# Emergency Preparedness and the Development of Health Care Coalitions

## A Dynamic Process

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**KEYWORDS**

• Health care coalition • Patient surge • Resilience • Emergency preparedness

**KEY POINTS**

- Federally funded Hospital Preparedness Program and the Public Health Emergency Preparedness Programs have become aligned.
- Preparing for medical surge in the hospital and community is difficult.
- Health care coalitions can enhance health system resilience.
- Hospital evacuation is difficult to plan for and to carry out.
- Emergency preparedness requirements have changed and have additional requirements as defined by the Centers for Medicaid and Medicare Services (CMS).

### INTRODUCTION

Health care emergency preparedness and the importance of a well-rehearsed, coordinated response have never been more important to the health security of a community or to the nation. Whether it is the threat of terrorism, climate change resulting in flooding, or a new virus for which there is no cure, the health care system will be on the forefront of response. The ability of hospitals, health care systems and the emergency medical system (EMS) to quickly transfer patients, be ready for critically injured people, provide medical counter measures (MCMs), or to initiate just-in-time training to staff to keep people safe is always uppermost for any first responder or hospital first receiver.[1] The role of the nurse in emergency preparedness may not always be visible. Historically, the nurse has not only been the bedside caregiver but a leader in seeing the larger picture when it applies to the hospital or health care community. Nursing process involves collaboration, which is the foundation for effective emergency preparedness and the process of emergency management.[2]

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## HOSPITAL EMERGENCY PREPAREDNESS: HISTORY

Hospital emergency preparedness is not a new idea. Hospitals as part of cities and towns in the 1930s were involved with civil defense programs after learning of the pre-war activities in Europe. World War II civil defense efforts and later on in the 1950s continued as communities prepared for potential nuclear attacks, and hospitals prepared for mass casualties. One the earliest hospital evacuation exercises took place in Portland, Oregon, in 1955 as part of Operation Green Light, a civil defense exercise.[3]

Historically, hospitals crafted a disaster plan with a trauma or mass casualty focus. The disaster plan began in the emergency department (ED) and ended when the patient was admitted to the hospital, died, or was discharged. Leadership for the hospital disaster plan was often carried out by nurses and other hospital leaders including: the nurse manager in the ED, trauma nurse coordinator, ED medical director, trauma medical director, hospital safety officer, or the hospital facility manager. Hospital EDs maintained a supply of medical surgical supplies, triage tags, and premade patient charts. The hospital engineering staff checked the emergency generator as part of the requirements for facility management, and load bank tests were carried out. Training on the hospital disaster plan usually occurred once a year and included a review of specific processes through table-top exercises. The greatest effort for training usually occurred in the ED. It is important to note that things have now changed.

Hospitals have coordinated as needed with local and state health departments, particularly in the development of large systems such as Emergency Medical Services for Children (EMSC), developing resources for large-scale mass emergency pediatric critical care,[4] emergency medical systems (EMS), and state trauma systems. Public health departments have historically taken the lead with viral or bacterial diseases that have had the potential to impact large numbers of the population such as norovirus, polio, varicella, rubella, meningitis, foodborne illness, and influenza. Highly virulent public health threats including Ebola virus disease (EVD), pandemic influenza, severe acute respiratory syndrome (SARS), and Zika virus disease require close coordination of both hospitals and public health officials to ensure accurate case counts, worker protection, protocols for testing, processing of laboratory samples, and early identification of those with the disease.

The National Defense Authorization Act for FY 1997 saw the allocation of funds aimed at enhancing domestic preparedness capabilities to respond to a weapons of mass destruction (WMD) incident. This act provided training to first responders (police and fire department) and to assist with the formation of metropolitan medical strike teams (MMSTs). WMD incidents are defined as terrorist-driven biological, chemical, radiological, and nuclear terrorism events. Training was provided to the 120 largest cities in the United States (by 1990 census data). The training, funded by the US Department of Defense (DoD), leveraged interagency coordination between US Federal Emergency Management Agency (FEMA), the US Department of Justice, and the DoD. Hospitals or the personnel responsible for emergency preparedness were not specifically included for training.[5] High-profile events such as the Atlanta Summer Olympics (1996) and the Salt Lake City Winter Olympics (2002) provided additional federal funds for first responders, public safety, and the development of patient care protocols. Hospitals may also choose to part of the National Medical Disaster System (NDMS). NDMS is a federal program comprised of partnerships between the Department of Health and Human Services (DHHS), the Department of Homeland Security (DHS) and the Department of Veteran's Affairs (VA). NDMS hospitals provide internal surge capability for disasters occurring in the United States, and also provide support to the military and VA hospital systems in providing casualty care for injured personnel from overseas conflicts.