National Association *of* Public Hospitals *and* Health Systems

ResearchBrief

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Designated Coordinators Boost Preparedness Efforts in Safety Net Hospitals

Introduction

Hospital emergency preparedness is an evolving and complex field. Increasingly stringent federal regulations and Joint Commission accreditation standards, as well as a growing community orientation towards emergency preparedness, have created an array of new tasks for hospitals. Most public hospital facilities assign disaster preparedness functions to existing staff, who take on this role in addition to their other responsibilities. However, to stay atop the ever-growing demand for disaster readiness activities, a new trend is emerging in public hospitals: the creation of a full-time, dedicated staff position with the sole responsibility of coordinating, integrating, and assessing preparedness activities for the hospital. The National Public Health and Hospital Institute's (NPHHI) 2006–2007 Emergency Preparedness Study indicates that 25 percent of public hospitals (15 of the 60 surveyed) have dedicated preparedness coordinators (see Figure 1). To gain insight into this emerging trend, NPHHI conducted a survey of dedicated disaster planners at NAPH facilities.

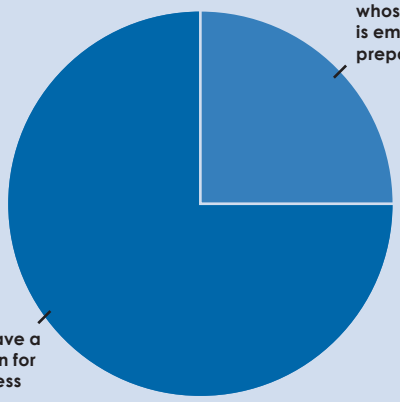
Increased Awareness Gives Rise to New Position

The dedicated preparedness coordinator is a relatively new position in public hospitals. Most (67 percent) were created after 2001, and 27 percent were created in 2005 alone, suggesting that recent terrorist and weather-related events have profoundly affected the landscape of emergency planning in public hospitals. When asked about the factors that gave rise to the creation of their position, 33 percent cited 9/11. Others included community pressure (40 percent), concern about Joint Commission compliance (27 percent), and the need for coordination of preparedness efforts (27 percent).

Disaster planning involves a wide range of activities, including coordinating hospital resources, developing comprehensive evacuation procedures, ensuring adequate surge capacity, and

FIGURE 1 Hospitals with a Designated Emergency Preparedness Staff Member

NAPH member hospitals with staff whose primary role is emergency preparedness	25%
Members who do not have a designated staff position for emergency preparedness	75%



SOURCE NPHHI 2006-2007 Emergency Preparedness Survey

effectively collaborating with outside agencies (e.g., local fire and police). Creating a job description for an emergency manager, therefore, is no easy task. Nearly half of respondents said that they did not know of any external guidelines that were helpful in developing their job descriptions. Of those who found outside materials, some (25 percent) credited Joint Commission, and others (17 percent) cited the expertise of existing hospital staff or (8 percent) the Hospital Incident Command System manual.

Because tasks carried out by the preparedness coordinator demand a range of skills, individuals in this role come from diverse backgrounds. Many hospitals expect emergency disaster coordinators to be emergency medical technicians (EMT)/paramedics or registered nurses. Others require that the coordinator have a master's degree in public health or health sciences. Other commonly required competencies include familiarity with grant funding, decontamination practices, the National Incident Management System (NIMS), and the Hospital Incident Command System.

Key Responsibilities

NPHHI asked each coordinator to share his or her job description. The most common roles and responsibilities include:

- Maintaining compliance with current regulations and standards for emergency preparedness, including local, state, federal, accreditation, and grant agencies;
- Assessing hospital disaster plans;
- Maintaining staff certification and training;
- Orchestrating emergency preparedness drills; and
- Serving on external committees/acting as hospital-community liaison for emergency preparedness.

Dedicated Role Proves Valuable

When asked about the value of having a position solely dedicated to disaster management, individuals in that role most frequently cited the ability of a planner to assimilate preparedness awareness into hospital culture. For example, one noted, "The emergency coordinator can integrate drills and exercises into our monthly schedule and weave emergency preparedness thinking into our daily operations." Others maintained that, because effective preparedness is reliant on hospital employee familiarity with disaster plans, emergency preparedness coordinators are able to tailor efforts to the individual hospitals.

Dedicated disaster planners also act as a liaison to outside agencies. Hospitals are required to collaborate with multiple agencies such as local hospital groups, local government, and local first responders. Many emergency preparedness coordinators attested to the enormous amount of work required to connect individual hospital preparedness efforts to the outside community. One reported, "It is not humanly possible to attend local, regional, and national meetings and [develop] the kinds of relationships that are necessary to establish a superior emergency management program without a full-time position."

The Joint Commission's 2006 accreditation standards state that a health care system must participate in one community-wide practice drill per year.[1] Emergency preparedness coordinators are able to coordinate with the community and plan these large-scale drills. Additionally, having a single coordinator allows outside agencies to identify the appropriate contact within a hospital. One emergency preparedness coordinator commented that the position has increased visibility of their hospital's preparedness efforts to outside agencies: "Communication and awareness locally and statewide have increased because of the liaison aspect associated with the coordinator position."

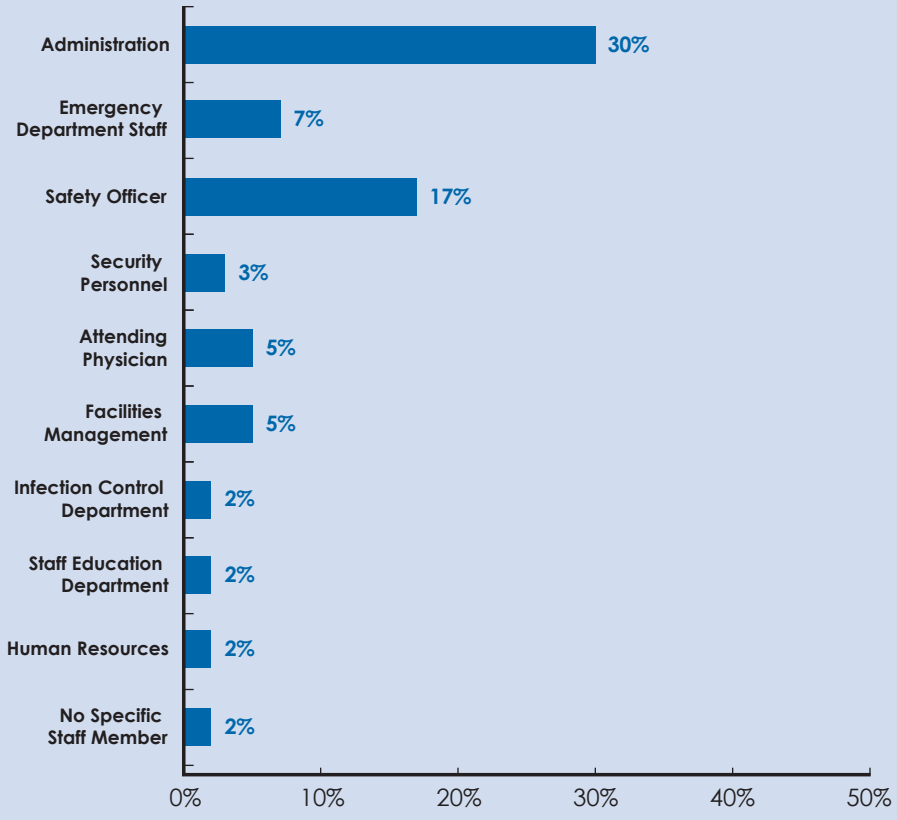
Finally, some coordinators reported that the creation of a dedicated position "has allowed the institution to gain access to grant funding." This is especially urgent because of the competitiveness of disaster funding. An emergency readiness coordinator can submit grant applications to the Health Resources and Services Administration (HRSA), as well as to programs like the Urban Area Security Initiative (UASI), and Metropolitan Medical Response System (MMRS). UASI is a specific federal grant program that was created to reduce area vulnerability and prevent terrorism and/or weapons of mass destruction (WMD) incidents.[2]

MMRS, on the other hand, is a specific Federal Emergency Management Agency (FEMA) program that develops plans, conducts training and exercises, and acquires pharmaceuticals and personal protective equipment in highly-populated areas to achieve the enhanced capability necessary to respond to a mass casualty event caused by a terrorist act.[3] These grant applications require specialized knowledge of disaster preparedness activities and collaboration with other local agencies.

Financial Challenges

One of the toughest challenges cited by dedicated emergency planners is financing preparedness efforts (40 percent). In the 2006–2007 NPHHI Emergency Preparedness Study, 85 percent reported receiving funding from the Health Resources and Services Administration (HRSA) in 2006. Other sources included monies from counties, states, the Centers for Disease Control (CDC), and other federal government sources.

FIGURE 2 **Hospitals without designated emergency preparedness coordinators assign emergency preparedness duties to a range of hospital personnel**



SOURCE NPHHI 2006-2007 Emergency Preparedness Survey

Safety net facilities with such coordinators must continuously define disaster preparedness as a hospital priority, reserve adequate funds for the position, and secure supplemental monies for other emergency preparedness activities.

Importantly, states administer HRSA's disaster preparedness dollars differently, and funds are primarily earmarked for particular training and equipment. Some states use federal HRSA funding to purchase specific supplies that they provide to hospitals, which means that hospitals have little say in how the dollars are spent. In most states, hospitals are not permitted to use HRSA funds for personnel.

Nearly all (93 percent) of dedicated disaster coordinator salaries come directly from hospital funds. Only one respondent had financing from external sources (i.e., two-thirds of his salary is funded by separate state funds). Because NAPH member hospitals are already under heavy financial pressures (the average margin in 2004 for NAPH members was 1.2 percent, 4 percentage points lower than the average margin of 5.2 percent for all hospitals in the US)[4], they lack resources available at other hospitals for hiring dedicated disaster planning staff. This means that safety net facilities with such coordinators must continuously define disaster preparedness as a hospital priority, reserve adequate funds for the position, and secure supplemental monies for other emergency preparedness activities.

Dedicated Staff Helps Organize Response

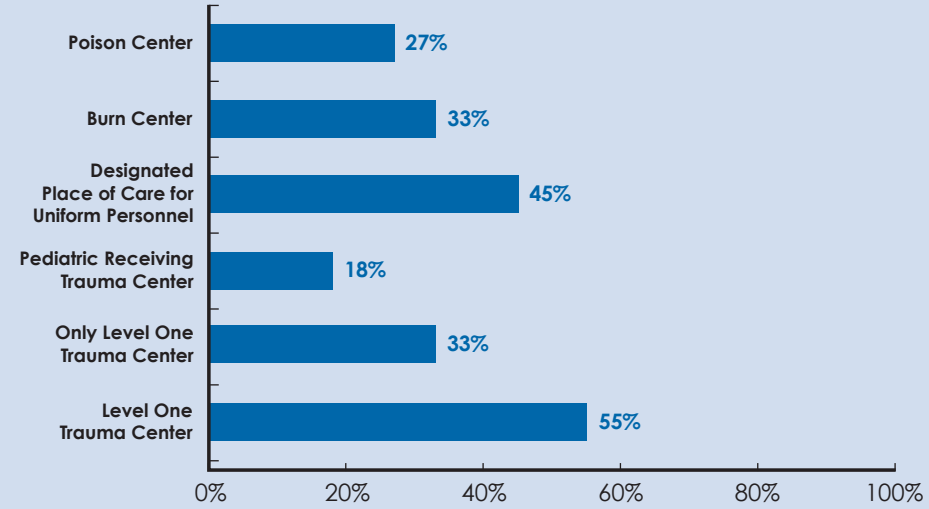
There is no consensus regarding which hospital staff member, other than a dedicated readiness response coordinator, should manage emergency preparedness-related tasks. The NPHHI Emergency Preparedness Study of 60 NAPH-member hospitals found that those facilities without a dedicated emergency preparedness coordinator placed the onus of managing disaster-related tasks on a diverse set of professionals, including: administrators (30 percent), safety officers (17 percent), emergency department staff (7 percent), attending physicians (5 percent), and others (see Figure 2). In contrast, disaster coordinator positions help facilitate response efforts at public hospitals by integrating preparedness practices into normal hospital operations, coordinating with the community, and maintaining grant funding for preparedness efforts.

Given that one out of every three NAPH member hospitals (33 percent) provides the only Level One trauma center in their counties, it is particularly essential that public hospitals have well-coordinated disaster response systems (see Figure 3). According to the American Hospital Association, NAPH members make up 44 percent of all burn care centers nationally.[5] Moreover, some NAPH members, like Atlanta's Grady Health System, serve their community as regional coordinating hospitals. Grady is among those who have opted to hire a dedicated emergency planning coordinator.

Conclusion

The enormous responsibility of public hospitals to care for their communities during an emergency, compounded by the increasingly complex disaster-related mandates, is beginning to give rise to a new trend in hospital staffing: dedicated disaster coordinators. Data from the NPHHI Emergency Preparedness Study indicates that

FIGURE 3 Percent of NAPH Hospitals with Unique Emergency Services



SOURCE NPHHI 2006-2007 Emergency Preparedness Survey

preparedness coordination in public hospitals is beginning to evolve from a set of activities and responsibilities assigned to a safety officer to a more robust set of roles that occupy a full-time position. Indeed, as preparedness continues to move toward an all-hazards, community focus, it is likely that dedicated disaster coordinator positions will become more common. Although there is no explicit source of federal financing available to help fund additional staff for this purpose and all costs must be borne by the hospital, this focus may prove helpful to adequate preparedness for the next disaster event. As aptly noted by San Francisco General Hospital's CEO Gene Marie O'Connell in explaining why her facility has opted to hire a full-time disaster planner, "All the daily internal and external threats that can occur make having a [dedicated] disaster coordinator a necessary part of the health care team. As it is often said, the only thing harder than planning for a disaster is explaining why you didn't." ■

This research brief is the third in a series reporting the results of the NPHHI 2006-07 Emergency Preparedness Survey. Findings from the NPHHI Preliminary Emergency Preparedness Survey *(September 2006) and* Hospital Staffing and Surge Capacity During a Disaster Event *(May 2007) are available on the NPHHI website. A complete report on the survey will be published in early 2008.*

Notes

1. *Joint Commission 2006 Hospital Accreditation Standards for Emergency Management Planning, Emergency Management Drills, Infection Control, and Disaster Privileges*: http://www.jointcommission.org/NR/rdonlyres/F42AF828–7248–48C0-B4E6-BA18E719A87C/0/06_hap_accred_stds.pdf. Accessed August 23, 2007.

2. Urban Area Security Initiative: http://secure.cityofno.com/portal.aspx?portal=107. Accessed September 13, 2007.

3. Metropolitan Medical Response System: http://www.fema.gov/mmrs/. Accessed September 13, 2007.

4. *America's Public Hospitals and Health Systems, 2004: Results from the Annual NAPH Hospital Characteristics Survey*. National Association of Public Hospitals and Health Systems.

5. American Hospital Association Survey Database, FY 2005.