

**INTEGRATING  
PROGRAM & PROFESSIONAL DEVELOPMENT IN  
HEALTHCARE EMERGENCY MANAGEMENT:  
TRENDS, PRINCIPLES & PRACTICES**

*December, 1998*

Department of Veterans Affairs  
Emergency Management SHG  
Training & Development

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# INTEGRATING PROGRAM AND PROFESSIONAL DEVELOPMENT IN HEALTHCARE EMERGENCY MANAGEMENT PROGRAMS

## ABSTRACT

The strategic intent, or mission of the Office of Emergency Medical Preparedness (OEMP) has been “to provide technical guidance, support, management, and coordination necessary to conduct programs ensuring health care for eligible veterans, military personnel and the public during Department of Defense (DoD) contingencies, natural, man-made and technological disasters.”<sup>1</sup> As part of the re-engineering of the Veterans Health Administration (VHA), OEMP has been identified as a headquarters function to become a Strategic Healthcare Group, or SHG. SHGs are multi-disciplinary groups, organized and aligned to support Service Lines of care by integrating data, skills, and “best practices” into system-wide policy, planning and service delivery strategies.<sup>2</sup> This paper identifies these key data, skills, and best practices in emergency management (EM), and proposes how these can be integrated into policy, planning and service delivery strategies which complement VHA’s direction towards a community healthcare management system.

## INTRODUCTION

The purpose of this paper is to describe important trends, principles and practices in health care, in EM and in professional development (PD) that are directly relevant to the future development of OEMP into EMSHG. PD is a human resource strategy that supports the organization’s strategic intent, culture and performance in the marketplace,<sup>3</sup> and thus is integral to organizational development.

The problem is designing and implementing EM programs of the highest quality and greatest value to our clients. Nationwide programs that strive to ensure health care for veterans, military personnel and the public during emergencies have implementation problems primarily due to the intergovernmental system. However, the literature and practical experience says capability development can best be enhanced by basing EM programs on valid assumptions about the behavior and motivations of individuals and groups, and by using intervention strategies with those responsible for continuity of care at the facility, community and network levels. This bottom-up, coordination-based approach provides more value because it is based upon the client’s needs and priorities, not on legal mandates.

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<sup>1</sup> OEMP Goals and Objectives, June 1997.

<sup>2</sup> Kizer, Fonseca, and Long, The Veterans Healthcare System: Preparing for the Twenty-First Century, Hospital and Health Service Administration, Journal of the American College of Healthcare Executives, Fall, 1997, p. 283.

<sup>3</sup> Vestal, Fralicz, Speier, Organizational Culture: The Critical Link Between Strategy and Results, Hospital and Health Service Administration, Journal of the American College of Healthcare Executives, Fall, 1997, p. 341.

This discussion is limited to identifying information from recognized authorities and translating these into implications for EMSHG.

What follows is a forecasting of the trends in the VHA health care system, in the practice of EM, and in PD initiatives both within the organization and industry-wide. System-wide policy, planning and service delivery strategies on which to build future PD efforts are identified and discussed, ending with recommendations for integrating program and professional development.

## **TRENDS IN THE VHA HEALTH CARE SYSTEM**

These trends include:

<u>FROM</u>	<u>TO</u>
Inpatient Acute Care	Ambulatory & Primary Care
Independence	Interdependence
Facility-centered	Patient-centered
Departments	Service Lines

### **ACUTE CARE TO AMBULATORY CARE**

Patterned after what was considered the best in American healthcare, for most of the past 50 years the Department of Veterans Affairs (VA) healthcare has focused primarily on acute inpatient care, high technology, and medical specialization. Now, in response to societal and industry-wide forces, the VHA is re-engineering the veterans healthcare system, changing the operational and management structure from individual hospitals to 22 Veterans Integrated Service Networks (VISNs) and transitioning the system to one that is grounded in ambulatory and primary care.<sup>4</sup>

### **INDEPENDENCE TO INTERDEPENDENCE**

Containing health care costs and other economic considerations have driven the process of integration within American health care. Prior to the 1970's there was almost total independence between physicians and hospitals. This "cottage industry" gave way to a period when physicians began to develop group practices and hospitals joined with other hospitals in other communities. This structure is referred to as "horizontal integration," (e.g. all facilities were of the same type or at the same stage of care available. This achieved pooled interdependence characterized by indirect relationships among facilities for economies of scale in purchasing, etc. All facilities operated similarly and there

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<sup>4</sup> Kizer, Fonseca, and Long, , The Veterans Healthcare System: Preparing for the Twenty-First Century, Hospital and Health Service Administration, Journal of the American College of Healthcare Executives, Fall, 1997, p. 283.

was some consolidation of staff. The clinical and administrative "sides of the house" were, however, still split organizationally.

In the 1990's, greater integration between the physicians and the healthcare system was occurring. This is referred to as "vertical integration," e.g. facilities were not all of the same type or at the same level/stage of care available. This model links the stages of production and distribution of health care into a chain spanning ownership or procurement of raw materials through to the consumer (satellite clinics, acute care centers, home health, nursing homes, etc.).

VHA's Vision for Change *is to create a clinically-integrated system* but first the system must reach vertical integration - thus the creation of VISNs is an intermediate step. A "clinically-integrated" system is referred to as a "Community Healthcare Management System," which seeks a hospital/health care alliance to include social services, education, etc. focusing on *health promotion and disease prevention*. This model is built on reciprocal interdependence between the clinical and administrative "sides of the house;" the healthcare system and its physicians, and the system and community.

#### **FACILITY-CENTERED TO PATIENT-CENTERED**

The VISN structure is based upon the concept of funding care for populations rather than on funding facilities. It aligns resources around patients by encouraging facilities to pool their resources, coordinate their services, rigorously manage their costs and blend their talents. This philosophy is operationalized by the merger and consolidation of individual treatment facilities; expanded sharing agreements between and among VA facilities; and implementing service lines of care at the VISN and facility levels.

#### **DEPARTMENTS TO SERVICE LINES**

A service line of care attempts to achieve an optimal sharing of resources, ideas and information in an effort to improve access, enhance quality, optimize efficiency and maximize service satisfaction.<sup>5</sup> Service lines are supported by the re-alignment of headquarters' functions into Strategic Healthcare Groups (SHGs).

#### **EMERGENCY MANAGEMENT SERVICE LINE**

The service line for ensuring continuity of care is the Environment of Care<sup>6</sup> (EC). The goal of the EC program is to provide a functional and safe environment for patients and other individuals served by or providing services in the

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<sup>5</sup> Kizer, Fonseca and Long, The Veterans Healthcare System: Preparing for the Twenty-First Century, Hospital and Health Service Administration, Journal of the American College of Healthcare Executives, Fall, 1997, p. 294.

<sup>6</sup> Joint Commission on the Accreditation of Healthcare Organizations.

organization.<sup>7</sup> Emergency preparedness is one of seven elements involved with protecting the EC of health care facilities nationwide, including all VA Medical Centers, as administered by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). The other elements of the EC include safety, security, hazardous materials and wastes, life safety, medical equipment, and utility systems. *{The title of this section, “emergency management” implies that “emergency preparedness” activities are only part of a more comprehensive system, and emergency management (EM) is by nature, an inter-organizational activity.}*

JCAHO created this “EM Service Line” after recognizing that a safe environment required the sharing of expertise between the various departments or functions within the healthcare facility which had significant roles in hazard mitigation, staff preparedness and the management of emergencies to ensure continuity of care. It is a multi-disciplinary team concerned with the design, education, implementation and evaluation of activities that are based upon the mission of that particular healthcare organization.

The intent of the emergency preparedness function within the EC is to prepare the internal organization to respond to disasters and to establish linkages to important community resources with which the hospital may need to coordinate information and support. Thus it aims to correct what one researcher found to be a common problem in the United States in 1985:

Disaster linkage is given little attention in Emergency Medical Service (EMS) system planning and operations. (M)edical sector disaster planning tends to be isolated from other community emergency planning efforts. Hospitals tend to develop medical disaster preparedness plans on their own according to guidelines of medical oversight groups such as the JCAHO without working with other organizations, except for providers of ambulance services and, occasionally, other hospitals. Planning tends to exclude providers of complementary or support services<sup>8</sup> {e.g. health departments, utility companies, etc.}

A recent review by the same researcher is not optimistic that any significant improvements have occurred:

More so than other crisis-relevant organizations, those in the EMS sector – particularly hospitals – face an uncertain and generally unsupportive financial environment. No research has been conducted on how the crisis in health care is affecting planning for disasters, but since disasters were never a major priority for most EMS organizations, we can assume they have moved down on the agenda.<sup>9</sup>

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<sup>7</sup> Ibid.

<sup>8</sup> Tierney, Emergency Medical Preparedness and Response to Disasters: The Need for Inter-organizational Coordination, Public Administration Review, Special Issue, 1985.

<sup>9</sup> Tierney, et. al., Disaster Response and Preparedness, 1997.

## **IMPLICATIONS**

- The shift from in-patient care to ambulatory care has resulted in fewer highly specialized hospitals in the community, dispersing the health care industry geographically out to satellite clinics and into patient's homes. This decentralization has increased the vulnerability of the infirm population(s) to the effects of disasters because the emphasis for disaster planning remains centered on national legal mandates and hospital facility requirements, not on managed care health systems.
- Another ramification of containing costs is the reduction of supplies and equipment maintained by healthcare facilities, which order today what they need tomorrow. Home health care has also created a population dependent upon medical logistics and infrastructure. While this may not be a problem in most disasters that occur at the local level, it may very well become critical in larger events that temporarily disrupt utility, communications and transportation systems.
- What emergency preparedness activities do occur within healthcare facilities are oriented on requirements imposed by the JCAHO. While the assessment of compliance with these standards has shifted from "evidence in writing" to more of "evidence of staff demonstrating knowledge on their roles," the standards do not incorporate EM processes or practices, nor has any research been conducted following a disaster to determine whether compliance with JCAHO standards made any difference, thus the standards may not even be valid.
- VA's (and the industry's) strategic intent is towards a clinically-integrated, community healthcare management system linked with private healthcare providers, social service organizations, education, etc. Research has shown that creating linkages between community organizations is key to developing the ability to manage the effects of disasters, although other research has indicated that most healthcare facilities pay little attention to disaster planning beyond that required by JCAHO.
- An important role of VA's healthcare system would be to provide leadership to the healthcare industry in comprehensive emergency management programs. First, to focus planning on patient's needs; second, to ensure that its facilities can survive and continue to function; third, to provide a coordinating role to other community health care system(s); and fourth, to serve as a backup resource to communities where access to health care has been severely disrupted.

## TRENDS IN THE PRACTICE OF EMERGENCY MANAGEMENT

Emergency management is the discipline and profession of applying science, technology, planning, and management to deal with extreme events that can injure or kill large numbers of people, do extensive damage to property, and create disruptions to community life.<sup>10</sup>

The trends in the practice of EM are:

FROM	TO
Hazard-specific	All-hazards
Agent-focus	Response-focus
Command & Control	Continuity, Coordination & Cooperation
Catastrophic	What Is Likely
Reaction	Proaction

### HAZARD-SPECIFIC TO ALL-HAZARDS

Emergencies and disasters occur in local communities, and the response to them involves a tiered system in America. Preparedness for emergencies is required at all levels – local, State, regional and national – as a basis for immediate response when an emergency threatens or occurs.<sup>11</sup> EM in the United States, thus, is an inter-organizational activity conducted in the intergovernmental system.

The fundamental legal power to deal with disasters resides at the State level with the Governor. This is referred to as police power (the 10<sup>th</sup> Amendment of the U.S. Constitution), or the general power to make laws for the protection of health, welfare, safety and the morals of the people.<sup>12</sup> The enforcement of these laws and the protection of public health and safety (response to emergencies) is a delegated responsibility of local government (town, city or county), carried out by law enforcement, fire protection and emergency medical service agencies. At a point when local resources are depleted or are insufficient to meet the needs posed by the situation, the chief executive of that political subdivision can request assistance from other local jurisdictions and/or from the Governor. The Governor can then make available any and all assistance needed by the local government. Then, at a point when the State's resources are insufficient, the Governor may request assistance from other Governors in adjacent States and/or from the President of the United States.<sup>13</sup> The assistance provided by the President is coordinated through the Federal Response Plan.

The traditional priorities of State and local governments have been on responding to natural and technological disasters, whereas the traditional focus

<sup>10</sup> Hoetmer, Introduction, Emergency Management: Principles and Practices for Local Government, International City Managers Association, Washington, D.C., 1991, p. xvii.

<sup>11</sup> VA policy 0320, p. 11.

<sup>12</sup> FEMA, Integrated Emergency Management Course.

<sup>13</sup> City of Indianapolis~Marion County, The Legal Basis of Emergency Response, 1990.

of the Federal government has been on continuity of government and civil defense from enemy attack. These two principal policy streams have shaped emergency management in the United States, resulting in an eventual alliance – albeit an uneasy one – an all-hazards orientation to EM policy, plan and programs.<sup>14</sup>

### EM POLICY

Since its creation in 1950, EM policy has evolved from a focus on civil defense against enemy attack to a doctrine of "dual use" (resources and capabilities developed for enemy attack could be applied to all types of natural disasters), through the creation of the Federal Emergency Management Agency (FEMA) to an "all hazards" orientation. Part of the re-orientation that occurred when FEMA was created was the consolidation of many separate agencies and programs dealing with various aspects of mitigation, preparedness, response and recovery into one approach.

The context for "all hazards" policy is called Comprehensive Emergency Management (CEM). CEM identifies the "life cycle" of disasters and the activities that correspond to them (e.g. these four phases are visualized as a circle, with recovery leading back to mitigation, and so on):

<b>EM Phase</b>	<b>Key Activities</b>
Mitigation	Building Codes Land Use Management Research Hazards Analysis Public Education
Preparedness	Warning & Communications Systems Resource Identification Emergency Plans Mutual-Aid Agreements Training & Exercises
Response	Alerting & Warning Shelter/Evacuation Search and Rescue Emergency Medical Services Mass Care
Recovery	Damage Assessment Crisis Counseling Debris Clearance Disaster Assistance Re-building <sup>15</sup>

<sup>14</sup> Drabek, The Evolution of Emergency Management, Emergency Management: Principles and Practices for Local Government, International City Managers Association, Washington, D.C., 1991, p. 3.

<sup>15</sup> Godschalk, Disaster Mitigation and Hazards Management, Emergency Management: Principles and Practices for Local Government, ICMA, pp. 136.

## EM PLAN AND PROGRAM

CEM is implemented through the Integrated Emergency Management System (IEMS). IEMS provides the basis for both the developments of the “all hazards” *plan* as well as an “all hazards” *program*. IEMS planning identifies *functions* that are required for all hazards.<sup>16</sup> The Federal Response Plan is an example of the IEMS methodology of identifying key functions needed in *any emergency* and organizing the various Federal agency capabilities into one approach (functions supported by VA are underlined below). IEMS attention to functions provided a way to integrate plans that had been based on different types of emergencies, or on different agencies.

### **Basic Plan**

(Overall management & coordination)

### **Emergency Support Functions**

Transportation  
Communications  
Public Works & Engineering  
Firefighting  
Information and Planning  
Mass Care  
Resource Support  
Health & Medical Services  
Urban Search and Rescue  
Hazardous Materials  
Food  
Energy

On the *program development* side, IEMS defines the *steps* that a community takes to assess its current capabilities and then devises strategies to close the gap between existing and desired levels of capabilities:

- Assessment of the status of the current program through an audit and the establishment of goals and priorities.
- An appraisal of hazards and their primary and secondary effects (needs assessment).
- Mitigation activities designed to reduce the effects of those hazards
- The development of capabilities (preparedness activities of staff education, planning, training, exercises, purchase of equipment/supplies)
- Emergency operations (response and recovery).
- Identification of shortfalls in capability (evaluation activities including, after-action critiques from exercises or actual events providing the feedback loop to unmet preparedness issues)
- A multi-year development plan to guide the overall mitigation, preparedness, response and recovery activities. The multi-year development plan is reviewed annually and its annual work increment guided by goals, objectives and strategies.<sup>17</sup>

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<sup>16</sup> Hoetmer, Introduction, Emergency Management: Principles and Practices for Local Government, International City Managers Association, Washington, D.C., 1991, p. xx-xx1.

<sup>17</sup> IEMS Course.

## EM IMPLEMENTATION

An approach that was first developed to enhance the effectiveness of inter-agency operations for large wildfires in southern California in the early 1970's has continued to evolve and become more universal to disaster management by all sectors. The Incident Management System (IMS), part of the National Inter-agency Management System (NIIMS), creates a structure conducive to integrating many organizations for on-scene operations. Consolidated action plans (underlined) provides the tactical coordination of the plan through management-by-objectives. The IMS is based upon eight system design criteria and is implemented through five management functions:

<b>Design Criteria</b>	<b>Management Functions</b>
<ul style="list-style-type: none"><li>• Common terminology</li><li>• Modular organization</li><li>• Integrated communications</li><li>• Unified management structure</li><li>• <u>Consolidated action plans</u></li><li>• Manageable span-of-control</li><li>• Pre-designated incident facilities</li><li>• Comprehensive resource management<sup>18</sup></li></ul>	Management Plans Logistics Administration Operations

The State of California realized the potential IMS had “above the scene” and has developed the Standardized Emergency Management System (SEMS), which all disaster-relevant agencies are required to use as a means of inter-organizational coordination at the incident site(s) and in emergency operations centers at the local government, county government, mutual-aid region, and State levels.<sup>19</sup> SEMS illustrated how the five functions of IMS enable any jurisdiction’s IEMS-based plan to be easily integrated into one approach for improved coordination. This management structure is, thus, perfectly suited for linkage with the Federal Response Plan (FRP)

VA Headquarters organizes its Disaster Coordinating Team (DCT) around key functions necessary to manage continuity of operations, delivery of services, and coordination of support to the FRP.

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18 National Inter-agency Incident Management System, Incident Management System, Operational System Description, Fire Protection Publications, Oklahoma State University, p. 7.

19 Governor’s Office of Emergency Services, State of California, Standardized Emergency Management System, Part II: Planning and Developing SEMS, B. Local Government, p. 5, 1994.

<b>Function</b>	<b>Primary</b>	<b>Alternate</b>
Coordination	Chief Network Officer	<u>Director, EMSHG</u>
Health Care Delivery	Under Secretary for Health (USH)	Dep. USH
Employee Information	DAS, Human Resources (HR)	ADAS, HR
Supply, Equip & Trans	DAS, Acquisition & Material Mgmt. (A&MM)	ADAS, A&MM
Vital Records	DAS, Information Resources Mgmt. (IRM)	ADAS, IRM
Finance	DAS, Financial Mgmt. (FM)	ADAS, FM
Damage Assessment	DAS, Chief Facilities Mgmt. Officer (FMO)	Dep. Chief, FMO
Communications	ADAS, Telecommunications (TC)	Dep. Dir., TC
News Media Liaison	DAS, Public Affairs (PA)	Dir., OPA Field Opts.
Law & Legislation	General Counsel (GC)	Dep. GC
Congression Relations	DAS, Congressional Affairs (CA)	Dir., CA
Burial Planning	Director, NCS	Dir., NCS Field Opts.
Veterans Benefits	Under Secretary for Benefits (USB)	Dep., USB
FEMA Liaison	DAS, Security & Law Enforcement	Dir., EPAD <sup>20</sup>

Hospital disaster plans have also changed radically over the last ten years. While it was common to only focus on how the hospital would manage external disasters (e.g. how it would expand to treat casualties arriving at the emergency room), planning then began to consider both internal and external events. Current plans now incorporate the principles of CEM, IEMS, and IMS/SEMS so that network, hospital and the community's emergency management plans can link. The example below was taken from the proposal a multi-disciplinary study group submitted in 1995 to illustrate how these principles could be applied to a comprehensive national, network, facility EM program.

<b>Functions</b>	<b>Coordinating Responsibility</b>
<b>Key Tasks</b>	
Management & Planning	Directors Office, Emergency Manager
Warning	
Alerting/Notifications	
Incident Action Planning	
Emergency Policies	
Situation Status	
Resource Status	
Liaison & Coordination	
Documentation & Reports	
Public Information	
Logistics & Finance	AM&M & Fiscal
Procurement/Contracting	
Compensation & Claims	
Time Accounting	
Cost Accounting	
Transportation	
Personnel	
Communications	
Supply	
Vehicle Maintenance	

<sup>20</sup> VA Handbook, 0320.1, p. E-2.

Plant & Utilities	Engineering
Communication/Information Systems	
Sanitation Systems	
Potable Water Systems	
Environmental Systems	
Patient Care Systems	
Structural Assessment	
Debris Clearance	
Records Preservation	
Business Relocation	
Construction/Demolition	
Safety & Security	Safety & Security/Law Enforcement
Hazardous Materials & Decontamination	
Fire Suppression	
Rescue	
Security	
Site/Perimeter Control	
Staging/Traffic Control	
Investigations	
Health & Medical	Chief of Staff
Patient Care	
Mental Health	
Patient Administration	
Patient Relocation	
Welfare Inquiries	
Fatalities Management	
Environmental Health <sup>21</sup>	

### **AGENT-FOCUS TO RESPONSE-FOCUS**

The all-hazards orientation is supported by research that identified two sets of demands which occur simultaneously during emergencies: *agent-generated demands*, or those caused by the hazard agent(s); and *response-generated demands*, or those created within and between the organizations, groups and individuals when responding to the agent.

Agent-generated demands include: warning, pre-impact preparation, search & rescue, care of the injured and deceased, attending to welfare needs, restoration of essential services, protection against continuing threat, and community order. Response-generated demands include communication, continuing assessment of the situation, mobilization and utilization of resources, coordination, and the exercise of authority.<sup>22</sup>

<sup>21</sup> EMPO, Study Group on Comprehensive Emergency Management Programs for VHA Healthcare Facilities, 1995.

<sup>22</sup> Dynes, Community Emergency Planning: False Assumptions and Inappropriate Analogies, International Journal of Mass Emergencies and Disasters, pp.151-2.

Let us assume that an earthquake produced a number dead and a number injured over a wide geographical area. The dead and injured can be considered agent demands on the emergency system. On the other hand, in order to handle those demands, the emergency system needs rapid and accurate communication; ways to mobilize and utilize human resources in search and rescue have to be coordinated with existing medical facilities; etc. In effect, there are certain demands made on the emergency system created by the response itself. The suggestion here is that emergency planning should focus on response-generated demands, rather than on possible agent-generated demands. Thus, planning should be directed towards developing an effective response...by concentrating on structures that facilitate coordination of a multi-organizational response.<sup>23</sup>

### **COMMAND & CONTROL TO CONTINUITY, COORDINATION & COOPERATION**

The assumptions upon which civil defense policy, plan and program approaches were based come from military experience. This command and control orientation is referred to as the military or “dominant” model. This, however, is changing in realization that command and control is not as appropriate an assumption as coordination and supervision in American society.

#### **DOMINANT MODEL**

Much of our current orientation to EM is based upon extending military experience to planning for domestic emergencies (largely a result of EM’s beginnings in civil defense from enemy attack). The military, or “dominant planning” model views emergencies as conditions of social chaos, rectified only through exercise of *command and control*. The dominant model is based upon several invalid assumptions: it assumes a sharp distinction between pre-emergency (normalcy) and emergency (chaos) periods, requiring extraordinary measures to put normalcy back in place. Inherent to this is the belief in the weakness of individuals and social structures, requiring planning to be directed at establishing command over the chaos and regaining control over the disorganization of people. Thus, only when command and control is established, can normalcy return.

The idea of command and control is undercut, however, by the actual organizational arrangements that evolved to support it. These are characteristically inter-governmental, inter-organizational and multi-disciplinary (federal-state-local, and within each level, the participating agencies and organizations include government, the private sector, volunteers, etc., who represent social services, engineering, medicine, etc.). The emergency management system has been described as “a loosely-coupled organizational system,” or one involving “shared governance.” Reflecting American society, beliefs in autonomy and pluralism resist the ability of any one organization to the control of another.

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<sup>23</sup>

ibid., p. 152.

## PROBLEM-SOLVING MODEL

A more realistic model is derived from research on organized behavior and is focused on the notion of *problem solving* – that emergencies are, in effect, sets of problems that have to be solved with some degree of speed and effectiveness by the existing resources. To solve problems, a social process needs to be created which can collect information, allocate resources, determine priorities among critical needs and utilize most effectively the resources, which are available.

The problem-solving model is based upon these assumptions:

Continuity - Emergency planning is, in effect, a guide for behavior appropriate to certain situations. *One key assumption is that the best predictor of behavior during emergencies is that behavior prior to them.* Planning should support the concept that social units (families, neighborhoods, plants, communities, etc.) are decision-making/problem-solving units in normal times and this does not change during emergencies. The problem-solving model assumes the resources from the pre-emergency community are relevant and sufficient. And that the conditions of the emergency period will not be characterized by social chaos but by the continuity of effort and structure. The problem-solving model does not assume what is needed is a top-down, rigidly controlled and highly centralized pattern of social organization. Since this pattern of social organization is not effective in pre-emergency communities, there is no reason to expect that it will be effective in emergency situations.

Coordination – *Another key assumption is that effective planning requires knowledge about the pre-emergency organizational domains.* Instead of creating "emergency-specific" authority, pre-existing authority serves as the base, and is enhanced by getting all of the players together in common planning and rehearsal activities, personal contact, liaison activities, establishing shared facilities, etc. If this is built on the base of pre-existing behavior - no detailed descriptions are necessary. The core of planning should be focused on mechanisms, techniques and facilities that promote inter-organizational coordination and common decision-making. Coordination provides the flexibility that supports the problem-solving model. Authority will change during the event - no need to determine it exactly prior to it - it gets sorted out as the event unfolds.

Cooperation – *The third key assumption is that emergencies do not create loss of personnel, but rather the reverse occurs, you have more manpower because of emergent behavior.* Problems lead to emergent phenomena. All problems cannot be solved through existing organizations, so planning needs to consider the utilization of volunteers. A key element of planning is to develop mechanisms for integrating emergent and convergent activities that are necessary to solve the problem. Improvisation is good and natural and is desirable as an approach to problem solving.<sup>24</sup>

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<sup>24</sup> Ibid., p. 153.

<sup>25</sup> Auf der Heide, The Apathy Factor, Disaster Preparedness: Principles of Preparation and Coordination, C.V. Mosby, 1989, pp. 24.

## **CATASTROPHIC TO WHAT IS LIKELY**

Disaster planners at the national level believe the best planning philosophy is to prepare for the worst case scenarios. They anticipate disasters involving tens of thousands of casualties *{e.g. the National Disaster Medical System and the VA/DoD Contingency Hospital System}*. ... There are, however, several problems associated with planning for disasters of this magnitude:

- They may conjure up hypothetical possibilities of such immensity as to make most despair at ever being able to cope with them. In other words, such scenarios *amplify apathy*.
- Most of the research on disasters in the United States has focused on relatively moderate events involving tens to hundreds of casualties. The applicability of this knowledge to cataclysmic disasters involving tens and hundreds of thousands of casualties is questionable. Although such “cataclysmic” disasters have occurred in foreign countries, the socio-political context is so different from the United States that it is unclear whether we can apply lessons learned from them to our own culture and form of government. In other words, while we now know a fair amount about how to plan for smaller disasters, we know little about how to plan for cataclysmic ones. Therefore, when it comes to applying limited resources to planning, *it makes sense to plan for those events for which we have the knowledge to plan*.
- Applying resources to prepare for the most improbable type of disaster – the cataclysmic one – is not cost-effective. It is also not the best approach when we have not first become proficient at handling small disasters, which are reasonably likely to occur. It is like signing up for very expensive dance lessons before learning to walk.<sup>25</sup>

Research has demonstrated, however, that domestic civilian disasters are characterized not by the need to care for life-threatening trauma but rather by a predominance of relatively low severity injuries, including those who have lost their normal sources of medical care. This fact is juxtaposed by the perception of disasters as emergencies that exceed the resources available to manage them, or “overwhelming” the community. Except in rural areas, the United States has enjoyed enough skilled personnel and sufficient medical facilities to respond to meet healthcare needs. More typically, the problems seen in disasters are not a shortage of resources but failures to coordinate their distribution. A study of 29 mass casualty incidents revealed there were supply shortages in only 6% of the hospitals involved in the responses and personnel shortages in only 2% of them. Many hospitals, in fact, had more staff and volunteers than they could actually use.<sup>26</sup>

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<sup>26</sup> Auf der Heide, Designing a Disaster Plan, Presentation to the Scientific Assembly of the American College of Emergency Physicians, Washington, D.C, September, 1995, pp. 3-5.

The Disaster Research Center studied community general hospitals and found five weaknesses in their ability to respond to external disasters (all response-generated demands):

- Mobilization
- Information processing
- Task Assignment
- Decision-making
- Inter-organizational relationships<sup>27</sup>

Primary attention should be paid to the common problems cited in the research and after-action reports of almost every disaster and training exercise:

- Little or no capability for inter-agency communication
- Ambiguity of authority
- Poor utilization (if any) of special resources
- Unplanned media relationships usually negative in nature.<sup>28</sup>

*(Please note that both of the lists above reflect response-generated demands.)*

### **REACTION TO PROACTION**

Similar to the trend in health care away from treating the effects of disease to preventing disease through health promotion, the trend in EM is not on reacting to disasters but on proaction to lessen the impact when disasters do occur by embracing the concept of mitigation, disaster-resiliency and sustainable development.<sup>29</sup>

### **IMPLICATIONS**

- Resources dedicated to preparing to respond to catastrophic disasters (deployment) need to be balanced with resources directed at preventing loss of essential services and improving the ability to solve common, response-generated problems seen in smaller, more frequent events (program development). Efforts to improve EM programs at the VISN, community and Medical Center levels are critically important to supporting Federal response efforts, since it is from those programs the assets come.
- EM programs should be based upon knowledge gained from research rather than on conventional wisdom based upon military experience. Research into organizational behavior following emergencies provides enough evidence that our traditional approach of designing programs to

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<sup>27</sup> Quarantelli, The Community General Hospital: Its Immediate Problems in Disasters, Disaster Research Center, 1970.

<sup>28</sup> Emergency Response Institute, Lessons Learned from the Disaster Research, Managing Emergency Operations: A Blueprint for Community Emergency Management, Olympia, WA., 1992.

<sup>29</sup> FEMA, National Mitigation Strategy.

“help the victims after a disaster” is not an appropriate priority, rather, programs need to be designed which provide people with the skills they will need to help themselves.

- Three approaches have served to integrate EM program development, disaster planning and incident management activities (CEM, IEMS, and IMS/SEMS) over the past 25 years, through the *attention to functions generic to all types of emergencies*. CEM provides the policy, IEMS provides the strategy for plan and program development, and IMS/SEMS provides the method for tactical implementation.

## **TRENDS IN PROFESSIONAL DEVELOPMENT**

Professional Development (PD) embodies activities designed to provide an organization’s employees the knowledge, skills and abilities (KSAs) required to be successful in the roles and responsibilities of their career. Within the organization, PD is a responsibility of the Training & Development (T&D) section.

The trends include:

<u>FROM</u>	<u>TO</u>
Ad Hoc	Professionalization
Prescriptive	User-Driven
Isolated	Integral

### **AD HOC TO PROFESSIONALIZATION**

PD within EM has been receiving increasing interest in recent years. Early efforts were lead by the Federal Emergency Management Agency (FEMA) through its Professional Development Series (PDS) of instructional courses offered through the State Emergency Management Agencies (non-resident courses) and resident courses at its National Emergency Training Center, which consists of the Emergency Management Institute and the National Fire Academy. A Home Study Series of courses also were available to provide an awareness of the field.

Professional associations emerged such as the International Emergency Management Association (IEMA), representing local emergency managers) and the National Emergency Management Association (NEMA) (representing state emergency managers), and the American Society for Professional Emergency Planners (ASPEP). One primary purpose was constituency building for more effective representation, and another was based on an interest to formalize the emerging profession. FEMA offered a certificate upon completion of the PDS, but at the time, the courses were still largely oriented on civil defense programs. IEMA exerted leadership in professionalizing the field through its Certified Emergency Manager program. This program was funded by FEMA and involved

five years of consensus-building, occupational and educational design to validate the critical KSAs. FEMA, in 1996, initiated its Higher Education Project, which today has promulgated and distributed an EM curriculum to all colleges and universities in the country. Since 1997, FEMA and NEMA developed the landmark Capability Assessment for Readiness (CAR) program evaluation tool, which will be paired with the National Fire Protection Association (NFPA) standard 1600, Recommended Practice of Emergency Management. NFPA 1600 will carry an accreditation, possibly through college and university programs participating in FEMA's Higher Education Project.

### **PRESCRIPTIVE TO USER-DRIVEN**

PD activities offered by T&D have employed direct and indirect approaches focused on the identification of relevant subject matter and systems to support the roles of selected headquarters staff and Area Emergency Managers (AEMs), who are generally GS-13/14/15 grade-level employees. These activities include education, training, independent study, field experience, networking, participation in case studies and mentoring. Employees are also encouraged to pursue educational opportunities offered by the State Emergency Management Agencies, professional associations, and training vendors.

PD activities have never been planned or funded on a multi-year basis, rather the formal education and training programs were conducted in response to events that occurred: Operations Desert Shield/Storm (1990-1), and thus the clinical and administrative updates to *the VA/DoD Contingency Hospital System*, leading into the *Preceptor Program* for two regions (1992-5); the publishing of the Federal Response Plan and Hurricane Andrew (1992), and the interest in training for *deployment*; the bombing of the Alfred P. Murrah Federal building (1995) and the Centennial Olympics (1996), leading to education efforts centered on the *management of the consequences of terrorism*.

Headquarters-supported activities include the Professional Development Library (PDL) where employees have received reference manuals on a monthly basis since 1992, and also attended an annual conference and agency meeting whose agendas reflect current issues and approaches to emergency health and medical services.

In an attempt to achieve a more user-driven approach, T&D developed the Roadmap to Professional and Program Standards (Roadmap) project which was initiated in 1996. Envisioned to “establish an on-going process linking individual and organizational development to produce enhanced performance.”<sup>30</sup> Its objectives were to:

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<sup>30</sup> Training and Development, Roadmap to Professional and Program Standards, September, 1996.

- Improve headquarters - field coordination
- Identify areas where headquarters could offer more effective support to the field
- Achieve more consensus between AEMs on major program activities and roles
- Base an internal certification on internal needs with similarity to the requirements of external professional credentialing (NCCEM<sup>31</sup>).

Why a different type of certification was felt necessary was that while AEMs basically coordinated EM programs, their work focused on the health and medical service function within the larger EM system. Another barrier posed by applying the NCCEM certification was its expense and the inability of the organization to neither fund employee certification, nor require they fund it themselves.

Once the field program managers reached consensus on what it was that made their programs successful, the designers hoped to eliminate the “program labels” (e.g. NDMS, VA/DoD, etc.) and arrive at two basic lists: key activities and education required. As a result of the first set of meetings, the key activities of AEMs were:

- Manage
- Educate
- Establish committees
- Liaison
- Plan
- Inter-agency coordination
- Analysis, evaluation and feedback

Specific education requirements were:

- Comprehensive emergency management
- Inter-agency coordination
- Emergency planning
- Incident management system
- Exercise design, management & evaluation

These and other findings from the first round of the Roadmap meetings were summarized by T&D and were incorporated into the following training plan:

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<sup>31</sup> National Coordinating Council on Emergency Management, Falls Church, VA.

T&D, using the “education required,” submits a three-phased curriculum to the Birmingham Education Center (BEC) for accreditation with the American College of Healthcare Executives (ACHE). These courses would comprise the educational portion of the “Basic Certification.” This coursework would include:

- Employees complete a Self-Assessment & Primer (conducted during the first quarter of Fiscal Year (FY) 1998).
- Conduct an Advanced Preceptor Course (Comprehensive Emergency Management for VHA Health Care Facilities) during the 2nd quarter of FY 98.
- Conduct a Deployment Course at the annual conference (3rd quarter, FY 98).
- After satisfactory completion of assignments and tests, the BEC would issue an ACHE-accredited “Basic Emergency Health & Medical Services Certificate.”
- Training and Development would then submit a proposal for specialist courses in the following four areas:
  - Environment of Care.
  - Multi-Facility Emergency Planning.
  - Field Operations.
  - Exercise Management.
- A Board of Visitors would be created to review and refine the Basic and Advanced Certificate Programs.<sup>32</sup>

### **ISOLATED TO INTEGRAL**

PD is a human resource strategy integral to – not isolated from – strategic intent, culture and performance.<sup>33</sup> A Program Guide on PD would integrate the data, skills and best practices of the profession and it would spell out the actions needed to prepare employees to successfully accomplish their responsibilities. These responsibilities would be based upon system-wide policy, organizational planning and service delivery strategies.

- **SYSTEM-WIDE POLICY: PROVIDING A COMPREHENSIVE CONTEXT**

CEM, IEMS and IMS are policy, plan and program foundations for the EM profession because the inclusive context they provide simplifies the fragmentation that results from the various legal mandates which assign emergency responsibilities. None of these principles are in conflict with VA’s policy on emergency preparedness, they are, in fact the means by which it is currently being implemented.

For example, VA policy states: VA will have sufficient capabilities ... to meet essential needs during a national emergency ...{which} includes *any occurrence*, natural disaster, technological or other emergency, including war or the threat of

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<sup>32</sup> Training and Development, Feedback from the Roadmap Project, June, 1997.

<sup>33</sup> Vestal, Fralicz, Speier, Organizational Culture: The Critical Link Between Strategy and Results, Hospital and Health Service Administration, Journal of the American College of Healthcare Executives, Fall, 1997, p. 341.

war, that seriously degrades or seriously threatens the capability of VA to meet its mandated responsibilities.<sup>34</sup>

VA's Director of Emergency Planning and Administration (responsible for overall Department emergency preparedness policy, plan and programs, and liaison to FEMA) was consulted on these questions: "Is the "all hazards" policy of CEM consistent with VA policy?" The answer was yes. Another question was "Has VA's policy changed over the last five years?" The answer was no. A third question was, "Can IEMS be used as the basis for planning and program development?" The answer was yes; in fact it is the basis for the assignment of responsibilities in the Handbook.<sup>35</sup>

- **ORGANIZATIONAL PLANNING: PLACING VETERANS FIRST**

The framework established in the Veterans Health Administration's (VHA) strategic plan for the period 1997-2002 should serve as a pattern for transitioning the Emergency Management Strategic Healthcare Group (EMSHG) into an organization that exemplifies the new VHA. The indented material was excerpted from the *Journey of Change II*. The discussion that follows the VHA Mission Goals and Domains/Themes adapts them to emergency management programs, including ideas for 2002 Strategic Targets, Annual Performance Measures and Operational Strategies and Actions. These ideas are merely extensions of the major points of this paper and primarily concern professional development within the larger context of organizational planning.

#### MISSION, VISION, STRATEGY, GOALS AND DOMAINS/THEMES

##### VHA MISSION STATEMENT

*The mission of the Veterans Healthcare System is to serve the needs of America's veterans by providing primary care, specialized care and related medical and social support services. To accomplish this mission, VHA needs to be a comprehensive, integrated healthcare system that provides excellence in healthcare value, excellence in service as defined by its customers, and excellence in education and research, and needs to be an organization characterized by exceptional accountability and by being an employer of choice.*

##### VHA VISION STATEMENT

*Healthcare VAlue begins with VA. The new veterans healthcare system supports innovation, empowerment, productivity, accountability and continuous improvement. Working together, we provide a continuum of high quality healthcare in a convenient, responsive, caring manner – and at a reasonable cost.*

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<sup>34</sup> VA Policy 0320, p. 3.

<sup>35</sup> Telephone conversation with Howard Boyd, January 7, 1998.

## VHA STRATEGY STATEMENT

*VHA's strategy is to provide excellent healthcare value and customer satisfaction to veterans through the integration of performance measurement, strategic planning and financial goals and targets to achieve a patient-oriented, ambulatory care-based, results-driven, organized system of coordinated healthcare delivery focused on continuous quality improvement.*

## MISSION GOALS AND DOMAINS/THEMES

In order to implement the VHA strategy, the *Prescription for Change* identified five mission goals that translate the Mission, Vision and Strategy into goals that are the organizing principles for aligning the activities in the strategic plan. The goals provide the basis for a long run plan that is unified, comprehensive and integrated.

Mission Goals I and II are accomplished through the Domains of Value which are the critical success factors for these mission goals, and yet, Value is embodied through all five mission goals. Mission Goals III, IV and V are accomplished primarily through Strategic Themes which are the critical success factors for these mission goals.

## EMERGENCY MANAGEMENT PROGRAMS AND THE VHA MISSION GOALS

### I. PROVIDE EXCELLENCE IN EM VALUE (AND) II. PROVIDE EXCELLENCE IN SERVICE AS DEFINED BY THE CUSTOMER.

- Technical Quality . Technical quality is defined as that which represents the successful application and appropriateness of techniques and technologies used to develop a comprehensive and integrated emergency management program and their subsequent evaluation.
- Cost/Price. Cost/price is defined as that which represents the efficient management of appropriated and other funds to operate the VHA EM program.
- Service Satisfaction. Service satisfaction is defined as that which represents the views of VISN and facility directors and their staff as to the time and ease of obtaining appropriate technical assistance, and to veterans as to the usefulness of guidance provided to them.
- Access. Access is defined as that which represents the non-interruption of access to patient care, medications and social support services.
- Functional Status. Functional status is defined as that which represents the ability of facilities to perform usual and necessary patient care activities after emergencies occur.

### III. PROVIDE EXCELLENCE IN EDUCATION AND RESEARCH.

- CAPITALIZE ON THE NEEDS OF AND SPECIAL OPPORTUNITIES AVAILABLE IN VHA.

The needs of VHA in terms of EM are to protect its patients, whether their care is home-based, through an outpatient clinic or as an in-patient. As health care has moved from a focus on acute care to wellness programs, EM has moved from a focus on response to emergencies to mitigation, or reducing or eliminating hazards that may cause injuries or illnesses. Mitigation, like preventive medicine, requires education based upon research. Special opportunities that exist within VHA include excellent education and medical media production systems that can be used to develop and deliver education programs that will assist veterans and employees with steps they can take to make their homes, vehicles, and workplaces safer.

- LINK EDUCATION AND RESEARCH WITH CURRENT AND FUTURE NEEDS OF VETERANS.

Hazards research benefits current and future needs of veterans and employees through a better understanding of individual and group behavior during emergencies. This knowledge, applied to facility and network EM planning, results in actions that are driven by needs and not by assumptions. Staff EM education programs revolve around their roles in various key activities other healthcare facilities have faced during similar emergency situations.

- INCREASE EXTERNAL AWARENESS AND COLLABORATIVE EFFORTS.

EM is, by nature, a multi-disciplinary activity (e.g. the health care facility's safety management program, the local public health and safety system(s), State and Federal agencies, non-profit and religious organizations, etc.). We all face various hazards depending on where we live. Professional groups, business interests and governmental entities invest a great deal of time and money into reducing the impact of disasters on people and property. Collaborative efforts are a necessity not only for financial reasons but perhaps more so because the problem has so many dimension.

### IV. BE AN ORGANIZATION THAT IS CHARACTERIZED BY EXCEPTIONAL ACCOUNTABILITY.

- LINK REWARD, RECOGNITION AND PROMOTION TO PERFORMANCE MEASUREMENT.

Performance measurement in EM programs is evolving through the efforts of professional associations, like the National Emergency Management Association; non-profit organizations like the American Red Cross; Federal agencies like the Federal Emergency Management Agency, and national initiatives like the Government Performance Results Act. Nationally-accepted standards now exist for emergency managers, emergency management programs, professional certification, and higher education programs at leading academic institutions. VHA could become a recognized leader by applying these examples to the healthcare field.

- BUILD A CULTURE OF TEAM-BASED EFFORT AND INDIVIDUAL ETHICS AND ACCOUNTABILITY.

Many articles have described the VA of a few years ago as having a highly centralized, command and control culture. The current leadership understood that when it was re-engineering the veterans healthcare system, the operant culture needed to change to more of one possessing the qualities of process, network and time-based cultures. EM programs are developed through creation of a process culture; implemented through collective action of various organizations (network culture) in situations that tend to change rapidly over time (time-based culture).

#### V. BE AN EMPLOYER OF CHOICE.

- MAINTAIN A HIGH LEVEL OF JOB SATISFACTION.

The satisfaction one has with one's job cannot be defined along one set of dimensions, although researchers have concluded that morale is linked with productivity through the degree of control one has over his/her work, and whether the goals of employees are in opposition with those of management. The establishment of goals and objectives in EM programs is critical because progress can take weeks or months, and participants – upon which the program depends – will decrease their commitment if nothing visible is happening.

- PROVIDE EQUAL OPPORTUNITY EMPLOYMENT.

EM has long been a male, caucasian profession, mainly due to its ex-military officer workforce. VHA's EM program benefits from the infusion of a diverse mix of backgrounds, skills and perspectives.

- PROVIDE A SAFE WORK ENVIRONMENT.

Providing for a safe work environment for all VHA employees is an important contribution EM makes through its collaborative effort with other VHA Services in the JCAHO's Environment of Care.

- PROVIDE TOOLS FOR CONTINUOUS QUALITY IMPROVEMENT AS A LEARNING ORGANIZATION.

Feedback from participants in EM programs drives corrective actions in future planning, training and exercises. Rehearsal activities have been found to increase improvisation needed to solve the many problems encountered during response to emergencies. The professional literature maintains that evaluations of effectiveness must be directed at the network of emergency response entities rather than on any one agency or individual. By the very nature of disaster, it requires a response from the entire system, and that system should not be dependent upon one link for its effectiveness. This not only ensures constructive critiquing, but also provides EM team building.<sup>36</sup>

#### SAMPLE 2002 STRATEGIC TARGETS

1. Increase to 100% the number of facility and network EM programs that include:
  - Goals, objectives and multi-year workplans.
  - Periodic internal/external audits and program reviews
  - Hazards vulnerability analysis and capability shortfall matrix
  - Resources inventory
  - Basic plan and functional annex plan formats
  - Geographic information system mapping of facility/community
  - Incident management system
  - Incident action planning
  - Mitigation, preparedness, response and recovery activities
  - Veterans disaster assistance services/helpline
  - Outreach to home-based care patients
  - Emergency sheltering services
  - Business continuity and restoration planning
2. Increase to 10% of the EMSHG budget funds dedicated to research.
3. Increase to 75% the number of Associate Director trainees that have participated in VHA EM education and training.
4. Increase to 75% of the EMSHG budget funds allocated to training be spent on attendance at skill-based courses.
5. Increase to 100% the number of VA health care facilities that have access to the EM national practice guidelines.

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<sup>36</sup> Emergency Response Institute, What Researchers Are Telling Communities, Community Emergency Management: Program Development and Strategies, Olympia, WA., 1992.

6. Increase to 100% the number of employees who have completed the VHA EM certification program and 75% of EM Coordinators (EPCs).
7. Increase to 100% the number of networks that sponsor multi-facility evacuation exercises.
8. Increase to 90% the proportion of VISN and Facility Directors that feel EM program provides value to their organization(s).

#### SAMPLE ANNUAL PERFORMANCE MEASURES

- Increase services available to veterans during and after disasters.
  - Increase collaboration with services involved in the Environment of Care.
  - Decrease the variability and increase accountability of EM program delivery.
  - Increase research activities that are linked with ensuring continuity of patient care.
  - Increase use of technology for education and training programs.
  - Increase participation of administrators and clinicians in emergency management training.
- **SERVICE DELIVERY STRATEGIES: CREATING EFFECTIVE PROGRAMS**

So, how does an organization with national program responsibilities realize its objectives through field programs more concerned with JCAHO inspections and local disasters?

The goal of emergency management is to create and maintain an effective organization to prevent, prepare for, respond to and recover from major threats to lives and livelihoods. A fundamental assumption is that plans alone are not effective unless they are supported by people and a process brought together by good management skills.<sup>37</sup>

Management is a process of planning, organizing, directing, and controlling organizational behaviors in order to accomplish a mission through a division of labor.<sup>38</sup> The EM program manager's task is to use a variety of resources,

<sup>37</sup> Ibid, Program Development.

<sup>38</sup> Wagner and Hollenbeck, Management and Managers, Management of Organizational Behavior, Prentice-Hall, Englewood Cliffs, N.J., 1992, p. 24.

techniques and skills to create a team of agencies and organizations who work through a process of steps (see page 9) that reduces the probability and impact of extreme events – and should a disaster occur, brings about a quick restoration of routines.<sup>39</sup> This task requires the roles of coordinator, facilitator and compromiser – not autocrat, since he/she has no control over the variety of individuals, organizations and levels of government whom are involved in EM.

## **RESISTANCE**

Resistance to preparedness for emergencies in American society is well documented. The same factors that constrain preparedness at the household level also exist at the organizational level: hazards have low salience for most organizations except when there is an imminent threat; disaster-related problems must compete with more pressing day-to-day concerns, inadequate levels of official support; and the lack of expertise.<sup>40</sup> Reasons for public apathy include a lack of awareness, an underestimation of risk, reliance on technology and fatalism or denial. Government apathy can result from: lack of an organized constituency advocating disaster preparedness, a difficulty in substantiating the benefits of preparedness, an overestimation of capability, and ambiguity of responsibility.<sup>41</sup> Thus, *motivational issues* are important considerations.

## **INTERVENTION THEORY**

Stimulating motivation and performance begins with a realization that EM program development is an intervention activity:

To intervene is to enter into an on-going system or relationship, to come between persons, groups, or objects for the purpose of helping them. There is an important assumption implicit here that should be made explicit, that the system exists independently of the intervenor.<sup>42</sup>

This view values the client system (VA health care facility, community, etc.) as an on-going, responsible entity obligated with control over its own destiny. Here, the intervenor helps a system become more effective at problem-solving, decision-making and decision implementation so that the system continues to become more effective in these activities and less reliant on the intervenor. The integral

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<sup>39</sup> Hoetmer, Introduction, Emergency Management: Principles and Practices for Local Government, International City Managers Association, Washington, D.C., 1991, p. xx

<sup>40</sup> Tierney, et. al., Preparedness and Response, Second Assessment of Hazards Research

<sup>41</sup> Auf der Heide, The Apathy Factor, Disaster Response: Principles of Preparation and Coordination, C.V. Mosby, 1989, pp. 14-23.

<sup>42</sup> Argyris, Intervention Theory and Methods, Classics of Organizational Theory, Brooks/Cole Publishing Co., Pacific Grove, CA., 1991, pp.188-192.

parts of any intervention activity are valid information, free choice and internal commitment.<sup>43</sup>

VALID INFORMATION is that which describes factors, plus their inter-relationships, which create the problem for the client.<sup>44</sup> Examples of valid information in EM programs would be: common problems seen by hospitals in disasters; the location of the facility in relation to areas of seismic risk and the types of structural damage caused by earthquakes; or research findings on individual and organizational behavior in emergencies.

FREE CHOICE puts the locus of decision-making in the client system, makes the client system responsible for its destiny and allows them to maintain the autonomy of their system.<sup>45</sup> In EM programs, being presented with an analysis of hazards and their effects on the hospital/community, program participants are encouraged to establish needs, priorities, goals and objectives to direct the mitigation and preparedness efforts. Free choice in response and recovery periods is exemplified by the assumptions of the problem-solving model, not the command and control model (see page 12).

INTERNAL COMMITMENT means the course of action or choice that has been internalized by each member so that he develops a high degree of ownership and has a feeling of responsibility about the choice and its implications. ... The individual who is internally committed is primarily under the influences of his own forces and not induced forces {e.g. establishing local needs and priorities versus complying with external requirements}.<sup>46</sup>

### **BASIS FOR SUCCESS**

The same planning process applied at the organizational level is applied to the implementation of programs. The determination of need, establishing priorities and setting goals by each program (e.g. local facility, VISN, Central Office, etc.) is essential to long-term, effective EM programs. Setting clear goals with attainable intermediate objectives is also crucial to maintaining the long-run involvement of the resource-providers. Finally, planning and managing by goals and objectives is important to the professional EM program manager in order to measure what is being accomplished, and determine future activities.

Performance is enhanced by goals that are both specific and difficult. Organizational scientists have concluded that difficult goals seem to produce greater effort and enhance persistence. Moreover, they are likely to encourage people to develop task strategies. The strategies tied to the goal-setting process

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<sup>43</sup> EMPO, *Intervention Theory*, Comprehensive Emergency Management Programs for VA Health Care Facilities, Indianapolis, 1993.

<sup>44</sup> Ayrigis, *Intervention Theory and Methods*, Classics of Organizational Theory, Brooks/Cole Publishing Co., Pacific Grove, CA., 1991, pp.188-192.

<sup>45</sup> Ibid.

<sup>46</sup> Ibid.

are at least equally critical. The goals serve to direct attention to the ends, but the strategies support the means to that end. A strategy is a plan of action that states an organization's goals and outlines the resources and activities required to achieve them.<sup>47</sup> *Developing and sharing strategies is a critical part of organizational, program and professional development.*

## **IMPLICATIONS**

- Significant changes have occurred in the health care marketplace that requires a total quality management approach to our emergency management practices in order to more effectively serve our customer – the VA healthcare facilities who provide care for veterans.
- EM involves complex relationships. It is an *interdisciplinary* (e.g. public administration, engineering, clinical medicine, public health, social services, etc.), *inter-organizational* (organizational units within VA and with other Federal agencies) and *intergovernmental* (with State agencies, local governments, and the private and non-profit sectors) activity. It is inherently an activity conducted with “outsiders” in a “loosely-coupled relationship.”
- The purpose of these activities is to reduce uncertainty or ambiguity of the roles and responsibilities of the participants in the EM program but the purpose of coordination can easily become confused with competition and result in conflict. Team building depends upon the establishment of interpersonal understanding and shared values that are the product of regular coordination.
- EM strives to improve the ability of individuals and groups to solve problems. To enable this, a social process is created which can collect information, allocate resources, determine priorities among critical needs and apply available resources most effectively. The pre-existing authority and autonomy of each participating individual, agency or organization is valued and maintained. Collective planning and rehearsal activities, personal contact, liaison, and establishing joint facilities promote inter-organizational coordination, common decision-making, and the ability to improvise. Emergency management, then, is part improvisation and part preparedness. Without improvisation, it loses flexibility in the face of changing conditions. Without preparedness, it loses some clarity and precision. Preparedness means to organize a response prior to an event; Improvisation means to organize a response during an event. Planning and preparedness improve the ability to improvise.<sup>48</sup>

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<sup>47</sup> Wagner and Hollenbeck, *Management of Organizational Behavior*, Prentice-Hall, Englewood Cliffs, N.J., 1992, p. 684.

<sup>48</sup> Dynes, Community Emergency Planning: False Assumptions and Inappropriate Analogies, *International Journal of Mass Emergencies and Disasters*, p. 153

## **RECOMMENDATIONS FOR INTEGRATING PROGRAM AND PROFESSIONAL DEVELOPMENT IN HEALTHCARE EMERGENCY MANAGEMENT PROGRAMS**

- ENGAGE IN ON-GOING, MULTI-YEAR, ORGANIZATION-WIDE PLANNING AND COLLABORATION TO IDENTIFY CRITICAL SUCCESS FACTORS FOR ENSURING CONTINUITY OF CARE FOR VETERANS.
- BUILD STRATEGIC ALLIANCES WITH DISCIPLINES RELATED TO THE ENVIRONMENT OF CARE AND FOCUS THE DEVELOPMENT OF NATIONAL CAPABILITIES ON THESE PROGRAMS AT THE NETWORK, COMMUNITY AND HEALTHCARE FACILITY LEVELS.
- SIMPLIFY THE PROGRAM FRAGMENTATION BY INCORPORATING ACCEPTED PRACTICES FOR EM POLICY, PROGRAM DEVELOPMENT, IMPLEMENTATION AND EVALUATION.
- ENGAGE IN RESEARCH TO DETERMINE DISASTER EFFECTS ON COMMUNITY HEALTHCARE SYSTEMS AND ESTABLISH FORMAL LINKAGES BETWEEN RESEARCH PRODUCERS, CLEARINGHOUSES AND USERS.