-hazards	Devices	Use of unilateral external fixation device for stabilization prior to major surgery	The device allowed soft tissue recovery in nearly all cases.
Hanley, 2008[110]	Augment resources	All-hazards	Mechanical ventilation and cross-training	Implementing a program that trains non-respiratory therapists to assist in providing mechanical ventilation (Project XTREME (Cross-training Respiratory Extenders for Medical Emergencies))	Pilot testing of Project XTREME demonstrated that evaluated individuals could successfully complete training based on cognitive and performance scores.
Jacobs, 2006[118]	Augment resources	Explosive	Information	Web application designed to be the primary communication and	State of CT participated in a DHS exercise. The web application was

Appendix Table C-5. Tested Strategies Lacking Comparisons Groups (KQ2)

Author, Year	Strategy	Mass Casualty Context	Innovation	Description	Results
			technology	resource management tool during a terrorist event or public health emergency (simulation)	successfully implemented to assess surge capacity and other resources.
Killeen, 2006[120]	Augment resources	All-hazards	Information technology	Wireless handheld device with an electronic medical record (EMR) for use by rescuers responding to MCEs (simulation)	Records real-time data electronically for simultaneous access by providers and incident command.
Körner, 2010[125]	Augment resources	All-hazards	Communications	Use of electronic call down system for radiology staff during an MCE	Successul test of system. Automated alarm procedure might be helpful and testing allows for estimation of the manpower reserve and calculation of maximum service capacities.
Lin, 2009[109]	Augment resources	All-hazards	Mechanical ventilation and cross-training	Bag-valve-mask technique training for medical students ias an alternative to mechanical ventilation	The majority of students (93%) knew proper head positioning technique in non-trauma cases after a 30 minute didactic session. All 31 students completed and passed the competency checklist.
Little, 2009[108]	Augment resources	Infectious Disease	Oxygen delivery	Method of providing an improvised oxygen delivery system (simulation)	An improvised system to deliver oxygen in the event of a disaster can be easily assembled and is both feasible and functional.
Lucas da Silva, 2008[123]	Augment resources	All-hazards	Information technology	Use of pervasive computing technology to non-obtrusively capture contextual information	Describes the concept of the technology, but prototype has not been built or tested.
Neyman, 2006[103]	Augment resources	All-hazards	Mechanical ventilation	Simulation study to determine if one ventilator could be modified to provide mechanical ventialtion for four adults simultaneously (simulation)	Single ventilator could sustain four 70-kg individuals for a limited duration.
Noordergraaf, 1996[121]	Augment resources	All-hazards	Information technology	Use barcoded identifiers to represent patients, injuries, facilities, and locations	Minimized errors and made exchange of data possible. The system communicates with the permanent hospital information system.

Appendix Table C-5. Tested Strategies Lacking Comparisons Groups (KQ2)

Author, Year	Strategy	Mass Casualty Context	Innovation	Description	Results
				(simulation)	Extensive training to use the tool was shown to be unnecessary.
Paladino, 2008[104]	Augment resources	All-hazards	Mechanical ventilation	4-limbed ventilator circuit connected in parallel (simulation)	Successful oxygenation and ventilation of 4 sheep with a single vent.
Rosenbaum, 2004[128]	Augment resources	Infectious disease	Re-purpose space	Conversion of existing space to create a negative-pressure room for respiratory isolation (simulation)	Use of portable HEPA filtered forced air was successful in establishing an operational negative-pressure room.
Sandlin, 2009[40]	Augment resources	Chemical	Information technology	Use of a customized laboratory information system (LIMS), the Emergency Response Management System (ERMS), at the Centers for Disease Control and Prevention (CDC) for rapid analysis of clinical samples (e.g. chemical warfare agents) and reporting of this data	A customized LIMS was developed to support emergency response laboratory activities at the CDC among all users.
Voelker, 2006[112]	Augment resources	All-hazards	Capacity augmentation	Fully equipped mobile surgical hospital (MED-1)	The hospital treated 350 patients per day during Hurricane Katrina.
Williams, 2010[105]	Augment resources	Infectious Disease	Mechanical ventilation	Use of a low oxygen consumption pneumatic ventilator for emergency construction (simulation)	Three prototypes demonstrated acceptable performance in a test lung model with regard to compliance and rate settings.
Bouman, 2000[98]	Optimize resource use	All-hazards	Information technology	Register patients using a bar code to facilitate patient flow	The patient bar system has been in effect in the Netherlands since the late 90s. It has had positive effects on the Major Incident Management Plan and has reduced registration errors.
Dan, 2009[88]	Optimize resource	Earthquake	Imaging	Use ultrasonography as a key	Ultrasonography was used during the Wenchuan Earthquake. It played an important role in the triage of earthquake victims, provided accurate and

Appendix Table C-5. Tested Strategies Lacking Comparisons Groups (KQ2)

Author, Year	Strategy	Mass Casualty Context	Innovation	Description	Results
	use			triage tool (actual event)	timely diagnosis of closed injury, bedside examination of severe cases, and interventional treatments.
Curtis, 2008[97]	Optimize resource use	All hazards	Information technology	Use of the SMART (Scalable Medical Alert Response Technology) to monitor unattended patients (exercise)	An initial evaluation in the ED via a pilot and a city-wide disaster drill showed promise. Future plans include modification of algorithms to reduce number of false positives and increasing integration of the system within the ED.
Gunawan, 2009[96]	Optimize resource use	All-hazards	Information technology	Use of a simple navigation aid for the walking wounded (simulation)	Use of an arrow-pointing prototype device provides sufficient guidance for the walking wounded to reach the targeted destination, sparing first responders as escorts.
Jokela, 2008[95]	Optimize resource use	All-hazards	Information technology	Use of Radio Frequency Identification (RFID) technology to provide online triage system for mass casualty	A simulation exercise demonstrated that use of RFID is feasible for use in the field.
Körner, 2009[91]	Optimize resource use	All-hazards	Imaging	Use of a CT triage protocol for MCIs (simulation)	Results from 2 large scale exercises demonstrated that a CT triage protocol was feasible and produced similar findings among the exercises conducted.
Levy, 2010[100]	Optimize resource use	All-hazards	Information technology	IT- hospital administration system, EMR, picture archiving and communication system	IT, including EMR, is feasible in a field hospital operation.
Ma, 2007[90]	Optimize resource use	All-hazards	Imaging	Utilization of ultrasound as a triage tool to aid clinicians in rapid screening (simulation)	Ultrasound imaging is feasible and may be applied to MCIs.
Malik, 2004[92]	Optimize resource use	Trauma	Triage tool	Use of multiple scoring systems in the triage process	Triage effectively accomplished at 3 levels using 3 different scoring systems (e.g. on site "Triage sieve", at the primary health care center "field categories of trauma patients", tertiary referral center "Advanced Trauma Life Support" (ATLS) secondary survey").

Appendix Table C-5. Tested Strategies Lacking Comparisons Groups (KQ2)

Author, Year	Strategy	Mass Casualty Context	Innovation	Description	Results
Mazur, 2009[89]	Optimize resource use	Hurricane	Imaging	Use of ultrasound by DMATs as a MCI triage adjunct (Actual event)	US is feasible to use in MCI and can assist in triage decisions.
Nilsson, 2008[102]	Optimize resource use	All-hazards	Training	Educational tool that links resource allocation decisions to patient outcomes	Pilot study conducted as part of a national training program.
Okumura, 2007[93]	Optimize resource use	Chemical	Triage tool	Triage and decontamination with colored clothes pegs (CCP) (simulation)	Effective use of CCP for triage and decontamination in a drill.
Roth, 2009[101]	Optimize resource use	All-hazards	Information technology	web based healthcare related all hazards electronic disaster manangement system (simulation)	Describes the tool and its potential uses.
Young, 2006[99]	Optimize resource use	Infectious disease	Information technology	Web-based triage tool for bioterror or ID outbreak (simulation)	Safely reduces the number of clinical positions in managing the Point-of-Dispensing (POD).
Zhao, 2006[94]	Optimize resource use	All-hazards	Information technology	Use of a portable tool by first responders in documenting and communicating triage of victims (e.g. TACIT software) (simulation)	Two field trials verified that a portable tool could efficiently work in prehospital response e.g. reduced triage collection time, improved collection accuracy.

Appendix Table C-6. Proposed strategies to allocate scarce resources during mass casualty events (KQ2)

Appendix Table C-6. Proposed strategies to allocate scarce resources during mass casualty events (KQ2)

Article No.	Organization, Task Force, or Panel	Title of Report or Article	Proposed Strategy
Altevogt, 2009[11]	Institute of Medicine	Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report	The IOM committee was convened to develop guidance that state and local public health officials and health-sector agencies and institutions can use to establish and implement standards of care to be applied in disaster situations. The committee recommended the development of consistent state crisis standards of care protocols with five key elements: 1) A strong ethical grounding; 2) Integrated and ongoing community and provider engagement, education, and communication; 3) Assurances regarding legal authority and environment; 4) Clear indicators, triggers, and lines of responsibility; and 5) Evidence-based clinical processes and operations. Recommendations on specific implementation strategies included: 1) Using "clinical care committees," "triage teams," and a state-level "disaster medical advisory committee" that will evaluate evidence-based, peer-reviewed critical care and other decision tools and recommend and implement decision-making algorithms to be used when specific life-sustaining resources become scarce; 2) Providing palliative care services for all patients; 3) Mobilizing mental health resources to help communities and providers; 4) Developing specific response measures for vulnerable populations and those with medical special needs; and 5) Implementing robust situational awareness capabilities to allow for real-time information sharing.
Lyznicki, 2007[180]	American Medical Association and American Public Health Association	Improving health system preparedness for terrorism and mass casualty events. Recommendations for action	One of eight priority areas dealt with expanding health system surge capacity. Specific recommendations included: funding IOM to conduct additional studies and to make recommendations; development and dissemination of model plans and strategies; development of inventories of community surge capacity assets; stimulate growth of volunteer emergency response teams; and ensuring that local emergency response plans provide appropriate distribution of patients across facilities.
Chapman, 2008[181]	Center for Disease Control and Prevention	Post-exposure interventions to prevent infection with HBV, HCV, or	Recommendations on the use of immunization and post-exposure prophylaxis for tetanus and occupational and nonoccupational exposures to bloodborne pathogens in mass casualty events. Pathogens considered include Hepatitis B virus, Hepatitis C virus, and HIV. Recommended interventions are tailored to risk category (penetrating injuries vs. mucous membrane exposure vs. superficial exposure). Recommendations do not directly address altered standards of care when

Appendix Table C-6. Proposed strategies to allocate scarce resources during mass casualty events (KQ2)

Article No.	Organization, Task Force, or Panel	Title of Report or Article	Proposed Strategy
		HIV, and tetanus in people wounded during bombings and other mass casualty events	vaccines are in short supply. Local authorities are directed to rely on local and state health departments, mutual aid agreements, and commercial vendors, and if necessary work with CDC to make up for shortfalls
Taylor, 2010[182]	European Society of Intensive Care Medicine's Task Force for Intensive Care Unit Triage	Chapter 6. Protection of patients and staff during a pandemic	Recommendations and standard operating procedures to protect patients and staff during a pandemic or mass casualty event. Key recommendations include (1) preparing infection control and occupational health policies for clinical risks relating to potential disease transmission; (2) decreasing clinical risks and provide adequate facilities through advanced planning to maximize capacity by increasing essential equipment, drugs, supplies and encouraging staff availability; (3) creating robust systems to maintain staff confidence and safety by minimizing non-clinical risks and maintaining or escalating essential services; (4) preparing formal reassurance plans for legal protection; (5) providing assistance to staff working outside their normal domains.
No Author, 2008[183] Lerner, 2008[184]	American College of Emergency Physicians, American Trauma Society, State and Territorial Injury Prevention Directors Association	Mass Casualty Triage: An evaluation of the Data and Development of a Proposed National Guideline	Proposed triage strategy known as SALT (Sort-Assess-Lifesaving Interventions-Treatment and/or transport), to serve as national all-hazards mass casualty initial triage standard for all patients. SALT begins with a global sorting of patients for prioritization of treatment based on ability to walk, follow commands or move. The next stage, assess, involves limited life-saving interventions such as controlling hemorrhages or opening airways. Patients are then prioritized for treatment and/or transport based on an assignment to one of 5 categories: immediate, expectant, delayed, minimal and dead. The prioritization process is dynamic and condition-specific.
Bradt, 2009[129]	Australasian College for Emergency Medicine Disaster Medicine Subcommittee	Emergency Department Surge Capacity: Recommendations of the Australasian	Proposed strategies to guide surge management in the Emergency Department (ED). Proposed strategies include dealing with space, staffing, supplies and equipment, and flow both preceding and during surge conditions. For example, recommendations relating to actual surge conditions in each category include: maximizing cohort care and minimizing one-on-one care (space), requesting surgical and critical care liaison points in ED (staffing); having a team member dedicated to restocking supplies in main cohort areas, allowing staff in these areas to maintain clinical roles (supplies and equipment), and considering the use of Focused Assessment with Sonogram in Trauma (FAST) to assist early disposition. A total of 22 specific strategies are proposed to optimize the use of resources prior to a mass casualty event, and 10 specific strategies

Appendix Table C-6. Proposed strategies to allocate scarce resources during mass casualty events (KQ2)

Article No.	Organization, Task Force, or Panel	Title of Report or Article	Proposed Strategy
		Surge Strategy Working Group	are proposed for implementation during a mass casualty event.
Christian, 2010[132]	European Society of Intensive Care Medicine's Task Force for Intensive Care Unit Triage during an Influenza Epidemic or Mass Disaster	Chapter 7. Critical care triage	Proposed elements of a standard operating procedure for providing critical care services during a mass casualty events, including: implementation of central triage committee integrated within incident management structure, clear lines of authority for all relevant actors, allocation of ICU care by triage officers according to inclusion/exclusion criteria, basis on which to reassess triage categories, medical record documentation criteria, and recommended components of triage officer training.
No Author, 2010[133]	Centers for Disease Control and Prevention	In A Moment's Notice: Surge Capacity for Terrorist Bombings	Proposed strategies to accommodate surge following terrorist activities using templates tailored to disciplines to address known challenges associated with surge capacity. Templates were created for EMS, ED Departments, Surgical Departments, ICU, Radiology, blood banks, hospitalists, administration, pharmaceuticals, and nursing care.
Rubinson, 2005[185]	Working group on Emergency Mass Critical Care	Augmentation of hospital critical care capacity after bioterrorist attacks or epidemics	The Work group recommends that triage decisions regarding the provision of critical care should be guided by the principle of seeking to help the greatest number of people survive the crisis. This would include patients already receiving ICU care who are not casualties of an attack.

Appendix Table C-6. Proposed strategies to allocate scarce resources during mass casualty events (KQ2)

Article No.	Organization, Task Force, or Panel	Title of Report or Article	Proposed Strategy
Bone, 1994[130]	Society of Critical Care Medicine Ethics Committee	Consensus statement on the triage of critically ill patients	In general, patients with good prognoses for recovery have priority over patients with poor prognoses. While uncertainty of prognosis is a crucial problem in critical care, providers should utilize predictive instruments with a full understanding of their strengths and limitations. Decisions to be made between patients with equivalent prognoses should be made on a first come, first served basis. Factors that should be considered are: 1) likelihood of a successful outcome; 2) patient's life expectancy due to disease(s); 3) anticipated quality of life of the patient; 4) wishes of the patient and/or surrogate; 5) burdens for those affected, including financial and psychological costs and missed opportunities to treat other patients; 6) health and other needs of the community; and 7) individual and institutional moral and religious values.
ATS Board of Directors, 1997[131]	American Thoracic Society Bioethics Task Force	Fair allocation of intensive care unit resources	One of the aims of the task force was to provide guidelines defining ethically appropriate and inappropriate criteria for admitting and discharging ICU patients and for the use of scarce resources in the ICU. The Task Force determined that patients meeting thresholds for medical need and benefit should be admitted on a first-come, first-served basis. Similarly, patients who continue to meet criteria for medical need and benefit should continue to receive ICU care. They should not be discharged prematurely with medical care inadequate for their needs in order to make room for a new ICU admission with even greater potential benefit. The Task Force considered it an error to use ICU prognostic systems *alone* to deny ICU admission. Criteria for use and discontinuation of a specific scarce resource were analogous to those for ICU admission and discharge based on thresholds of sufficient medical need and potential benefit and should be offered on a first-come, first-served basis.

Appendix Table C-7. Public perceptions and concerns about mass-casualty scarce resource allocation strategies (KQ3)

Appendix Table C-7. Public perceptions and concerns about mass-casualty scarce resource allocation strategies (KQ3)

Author, Year	Type of Study	Objective *(Type of MCE)*	Study Location	Population Characteristics (n = sample size)	Key Findings	Quality Score (of 7)
Docter, 2011[134]	Deliberative forum	To test how the resource allocation plan of the Australian government (for antiviral drugs and vaccines) corresponds with community views about the priority groups in a severe pandemic *(pandemic influenza)*	Adelaide, Australia	Participants in the age group 20 - 29 were absent; oversampling of female members (n < 12)	*Resource Allocation Policy:* 1. A committee consisting of a variety of experts and policy makers, but not politicians, should make allocation decisions. They are essential for the fair and effective allocation of scarce resources. *Priority Criteria:* 1. Both antiviral drugs and vaccines were allocated to groups in the following order: primary health-care workers, viral and vaccine researchers and workers, essential workers and military; 2. Lowest priority groups include: political decision makers; elderly, chronically ill and disabled people were excluded.	4
Braunack-Mayer, 2010[135]	Deliberative forum	To elucidate informed community perspectives on the allocation of scarce pharmaceuticals in a pandemic *(pandemic influenza)*	Adelaide, Australia	6 females (n = 9)	*Resource Allocation Policy:* 1. Preserving society in the long run, rather than saving the most lives, was the goal if forced to choose between the two. *Priority Criteria:* 1. Priorities should be given to the following potential recipients in the order of: health care workers, researchers and laboratory staff dealing with pandemic influenza, essential services (water, power, waste, etc.), and military; 2. The elderly and the chronically ill were explicitly excluded from the list of potential recipients.	3

Appendix Table C-7. Public perceptions and concerns about mass-casualty scarce resource allocation strategies (KQ3)

Author, Year	Type of Study	Objective *(Type of MCE)*	Study Location	Population Characteristics (n = sample size)	Key Findings	Quality Score (of 7)
Poll, 2010 [136]	Telephone survey	To understand the public's opinion about prioritizing children's needs in disaster planning and response *(disaster – unspecified)*	United States	U.S. residents (n = 1,030)	*Resource Allocation Policy:* 1. The same medical treatments currently available for adults should also be readily available for children . *Priority Criteria:* 1. If resources are limited and tough decisions must be made, children should be given a higher priority for life-saving treatments rather than adults with the same medical condition.	2
PEPPPI, 2005 [137]	Deliberation meeting and feedback session	To pilot test a new model for engaging citizens on vaccine related policy decisions when supplies of vaccine are limited and scarce resources need to be allocated efficiently in a severe pandemic *(pandemic influenza)*	GA (Atlanta), MA, NE, OR	Adults aged 18-78; a larger proportion of participants aged 55-64; more females, more participants with higher education (n = 250)	*Resource Allocation Policy:* 1. The goals of the allocation system should be 1) assuring the functioning of society using the minimum number of vaccine doses, and 2) reducing the individual deaths and hospitalizations due to influenza (protecting those who are vulnerable and at risk); 2. Transparency and open communication are key to ensure the fairness and trust essential to the plan's success; 3. The federal government role should be providing broad guidance; responsibility for more specific interpretation and implementation should remain with state and local health authorities; 4. Public health experts rather than political appointees should make the vaccine priority decisions. *Priority Criteria:* 1. Top priorities should be given to society's caretakers and persons at high risk; 2. Little support for giving priorities to young people, using a lottery system, or "first come, first served".	5

Appendix Table C-7. Public perceptions and concerns about mass-casualty scarce resource allocation strategies (KQ3)

Author, Year	**Type of Study**	**Objective** ***(Type of MCE)***	**Study Location**	**Population Characteristics** **(n = sample size)**	**Key Findings**	**Quality Score (of 7)**
Vawter, 2010 [138]	Community forum, small group discussion, solicitation of written comments	To solicit broader public input on rationing scarce health resources in Minnesota in a severe influenza pandemic *(pandemic influenza)*	MN	66% females, 9% Hispanic/Latino, 82% White (n = 441)	*Resource Allocation Policy:* 1. Three objectives should be balanced when rationing health care resources allocation: 1) reduce deaths, 2) treat people fairly, and 3) protect public health and infrastructure; 2. Transparency and public education are important to ensure fairness. *Priority Criteria:* 1. Priority rationing should not be based on gender, race, ability to pay, or first-come first served; 2. A large majority supported age-based rationing and prioritized children and young adults before seniors; seniors over age 85 were de-prioritized by some; 3. It is important to pay attention to the needs of vulnerable populations.	3

Appendix Table C-7. Public perceptions and concerns about mass-casualty scarce resource allocation strategies (KQ3)

Author, Year	Type of Study	Objective *(Type of MCE)*	Study Location	Population Characteristics (n = sample size)	Key Findings	Quality Score (of 7)
Public Engagement Project, 2009 [139]	Public engagement forum	To better understand the public's values and priorities regarding the delivery of medical services during a severe influenza pandemic *(pandemic influenza)*	WA (Seattle / King County)	70% females; 2/3 Whites; diverse age span and education level; large number of participants living near poverty line (n = 123)	*Resource Allocation Policy:* 1. Altered decision-making processes and protocols will be required to determine allocation of scarce medical resources during an influenza pandemic; 2. The system should be relatively simple to support successful implementation and administration but should be consistent at state or national level; 3. Guidelines should allow some flexibility to facilities; 4. The goals of the allocation decisions should be 1) treat as many people as possible even if it means compromised standard of care; 2) The prioritization system should be fair and accessible to all people. *Priority Criteria:* 1. Priority treatment should be given to health care providers and first responders; 2. Children and pregnant women should receive some priority when all other factors are equal; 3. Survivability is a priority treatment consideration; 4. Strategies rejected: "first come, first served", randomization, ability to pay, strategies that discriminate according to race, gender, culture, legal status, nationality, or language. *Other:* 1. Decisions for withdrawing life-saving care should be made by the patient or patient's family with input from a doctor or health care provider.	5

Appendix Table C-7. Public perceptions and concerns about mass-casualty scarce resource allocation strategies (KQ3)

Author, Year	Type of Study	Objective *(Type of MCE)*	Study Location	Population Characteristics (n = sample size)	Key Findings	Quality Score (of 7)
Bailey, 2011 [140]	Web-based survey	To investigate the views of students and staff at the university on the allocation of scarce resources during an influenza pandemic *(pandemic influenza)*	Edmonton, Canada	Students and staff at University of Alberta; 70% females (n = 5,220)	*Resource Allocation Policy:* 1. The goals of the allocation system include: save the most lives, follow a ranking system, and save those most likely to die, with most respondents supporting "save the most lives". *Priority Criteria:* 1. Most respondents gave the highest priority to health care workers and emergency workers , followed by children; 2. Lower priority was given to politicians; 3. "First come, first served" was least preferred.	5

Appendix Table C-8. Strategies to engage providers in mass casualty scarce resource allocation (KQ4)

Appendix Table C-8. Strategies to engage providers in mass casualty scarce resource allocation (KQ4)

Author, Year	Content Focus	Study Location	Study design	Type of mass casualty event	Engagement Strategy	Who Engaged Whom	Findings (Outcome)	Outcome Modulators (Facilitators or Barriers)	Quality score (of 4)
Buehler, 2006[151]	Reduce demand (Biological counter-measures)	GA (metro-politan level)	Descriptive -- case study of operational partnership	Unspecified	Public health-business partnership for mass dispensing	State and local PH and voluntary business coalition *engaged* local PH, schools, businesses	1200 business volunteers participated in 3 mass dispensing drills at public and business sites	*Facilitators:* Personal relationships, business commitment to service, strategic engagement by senior business and government officials, business model, conceptual link between business and community continuity, links to multiple government agencies *Barriers:* government procurement regulations; potential shifts in government priorities; different management styles; occasional government disorganization; confidentiality of proprietary information; liability; ongoing differences in perspective	4

Appendix Table C-8. Strategies to engage providers in mass casualty scarce resource allocation (KQ4)

Author, Year	Content Focus	Study Location	Study design	Type of mass casualty event	Engagement Strategy	Who Engaged Whom	Findings (Outcome)	Outcome Modulators (Facilitators or Barriers)	Quality score (of 4)
Dayton, 2008[144]	Optimize resource use	Central Brooklyn, NY	Descriptive – surge plan development	All-hazards	Organization of de novo regional hospital planning group and cooperative hospital level surge planning for central Brooklyn	Hospitals *engaged* city PH to develop planning group; new hospital consortium organization *engaged* individual hospitals	De novo planning group created; surge space/beds designated at each hospital to meet regional needs (+22% beds: 987 baseline to 1207 surge); protocol for notification and plan activation developed	*Facilitators:* Willingness of hospitals to plan cooperatively; national standards provided planning target	4
Gutsch, 2006[186]	Optimize resource use (triage)	Munich, Germany	Observational, post-test	Unspecified	Use of mSTART triage algorithm by trained emergency management technicians (EMTs)	Policy makers, hospitals, academia and first responders *engaged* EMTs	Demonstrated excellent performance of trained EMTs in initial pre-hospital triage using algorithm: 244 EMTs trained and divided into 11 teams that triaged 132 persons in median 35 seconds each (average 41 seconds), which compares favorably with emergency physician average of ~3 minutes; EMT critical red over-triage 5.3% and critical red under-triage 3% (both are considered excellent), sensitivity 88%, specificity 94%		4

Appendix Table C-8. Strategies to engage providers in mass casualty scarce resource allocation (KQ4)

Author, Year	Content Focus	Study Location	Study design	Type of mass casualty event	Engagement Strategy	Who Engaged Whom	Findings (Outcome)	Outcome Modulators (Facilitators or Barriers)	Quality score (of 4)
Koh, 2006[147]	Optimize resource use	Boston, MA	Descriptive – surge plan development, observational testing	Unspecified	Incorporation of CHCs into surge plan, with training for CHCs and three event-based tests	City PH & state primary care association *engaged* hospitals, CHCs, EMS in planning; City PH, EMS & academia *engaged* CHCs in training and first responders, hospitals and CHCs in tests of plan	Surge-related roles and responsibilities for CHCs delineated in plan; plan tested in city-wide preparation for Democratic National Convention and 2 outbreak investigations (e.g., screened 1500 persons for TB in one investigation)	*Facilitators:* CHCs were willing to participate and some were already integrated with nearby hospital; excellent academic partner provided high quality technical assistance *Barriers:* Variability in CHC sizes and resources precluded “one size fits all” approach; CHC staff had limited time & resources for training, testing	4
Moser, 2005[149]	Optimize resource use	Utah (regional level)	Descriptive – planning process	Unspecified	Broadly inclusive regional hospital level planning process to identify 1250 additional (surge) beds state-wide; regional approach to be replicated throughout state	State PH and state university medical center *engaged* multiple hospital and non-hospital facilities, professional associations, state and local PH, transit, EMS and church groups	State coordinating group identified broad range of public and private sector task force members and created regional surge plan through systematic iterative process	*Facilitators:* Broadly inclusive and iterative process; begin with small group; identify key personnel early; use prominent players for credibility; central planning office	3
Sanddal, 2004[81]	Optimize resource use (triage)	IA, RI, WA (local site in each)	Observational, pre-post and follow-up	Unspecified	Training and drills to assess performance in using JumpSTART algorithm for pediatric triage by pre-hospital care personnel and school nurses	Advisory committee (pre-hospital care personnel, nurses), EMT association, & school nurse association *engaged* pre-hospital care staff and school nurses	Successful testing of pediatric triage algorithm, tested in 3 states; mean performance score 6.22/11 pre-test, 8.25 post-test (paired t test < 0.001, CI 1.41-2.66), mean performance score 3 months later: 8.41	*Facilitator:* Involvement of advisory committee and relevant professional associations to support selection and engagement of participants to test algorithm	4

Appendix Table C-8. Strategies to engage providers in mass casualty scarce resource allocation (KQ4)

Author, Year	Content Focus	Study Location	Study design	Type of mass casualty event	Engagement Strategy	Who Engaged Whom	Findings (Outcome)	Outcome Modulators (Facilitators or Barriers)	Quality score (of 4)
Ginter, 2010[150]	Augment resources	AL, MI, FL, LA, TN	Descriptive – planning process	All-hazards (“natural and manmade”)	Organization of five neighboring states into a voluntary disaster pediatric surge network	2 state PH and regional PH preparedness center *engaged* pediatric hospitals and major clinics, state PH, and emergency responders	Established pediatric surge network, operational handbook, formal MOU	*Facilitators:* “Highly-reliable organization” model previously established and adaptable to surge network development *Barriers:* Planning process is time-consuming (5 yrs), inter-state agreements are more complicated than intra-state ones	4

Appendix Table C-8. Strategies to engage providers in mass casualty scarce resource allocation (KQ4)

Author, Year	**Content Focus**	**Study Location**	**Study design**	**Type of mass casualty event**	**Engagement Strategy**	**Who Engaged Whom**	**Findings (Outcome)**	**Outcome Modulators (Facilitators or Barriers)**	**Quality score (of 4)**
Albanese, 2007[126]	Augment resources	CT (state level)	Observational, 2 post-tests	Radiological, nuclear	Enrollment, education, training and exercise of qualified laboratory staff for preparing biodosimetry specimens (to test radiation exposure)	State biodosimetry laboratory *engaged* hospital and commercial laboratories statewide	Augmentation of critical laboratory capacity, skills retained 6 months after training (functional drill): 30 of 33 labs were qualified; Staff in 30 labs were trained 22 of 30 labs volunteered to participate in surge network 79 personnel trained to date in 19 of these labs 37 participated in drill: (a) every specimen met standards; (b) average turnaround time (specimen preparation) = 199 minutes	*Facilitators:* most laboratories were already qualified because of existing equipment; education allayed safety concerns *Barrier:* Many laboratories had safety concerns (before training)	4

Appendix Table C-8. Strategies to engage providers in mass casualty scarce resource allocation (KQ4)

Author, Year	Content Focus	Study Location	Study design	Type of mass casualty event	Engagement Strategy	Who Engaged Whom	Findings (Outcome)	Outcome Modulators (Facilitators or Barriers)	Quality score (of 4)
Kelen, 2006[141]	Augment resources	MD	Descriptive – planning process	Unspecified	Development of evidence-based "reverse triage" classification system through systematic expert consensus process using formally-defined real-time anonymous virtual network	Academic medical center leaders *engaged* 39 clinician and non-clinician experts	Evidence-based 5-category patient classification system based on agreed-upon risk tolerance levels	*Barriers:* absence of evidence that expert opinion-based system would result in safe practice; did not include experts from broad range of hospital types	4
Terriff, 2001[143]	Augment resources	Spokane, WA (regional level)	Descriptive – planning, tabletop exercise	Biological	Pharmacy-led development of regional pharmaceutical preparedness policies and procedures (protocol) for response to BT event -- pre-911	Hospital pharmacy department, county EMS and Army *engaged* first responders, hospitals, non-hospital facilities, FEMA, USPHS, FBI, and state PH	Technical documentation & city-wide policy and protocol for medical management of BT (obtaining antidotes), including plan for local stockpiles, resource sharing across region (city)	*Facilitator:* Initiative of pharmacy department in one hospital and interest of all participants in city-wide planning	4
Vawter, 2010[138]	Crisis standards of care (rationing scarce resources)	MN (state level)	Descriptive – planning process	Pandemic influenza	Developing proposed ethical frameworks and procedures for rationing scarce health resources within a state	State government, university and health care ethics center *engaged* local governments, experts, general public and a few (not many) health care providers (hospital, non-hospital, other)	Decision tools – ethics guidance: Multiple ethical frameworks for setting rationing priorities (for vaccine, N95 respirators, surgical masks, antiviral drugs for prophylaxis and for treatment, mechanical ventilators) -- principles, objectives, general strategies	*Facilitators:* involvement of ethicists, extensive public input, specific resource items *Barriers:* resulted in decision tool (not plan); one size does not fit all; very few providers were reported as involved	3

Appendix Table C-8. Strategies to engage providers in mass casualty scarce resource allocation (KQ4)

Author, Year	Content Focus	Study Location	Study design	Type of mass casualty event	Engagement Strategy	Who Engaged Whom	Findings (Outcome)	Outcome Modulators (Facilitators or Barriers)	Quality score (of 4)
Kanter, 2009[142]	Crisis standards of care (altered standards of care)	US (experts drawn from different states)	Descriptive – planning process	Unspecified	Systematic development of consensus on appropriate pediatric crisis standards of care through modified Delphi process involving hospital pediatricians	Hospital pediatric leaders *engaged* other acute care hospital-based pediatricians	Consensus on non-ICU interventions but not on ICU interventions	*Facilitators:* Structured process, conducted via email (cheap, efficient), anonymity of experts, flexible approach, use of established scoring system as endpoints *Barriers:* No face-to-face discussion among experts, no full consensus on some elements, need to coordinate with government regulations potentially over-rides expert consensus	3
Levin, 2009[148]	Crisis standards of care (altered standards of care)	MA (state level)	Descriptive – planning process	Pandemic influenza	State level planning to establish framework and ethical principles to guide development of altered standards of care protocols	State PH and academia *engaged* local PH, hospitals, non-hospital healthcare facilities, other health agencies, non-government entity, general public	Consensus state-level framework (guidelines) and decision making protocol for altered standards of care (ASC); 4 goals, 7 principles – decision-making protocol to determine ASC	*Facilitators:* Excellence of academic institution; involvement of ethicists, legal counsel, and broad stakeholder base	3

Appendix Table C-8. Strategies to engage providers in mass casualty scarce resource allocation (KQ4)

Author, Year	Content Focus	Study Location	Study design	Type of mass casualty event	Engagement Strategy	Who Engaged Whom	Findings (Outcome)	Outcome Modulators (Facilitators or Barriers)	Quality score (of 4)
Grier, 2006[145]	Manage demand Optimize resource use Augment resources	CA, FL, IL, OR, LA, MO (state level in each)	Case studies – planning process	Unspecified	1. Top-down county planning model, master Mutual Aid Agreement (CA, IL) 2. Decentralized regional planning (FL, LA) 3. Decentralized rural planning (OR) 4. Hospital-directed tiered regional planning model (IL, LA, MO) 5. Third-party directed planning model (MO)	1. State PH *engaged* local PH, hospitals 2. Hospitals, state hospital association *engaged* hospitals 3. Regional medical center *engaged* hospitals 4. Designated regional hospital *engaged* hospitals 5. State PH and designated hospital *engaged* hospitals	Multiple surge capacity planning models based on plans in 8 localities in 6 different US states	*Facilitators:* Planning centered on hospitals (no major mix of organizational cultures); third-party-directed planning model minimized competition among hospitals *Barriers:* Culture differences between PH and hospitals, competition among hospitals	4
Dausey, 2006[187]	Manage demand Optimize resource use Augment resources Crisis standards of care	Three US metropolitan areas (not specified)	Tabletop exercises	Pandemic influenza	Development and pilot testing of tabletop exercise template for local level governments and providers	State PH and RAND *engaged* local PH & elected officials, hospitals and private practitioners, law enforcement	Tested tabletop exercise template applicable to localities across the U.S.	*Facilitators:* Excellence of technical partner, willingness of participants	4

Appendix Table C-8. Strategies to engage providers in mass casualty scarce resource allocation (KQ4)

Author, Year	Content Focus	Study Location	Study design	Type of mass casualty event	Engagement Strategy	Who Engaged Whom	Findings (Outcome)	Outcome Modulators (Facilitators or Barriers)	Quality score (of 4)
Lurie, 2008[146]	Optimize resource use Augment resources Crisis standards of care	2 US localities and 3 regions (not specified)	Tabletop exercises	Pandemic influenza	Pilot testing of local, regional and national level tabletop exercises for the Veterans Health Administration (VHA)	Central federal health provider agency (VHA) *engaged* local and regional VA hospitals and non-hospital facilities, local hospitals, state and local PH and local first responders	Tested tabletop exercise templates for local and regional use by VA system, engaging government and public and private providers	*Facilitators:* ability to share and use exercise templates across VA system nationwide, VA engagement with local communities, mutual respect between local VA providers and their communities, integrated VA health system with electronic health records and hotlines enable patient flow management Barriers: unclear who decides on resource sharing between VA and local facilities, different levels of care between VA and local hospitals, organizational culture differences between VA and local providers (command vs. collaboration)	4

Appendix D. Excluded Studies

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Short Form Rejects

No Key Questions Addressed (N=583)

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Appendix D. Excluded Studies at Short Form Screening

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Appendix D. Excluded Studies

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Short Form Rejects

No Key Questions Addressed (N=583)

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Appendix D. Excluded Studies at Short Form Screening

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Appendix D. Excluded Studies at Long Form Screening

Did not assess the public's opinions directly

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Appendix E. Key Elements of State Plans

Appendix E. Key Elements of State Plans

	Keep Non-Critical Patients out of the Hospital Emergency Departments	Encourage the Public to Self-Quarantine	Triage	Use Health Care providers and Non-Medical Staff More Efficiently	Balance the Load Across Different Facilities	Re-Purpose Existing Resources	Substitute Effective Alternatives	Increase Reserves and Stockpiles	Negotiate Mutual Aid Agreements	Define Priority Groups	Be Prepared to Provide Comfort Care	Adopt Crisis Standard of Care
	Strategies to Reduce Demand		Optimize Existing Resources				Strategies to Augment Existing Resources			Crisis Standards of Care		
Arizona									X	X		X
California	X		X	X	X	X		X	X	X	X	X
Colorado	X		X	X	X							X
Florida				X		X				X		X
Guam					X			X		X		X
Minnesota	X				X	X	X	X	X			X
Nevada		X			X			X		X		
New York												X
North Dakota								X		X		X
Utah	X					X						X
Washington		X	X		X			X	X	X		
Wisconsin							X					X