The events of September 11, 2001, brought to light many gaps in our ability to prepare for, respond to, and recover from a major incident. They demonstrated the urgent need for national standards for incident operations, communications, personnel qualifications, resource and information management, and supporting technology. Communication equipment was not interoperable, and no one system could ensure preparedness, response, and recovery coordination and cooperation across all provider levels. Since that day, hospitals have faced new challenges to protect and care for their communities, especially in regard to the threat of bioterrorism.

In the United States, federal-level guidance and program development in disaster preparedness improvement has since soared. A number of crucial programs and documents guide comprehensive emergency management (CEM), which consists of the preparedness, response, recovery, and mitigative actions of healthcare providers. Exhibit 2.1 depicts these four phases of comprehensive emergency management.

All disasters are local. Response is progressive and can involve assistance from higher levels of the emergency management community. Once the resources of one level are expended, support from a higher level may be requested. Requests move from the local, to the county (or parish or burrough), to the state and federal levels, creating a layered response strategy.

Each level of response expands the healthcare organization’s capabilities. An effective response requires participation from private entities, nongovernmental agencies, tribal or local jurisdiction government resources, state-level resources, and federal resources. Most incidents are resolved at the local or regional level, without the intervention or involvement of the federal government. If federal involvement is needed, it is focused on specific authorities or day-to-day functions, such as a hazardous materials response.
The goals of our national response doctrine are saving lives and protecting property and the environment. It is rooted in our federal system and the constitutional division of responsibilities between federal and state governments. It reflects the history of emergency management and the wisdom of responders and leaders at all levels and gives elemental form to the *National Response Framework* (NRF), or the *Framework*. The doctrine is made up of five key principles (DHS 2008, 8):

1. Engaged partnership
2. Tiered response
3. Scalable, flexible, and adaptable operational capabilities
4. Unity of effort through unified command
5. Readiness to act

The *Framework* sets out the roles and responsibilities of key implementers at the local, tribal, state, and federal levels. This includes the roles of private sector and nongovernmental organizations (NGOs) (DHS 2008, 15).
Dr. John Harrald (1998) of George Washington University describes public sector emergency management as having “the objectives of preserving the lives and social welfare and protecting the property of a defined population (city, county, state, country, region, etc.). Emergency management has typically been the province of government and not-for-profit organizations such a FEMA and the American Red Cross. These organizations exist because the population at risk requires their services: mitigation, preparation, response and recovery.”

The Local Role

In that all disasters are local, response begins at the local level. Local leaders and emergency managers prepare their communities to manage incidents through the organization of resources and agencies in a spirit of cooperation, collaboration, coordination, and communication.

The local area may not have a designated emergency management agency (EMA) or an emergency operations center. Instead, these may be present only at the county level. However, an EMA structure and system exists to support healthcare delivery at each locality in a disaster. Each level of response brings an increased capability and additional personnel and resources to support a successful response.

The local area will stage the initial response to an event using local resources. If its resources are depleted or inadequate to respond to the event, it may request additional support from its county-level EMA. In a large event, multiple counties may be asked to respond. This request may be made to the county EMA director by the local EMA director, if there is one, or by the chief elected or appointed official (mayor or city or county manager). The local emergency manager has the day-to-day authority and responsibility for overseeing emergency management programs and activities.

The Four Cs of Successful Integration

Although these four items are important in every interaction and aspect of emergency management, it is imperative that they start at the local healthcare level.

1. Communication
Disasters require healthcare providers and entities to maintain open channels of communication with multiple entities to facilitate resource requests and deployment, emergency notifications, and situational updates. Different devices are available to assist
communications; however, they must be “multiple and redundant” and should allow providers to communicate in a planned manner with all agencies critical to the healthcare response. Exercises and drills should be conducted to test and improve communication plans and systems.

2. Cooperation
Healthcare organizations compete for patients and the services they require. In this competitive environment, information is carefully guarded. Healthcare providers deliver care to each individual, focusing on the health status of one person at a time.

Public health provides services to the general population. Health departments promote wellness and manage infectious diseases or unhealthy environmental conditions, among other responsibilities. Only since the advent of federal bioterrorism preparedness programs in the past few years have health departments ventured beyond their usual scope of activities. Yet public health departments license healthcare facilities, and this creates a natural tension between these types of organizations.

Healthcare facilities and public service agencies, including EMAs, operate in different worlds. With the exception of emergency medical services (EMS), their respective activities have few natural intersections. Joint planning and preparedness activities, such as drills and exercises, can lower these barriers to cooperation.

3. Collaboration
Three activities promote and develop collaboration and better integrate the healthcare community with its community partners in emergency preparedness and response: planning, training, and exercising.

Using a standard format for plans allows others to easily understand and cooperate during the planning process, simplifying the sharing of information and exchange of knowledge. Planning together also helps each party understand the others’ resources and capabilities. The most important outcome of collaborative planning is not the plan itself but the relationships that develop through the planning process.

Training and performing disaster exercises together to test the plans are crucial to build relationships, strengthen response, and create an environment of trust and familiarity.

4. Coordination
Coordination is creating activities that are in harmony with the efforts of others. In a medical coordinating center, healthcare facilities and public health agencies can work together to coordinate management of the health effects of a major incident.
And the Joint Information Center can provide a single voice to send a message to the public or to all participating agencies and organizations.

Local-level partners in strengthening the healthcare response may include:

- Public safety: local police or sheriff, fire services and hazmat, EMS
- Education: local school districts, universities and community colleges, vocational and technical schools
- Transportation: city and county department of transportation; city airports
- Human services: welfare and homeless services, social services agencies, mental health/counseling services
- Health resources: local public health departments, local environmental protection agencies
- Infrastructure: city utility companies (water, power, sewer), public works
- Local media outlets

**The State Role**

The primary role of state government is to supplement and facilitate local efforts before, during, and after incidents. Thus, the role of the state EMA is to assist local areas and agencies in all activities related to CEM.

At the local and state levels, EMAs play a critical role in supporting the response to any major incident or disaster. States provide resources and support to responses at the local and county level. When state resources are scarce or when the event exceeds the state’s ability to respond appropriately, the governor may make a formal request of the president for federal assistance. This occurs through the granting of one of two types of presidential disaster declarations.

State-level partners of interest to healthcare providers may include:

- The state Homeland Security advisor
- The director of the state EMA
- State departments and agencies
- Indian tribal leaders
- Public safety: state police or patrol, the state fire marshal, the state EMS agency
- Education: universities and community colleges, vocational and technical schools
- Transportation: the department of transportation, the highway and roads department, aviation administrations
- Human services: welfare and social services agencies, mental health/counseling services, labor services
* Health resources: state health departments, environmental agencies, the radiation regulatory agency
* Infrastructure: utility companies (water, power, sewer), communications companies (telephone, Internet)

**Federal Direction**

The president leads the federal government response effort to ensure that the necessary coordinating structures, leadership, and resources are applied quickly and efficiently to large-scale and catastrophic incidents. Through the Homeland Security Council and the National Security Council, Cabinet officers and other department or agency heads provide national strategic and policy advice to the president (DHS 2008, 24). When state resources are depleted or inadequate to stage an effective response to a disaster, the governor may make a formal request of the president for a federal declaration of disaster. This declaration is beneficial in a large-scale incident, as it provides access to federal resources and initiates federal disaster reimbursement mechanisms.

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**Exhibit 2.2 Bottom-Up Response**

![Diagram of federal, state, and local response levels with an incident commander at the top and bottom]
Exhibit 2.2 illustrates the “bottom up” response to a local incident, with resources and assistance starting at the local level and supported with a state response and, if warranted, a federal response.

**Who’s in Charge? Federal Declaration of Disaster or Public Health Emergency**
The Pandemic and All-Hazards Preparedness Act of 2006 (P.L. 109-417) designates the secretary of the Department of Health and Human Services (HHS) as the lead for all federal public health and medical responses to public health emergencies and incidents covered by the National Response Plan (NRP) or its successor, the National Response Framework (NRF). The HHS assistant secretary for preparedness and response (ASPR) is the secretary’s principal advisor on matters related to federal public health and medical preparedness and response for public health emergencies.
Under the NRF, HHS is the lead agency for Emergency Support Function (ESF) 8, the Public Health and Medical Services Annex, and the Biological Incident Annex. HHS also plays a significant role as a supporting agency for ESF 6, the Mass Care, Housing, and Human Services Annex.

**What’s an 1135 Waiver?**
Section 143 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 authorizes the HHS secretary to temporarily waive or modify Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) requirements when the president declares an emergency or major disaster pursuant to the Stafford Act or the National Emergencies Act and the HHS secretary declares a public health emergency.

Certain Program Requirements That May Be Waived (abbreviated)

- Conditions of participation
- Pre-approval requirements for providers or for healthcare items or services
- Requirements that physicians and other healthcare professionals hold licenses in the state in which they provide services
- Sanctions under EMTALA for redirection of an individual to another location to receive a medical screening examination pursuant to a state emergency preparedness plan
- Sanctions related to Stark self-referral prohibitions
- Deadlines and timetables for performance of required activities
- Limitations on payments to permit Medicare Advantage enrollees to use out-of-network providers in an emergency situation
- Sanctions and penalties arising from noncompliance with HIPAA privacy regulations, in 3 areas, for a 72-hour period after a hospital implements its disaster protocol

Source: Ray (2009, 254)
The Federal Declaration of Disaster or Public Health Emergency
During a public health or other emergency, the ability of a government official to declare an emergency can be an important tool from a legal perspective. While HHS has broad authority to assist states and other entities during an emergency, even without a public health emergency (PHE) declaration, such a declaration can facilitate HHS’s preparation and mobilization by authorizing the secretary to take certain actions to respond to the emergency. It may allow officials to exercise special powers and permit them to suspend certain legal requirements to respond to the event.

Two types of disaster declarations may be made at the federal level:

1. A presidential declaration of an emergency or major disaster, under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), which usually requires a formal request by a state governor
2. A Public Health Emergency (PHE) declaration, which the HHS secretary may declare under Section 319 of the Public Health Service (PHS) Act without a formal request from a governor or other entity

THE NATIONAL STRATEGY FOR HOMELAND SECURITY: THE FRAMEWORK, THE GOAL, AND HSPDS

Recognizing the inherent weaknesses caused by inadequate and uncoordinated emergency systems, the president issued two directives that resulted in our national strategy for Homeland Security, Homeland Security Presidential Directives (HSPDs) 5 and 8, mandating the development of a fully integrated and interoperable planning and response system. Exhibit 2.3 illustrates the National Strategy for Homeland Security. It presents the related HSPDs and the national initiatives that complement them.

HSPD-5 mandated the establishment of a single, comprehensive system to manage incidents, the National Incident Management System (NIMS), while HSPD-8 required a national domestic all-hazards preparedness goal with mechanisms for improved delivery of federal preparedness assistance to state and local governments (Bush 2003).

HSPD-5

HSPD-5 institutionalized the all-hazards approach and promoted full integration of all phases of incident management. It included the NRP and NIMS (Hess 2004).
The NRP, using the NIMS, provides structure and mechanisms for national-level policy and operational direction for federal support to state and local incident managers, and for exercising direct federal authorities and responsibilities. Other objectives were to (Hess 2004):

- ensure a system that allows all levels of government to work efficiently and effectively together,
- provide seamless integration of resources and capabilities,
provide a common lexicon and systems for horizontal and vertical integration,
+ establish networks and systems for effective communication,
+ ensure full integration of the crisis and consequence management components of incident management, and
+ eliminate any barriers between the criminal investigation and emergency response components in a terrorism event.

HSPD-5 designates the secretary of Homeland Security as the principal federal official for domestic incident management. In catastrophic events, the secretary may designate a principal federal official (PFO) as his or her representative. The PFO provides senior leadership for the event but does not replace or duplicate the roles of other emergency managers.

HSPD-8

On December 17, 2003, the president issued HSPD-8. A companion to HSPD-5, this directive establishes policies to strengthen the nation’s preparedness to prevent and respond to threatened or actual domestic terrorist attacks, major disasters, and other emergencies by

+ requiring a national domestic all-hazards preparedness goal,
+ establishing mechanisms for improved delivery of federal preparedness assistance to state and local governments, and
+ outlining actions to strengthen the preparedness capabilities of federal, state, and local entities.

NATIONAL PREPAREDNESS GUIDELINES AND STRATEGY

The national strategy for Homeland Security uses a capabilities-based planning approach: planning, under uncertainty, to provide capabilities suitable for a wide range of threats and hazards within an economic framework that necessitates prioritization and choice (DHS 2010). The strategy states that our nation should focus its efforts on four goals:

1. Prevent and disrupt terrorist attacks.
2. Protect the American people, our critical infrastructure, and key resources.
3. Respond to and recover from incidents.
4. Continue to strengthen the emergency-preparedness foundation.

By 2005, planning tools had become available to assist in implementation of the national preparedness goal (NPG). Using 15 national planning scenarios of plausible catastrophic terrorist attacks, major disasters, and other emergencies, a universal task list (UTL) provides a menu of tasks from all sources that may be performed in major events. The target capabilities list (TCL) provides guidance on specific capabilities and levels of capability that federal, state, local, and tribal entities will be expected to develop and maintain.

**NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS)**

NIMS is a companion document to the NRP, superceded by the NRF. It provides standard command and management structures that apply to response activities and a consistent nationwide template to enable all government, private sector, and nongovernmental organizations to work together during domestic incidents. NIMS provides the common operational concepts and basic organizational structure to ensure seamless transitions and integration of resources. This compatibility and interoperability is critical, especially in incidents that exceed local boundaries. The organizational structure ensures that responders from anywhere in the nation can work together, regardless of the nature or the location of the incident. Responders know where they fit into the organization, they know their own roles and responsibilities, and they know what is expected of them.

**Components of NIMS for Hospitals and Healthcare Systems**

NIMS is built in a flexible framework around five key components:

1. Adoption of NIMS
2. Planning
3. Training and exercises
4. Communications and information management
5. Command and management

The *NIMS Implementation Activities for Hospitals and Healthcare Systems* (FEMA 2006) lists 14 activities related to these five components that must be completed for hospitals and healthcare systems to comply with NIMS.
Part I: Introduction and Preparedness

FY 2008 NIMS Compliance Objectives

Adoption

1. Adopt NIMS throughout the healthcare organization, including all appropriate departments and business units.
2. Ensure Federal Preparedness awards support NIMS Implementation (in accordance with the eligibility and allowable uses of the awards).

Preparedness: Planning

3. Revise and update emergency operations plans (EOPs), standard operating procedures (SOPs), and standard operating guidelines (SOGs) to incorporate NIMS and National Response Framework (NRF) components, principles, and policies, to include planning, training, response, exercises, equipment, evaluation, and corrective actions.
4. Participate in interagency mutual aid and/or assistance agreements, to include agreements with public and private sector and nongovernmental organizations.

Preparedness: Training and Exercises

5. Identify the appropriate personnel to complete ICS-100, ICS-200, and IS-700, or equivalent courses.
6. Identify the appropriate personnel to complete IS-800 or an equivalent course.
7. Promote NIMS concepts and principles into all organization-related training and exercises. Demonstrate the use of NIMS principles and ICS Management structure in training and exercises.

Communications and Information Management

8. Promote and ensure that equipment, communication, and data interoperability are incorporated into the healthcare organization’s acquisition programs.
9. Apply common and consistent terminology as promoted in NIMS, including the establishment of plain language communications standards.
10. Utilize systems, tools, and processes that facilitate the collection and distribution of consistent and accurate information during an incident or event.

Command and Management

11. Manage all emergency incidents, exercises, and preplanned (recurring/special) events in accordance with ICS organizational structures, doctrine, and procedures, as defined in NIMS.
12. ICS implementation must include the consistent application of Incident Action Planning (IAP) and common communications plans, as appropriate.
13. Adopt the principle of Public Information, facilitated by the use of the Joint Information System (JIS) and Joint Information Center (JIC) during an incident or event.
14. Ensure that Public Information procedures and processes gather, verify, coordinate, and disseminate information during an incident or event.
Hospitals are not mandated to comply, but they will not receive certain federal funding if they do not. The National Bioterrorism Hospital Preparedness Program of the HHS assistant secretary for preparedness and response (ASPR) to the state’s department of health has provided implementation guidance and deadlines. The current 14 implementation activities are consistent with the NIMS components. Exhibit 2.4 illustrates the 14 implementation activities for hospital compliance.

THE NATIONAL RESPONSE FRAMEWORK (NRF)

The NRF replaces the NRP. NRF provides guiding principles for a unified national response. It is built on a scalable, flexible, and adaptable coordinating structure to align key roles and responsibilities across the nation. It describes specific authorities and best practices for managing incidents that range from the serious but purely local to large-scale terrorist attacks or catastrophic natural disasters. Most important, it builds upon NIMS, which provides a consistent template for managing incidents (DHS 2008, 1).

The National Response Framework (NRF)
The Framework is made up of the core document, the Emergency Support Functions (ESF), Support and Incident Annexes, and the Partner Guides.

- The Core Document lays out the doctrine that guides our national response, explains the roles and responsibilities of the individuals and organizations involved, presents the response actions that should be taken, and lists the response organizations and planning requirements needed to achieve an effective national response to any incident.
- Emergency Support Function (ESF) Annexes group federal resources and capabilities into the functional areas that are most frequently needed in a national response.
- Support Annexes describe essential supporting aspects that are common to all incidents, such as financial management and private sector coordination.
- Incident Annexes address unique aspects of our responses to seven broad incident categories (e.g., mass evacuation, biological, cyber).
THE CATASTROPHIC INCIDENT SUPPLEMENT (CIS) TO
THE CATASTROPHIC INCIDENT ANNEX TO THE
NATIONAL RESPONSE FRAMEWORK (NRF-CIS)

A catastrophic incident, as defined by the National Response Framework, is any natural
or man-made incident, including terrorism, that results in extraordinary levels of mass
casualties, damage, or disruption severely affecting the population, infrastructure,
environment, economy, national morale, and/or government functions. A catastrophic
incident could result in sustained nationwide impacts over a prolonged period of time;
almost immediately exceeds resources normally available to state, tribal, local, and
private-sector authorities in the impacted area; and significantly interrupts governmen-
tal operations and emergency services to such an extent that national security could
be threatened. These factors drive the urgency for coordinated national planning to
ensure accelerated federal and/or national assistance (DHS 2008).

A catastrophic incident will likely trigger a presidential major disaster declara-
tion. In these situations, the National Response Framework Catastrophic Incident
Annex (CIA) is designed to address (DHS 2008)

1. no-notice or short-notice incidents of catastrophic magnitude,
2. where the need for Federal assistance is obvious and immediate,
3. where anticipatory planning and resource pre-positioning were precluded, and
4. where the exact nature of needed resources and assets is not known.

The planning assumption is that a catastrophic incident will result in many
casualties and displaced persons, possibly in the tens to hundreds of thousands. In
an incident response, human life-saving operations are given priority.

INCIDENT CONDITIONS

Normal procedures for certain emergency support functions may be expedited or
streamlined to address the magnitude of the incident. The federal government and other
national entities will provide expedited assistance in one or more of the following areas:

- Mass Evacuations (ESF #5)
- Mass Care, Housing, and Human Services (ESF #6)
- Search and Rescue (ESF #9)
- Victim Decontamination (ESF #8) or Environmental Assessment and Decon-
tamination (ESF #10)
The Emergency Support Functions of the NRF

The federal resources of the NRF are organized along 15 ESFs. Each has a designated coordination agency, which is supported by resources from across the entire array of federal agencies and resources. The ESFs and their primary federal coordinating agency are:

- ESF #1: Transportation (DOT)
- ESF #2: Communications (DHS/National Communications System)
- ESF #3: Public Works and Engineering (DOD/U.S. Army Corps of Engineers)
- ESF #4: Firefighting (U.S. Department of Agriculture)
- ESF #5: Emergency Management (DHS/FEMA)
- ESF #6: Mass Care, Housing, and Human Services (DHS/FEMA)
- ESF #7: Resource Support (GSA)
- ESF #8: Public Health and Medical Services (HHS)
- ESF #9: Urban Search and Rescue (DHS/FEMA)
- ESF #10: Oil and Hazardous Materials Response (EPA)
- ESF #11: Agriculture and Natural Resources (U.S. Department of Agriculture)
- ESF #12: Energy (DOE)
- ESF #13: Public Safety and Security (DOJ)
- ESF #14: Long-Term Community Recovery (DHS/FEMA)
- ESF #15: External Affairs (DHS)

Health and medical functions fall primarily under ESF#8, Public Health and Medical Services, and ESF#6, Mass Care, Housing, and Human Services. HHS is the lead federal agency for ESF#8, with operational control of the U.S. Public Health Service. HHS also plays a significant role as a supporting agency for ESF#6, with FEMA as the lead federal agency.

REGULATORY AND STANDARDS-SETTING AGENCIES

A plethora of federal agencies provide input into the regulation and guidance of healthcare preparation for and response to disasters and critical events. The following is a list of agency categories and examples of each.
The Federal Response Process

Guiding principles for a proactive federal catastrophic incident response include the following.

- The primary mission is to save lives, protect property and critical infrastructure, contain the event, and protect the national security.
- Standard procedures may be expedited or temporarily suspended in the immediate aftermath of a catastrophic magnitude event.
- Pre-identified federal resources are mobilized and deployed.
- Notification and full coordination with states occur, but the rapid mobilization and deployment of critical federal resources should not be delayed by the coordination process.
- The secretary of Homeland Security immediately begins implementation of the NRF-CIA. Federal departments and agencies immediately
  - take actions to activate, mobilize, and deploy incident-specific resources in accordance with the NRF-CIS;
  - take actions to protect life, property, and critical infrastructure under their jurisdiction and provide assistance within the affected area;
  - commence those hazard-specific activities established under the appropriate and applicable NRF Incident Annexes, including the NRF-CIA; and
  - commence those functional activities and responsibilities established under the NRF ESF Annexes.

Based on notice and time for coordination and assessment, NRF-CIA actions that the federal government may take in response to a catastrophic incident may include

- mobilization and deployment of resources by scenario type;
- predeployment of appropriately tailored elements specified in the NRF-CIS, to meet the anticipated demands of the specific incident scenario; or
• provision of DOD capabilities in the following support categories: aviation, communication, defense coordinating officer/element, medical treatment, patient evacuation, decontamination, and logistics.
Appendix 2.1: Using the Hazards and Vulnerability Analysis

1. A hazards and vulnerability analysis (HVA) is used to determine the hazards that pose a realistic risk of interrupting continuity of patient care services and demand for care, and other consequences of a disaster.

2. The HVA is a fundamental component of a comprehensive emergency management program and is a compliance requirement among many licensing and accreditation organizations.

3. Hazard-specific risks are determined by comparing the likelihood of an event occurring, the potential impacts to the organization, and mitigation activities that would be deployed. It is completed using input from clinical and nonclinical disciplines.

4. By prioritizing hazards, an organization is able to strategically fund appropriate mitigation activities. This is particularly prudent considering the competing resource priorities of more direct patient care–related programs.

5. Hazard-specific response plans will guide healthcare responders with precise, event-related activities.

6. Response guides should include how an incident is assessed; trigger points for response activation; recommendations of who should be mobilized; and specific actions, resources, and equipment needed for the response.

7. Response guides should be routinely tested, evaluated, modified, and re-tested to ensure high levels of organizational response competency.

8. The HVA should be evaluated annually and following each exercise or actual incident.

9. The HVA priorities and planning activities should be shared with community response agencies to improve overall regional response capability.

10. In most cases, the HVA, combined with measurable mitigation activities, can reduce organizational costs such as insurance requirements or recovery costs.

Source:
Mitch Saruwatari
Vice President, Quality and Compliance
LiveProcess, Inc.
October 2009
Appendix 2.2: Ethics in Healthcare Management

- Discuss how your organization would approach ethical issues in a disaster before the disaster occurs. Crisis situations are not the time to have philosophical discussions about belief systems, cultural issues, or altering your standard of care. These ethical conversations need to happen in a thoughtful, reflective environment, where all parties potentially involved in the outcome can provide input.

- Know your legal landscape. Know what laws and standards related to disaster management apply to your facility and your response to a situation. Who has authority in a disaster to make ethical and legal decisions? Have those people been participants in discussions about issues related to disasters? Do you know what are considered “acceptable exceptions” to patient care in a disaster? For example, when is it permissible to deviate from EMTALA or HIPAA regulations? Develop and maintain a list of resources for legal assistance and information and put it in your disaster response handbook.

- What planning have you done to expand your scope of services in a disaster beyond medical surge planning? Have you considered extending the scope of services for some of your staff? How will you manage volunteers coming into your facility? Will you alter your facility to accommodate patients beyond your bed capacity? Have you discussed how you would alter your standards of care (such as universal precautions) in a disaster?

- Play the game “Worst Case Scenario” for your agency or facility. Have some hard conversations about the worst situations you can imagine and discuss how you would manage those situations from an ethical standpoint. What if there were an epidemic and you had to decide who got treatment and who would be left to die?

- Don’t assume! Do not assume that someone else will be making ethical legal decisions in a disaster. You never know what situation you may face. Hurricane Katrina taught us that lesson. The established lines of authority may not exist—you may be the only authority!

- What planning have you or your healthcare partners in the community done for vulnerable populations in a disaster? Special needs populations will have different and specialized needs in a crisis and will require more of your
resources. How have you planned for these individuals? What ethical dilemmas would their care create?

- Identify resources. Know where you are going to get scarce resources. Have mutual aid agreements in hand with other healthcare facilities and with vendors so you have backup planning when the expected resources are not available or run out. This will avoid having to make ethical decisions as to who will get resources and who will not.

- Talk with your staff about ethical issues in disasters. What do they think their obligations are in a disaster? Should they be required to risk their lives? Would they choose their family over work, and if so, how can you help them to be better prepared at home for a disaster so they can report to work?

- Include ethical issues in your training exercises. Present your team with potential situations that make them consider what ethical decisions they may have to make.

- Know thyself! Examine your own cultural, religious, and life experiences and think about how you would react and make ethical decisions in a disaster. Again, the first time to have this conversation is not during the crisis, when decision-making skills and stress management are at their lowest level.

Source: Dee Grimm, RN, JD
CEO
Emergency Management Professionals