

BoardBrief

Knowledge Resources for Health Care Governing Effectiveness

Preparing for the Worst, Leading with the Best The Hospital Board's Role in Disaster Readiness

September 11, 2001 opened the nation's eyes to the reality of terrorist attacks on American soil, and caused the nation and its hospitals to thoroughly examine their readiness for all types of disasters, both natural and manmade. Emergency preparedness and response teams have been developed nationwide, and are given real-life tests with every hurricane, explosion, earthquake, fire or other emergency situation.

With each new disaster - most recently the widespread damage caused by the earthquake in Japan and devastating tornadoes and flooding in the Southern states, hospitals continue to fine-tune their local disaster readiness plans, and further detail how they will work with regional teams when disaster strikes.

When disasters happen, members of the community look to the hospital as a stable, safe place. Whether it's an immediate medical need, a search for food, shelter and electricity, or just fear of the unknown, recent disasters have shown that people consider their local hospital to be their safety net. After the attacks on the World Trade Center on September 11, St. Vincent's Hospital in New York City treated roughly 800 patients, but it received a crowd of close to 25,000 family members, volunteers and others who were unsure of where to go.¹

Although the board of trustees is not responsible for the development and implementation of the hospital's disaster plan, it is the board's fiduciary responsibility to ensure that a clear plan

is in place, and the funding and resources necessary to carry out the plan are available. Not only is the board ultimately responsible for ensuring that their organization is fully-prepared in the event of a disaster, they also have an opportunity to use disaster planning to improve the quality of service provided to the community, strengthen community relationships, and build lasting community trust and partnerships that benefit the hospital in many ways.

A Fiduciary Responsibility— And More

Joe Cappiello, past vice president of Accreditation Field Operations for The Joint Commission, says much of a hospital's readiness capacity rests with its governing board. "Hospital boards of directors have a fiduciary responsibility to ensure [that their] hospital is financially stable and is able to render care to the community in the face of a disaster," he says.

Ensuring a responsible and implementable disaster plan is in

place is more than just the board's fiduciary responsibility. The recent passage of health care reform legislation includes specific requirements for emergency medical care, and it is also required for Joint Commission accreditation.

New Requirements of Health Care Reform Legislation. Title IX, section 9007 of the recently passed health care reform act (the *Patient Protection and Affordable Care Act*) includes a requirement for charitable hospitals to have a written Emergency Medical Care policy in place that requires provision of



emergency care regardless of eligibility under the financial assistance policy. This means that not only must hospitals have a policy in place for how to provide care to patients during times of emergency, boards need to ensure their organizations are prepared financially to handle the initial cost and long-term financial implications of caring for patients during an emergency.

In addition, the reform legislation includes a provision for grant funding for regionalized systems for emergency care and increased capacity of trauma centers. Grants are focused on assisting states and Indian tribes to prepare for disasters, with state awards focusing on building capacity, collaboration, expediency and appropriate delivery of care. The inclusion of grant funding in the Act presents an opportunity for hospitals seeking funding for pilot projects, but also highlights the importance the government is placing on hospitals' ability to prepare for and respond to disasters.

Joint Commission Requirements. For hospitals accredited by The Joint Commission, the board of trustees is responsible for understanding and ultimately ensuring compliance with Joint Commission standards relating to disaster preparedness. Accreditation includes specific requirements relating to developing a written Emergency Operations Plan, conducting a hazard vulnerability analysis, working with community partners, ensuring a communication plan is in place, and conducting annual drills. As an extension of these requirements, boards of trustees can further take a meaningful

role in disaster readiness by encouraging the hospital's collaboration with other hospitals, local and regional

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**-Michael Leavitt,
Former Secretary,
Department of Health
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governmental agencies, local police and fire departments and county emergency management efforts (for more detailed information about hospitals' accreditation requirements, see the table *The Joint Commission Requirements* on page three).

Recent Fines and Litigation.

In addition to recent legal requirements relating to emergency preparedness, as not-for-profit hospitals come under increased scrutiny for meeting the "community benefit standard," their preparedness for a disaster and ability to carry out that plan when a disaster does occur has also come under increased scrutiny. In recent years, hospitals nationwide have faced fines and lawsuits for not meeting their requirements for disaster preparedness.

Most notably, Pendleton Memorial Methodist Hospital and its corporate parent Universal Health Services of Pennsylvania have faced lawsuits for negligence relating to not being prepared for the scale of the disaster

caused by Hurricane Katrina. Three years prior to the hurricane the hospital conducted an analysis of its vulnerability for flooding and determined that its generator could not withstand flood waters of over two feet. Despite the documented concern, the hospital did not resolve the issue that then resulted in a loss of power after the storm. A lawsuit from a family was settled confidentially, but alleged that the hospital's negligence resulted in her death because there was no power for her respirator. Although the results of the settlement are sealed, other trials related to care provided at the hospital immediately following Hurricane Katrina are still pending.

In an interview with *USA Today*, Edward Sherman, a Tulane University law professor, said that the case has implications for the future expectations of health care organizations, stating that "The LaCoste lawsuit could make hospitals across the country liable if their power gets knocked out by snowstorms, tornados, or other calamities...I'm not at all sure hospitals in the past had thought about the liability for lack of emergency preparedness. This changes that."^{22, 23}

It Can't Be Ignored. Despite legal and regulatory requirements and recent litigation, disaster preparedness is too often not a top priority for many hospital

Board Empowerment is Key

Although the board is not responsible for the ins-and-outs of its organization's disaster preparedness plan, the board sets the course for success or failure. And the board is ultimately responsible for the organization's ability to respond to a disaster.

As a result of the Oklahoma City bombing, and then a tornado that caused massive casualties, Oklahoma's Metropolitan Medical Response System established an Medical Emergency Response Center. The development of the center was challenging, in part because of the requirement that hospitals typically in competition with one another work together. In an interview with *Trustee Magazine* about the development of the center, the director of Oklahoma's Metropolitan Medical Response System, Michael Murphy, said that "There has definitely been a learning curve and a cultural change in transforming a typically competitive health care environment to one of cooperation and support...But it could not have happened without the support of hospital CEOs and boards. Their support is worth its weight in gold. Boards tend to empower the CEO with the resources they need to put the plans in place. The CEOs were critical in legitimizing our efforts and getting the rest of the hospital staff behind it."¹

The Joint Commission Requirements

The Joint Commission devotes an entire section of its accreditation manual to hospitals' emergency preparedness. Specific requirements include:

- ❑ Engaging in planning activities prior to developing a written Emergency Operations Plan, including, but not limited to:
 - The participation of hospital leaders in planning activities;
 - Conducting a hazard vulnerability analysis to identify potential emergencies that could affect the demand for hospital services in the event of an emergency, as well as the hospital's ability to provide those services, the likelihood of those events occurring, and the consequences of those events;
 - Working with community partners to prioritize the potential emergencies identified in the hazard vulnerability analysis; and
 - Communicating hospital needs and vulnerabilities to community emergency response agencies and identifying the community's ability to meet its needs.
- ❑ Ensuring an Emergency Operations Plan is in place, including, but not limited to:
 - The participation of hospital leaders in the development of the Emergency Operations Plan;
 - Developing and maintaining a written Plan that describes the response procedures to follow when emergencies occur; and
 - An identification of the hospital's capabilities, and response procedures for when the hospital cannot be supported by the local community to provide communications, resources and assets, security and safety, staff, utilities, or patient care for at least 96 hours.
- ❑ An Emergency Operations Plan that describes how the hospital will communicate during emergencies, such as how staff will be notified; how external authorities will be notified; how the hospital will communicate with patients, their families and the media; hospital communications with suppliers and vendors; and how the hospital will communicate with other health care providers in the area. In addition, the hospital must have a plan for communicating the names of patients and the deceased with other local health care organizations and with third parties, and for communicating with alternative care sites identified. Finally, the communication plan must include backup systems and technologies for communicating, in preparation for traditional communication systems (such as telephones and email) not functioning.
- ❑ An Emergency Operations Plan that describes how the hospital will manage resources and assets during emergencies, such as obtaining and replenishing medications and supplies; sharing resources and assets with other local health care organizations; arrangements for transporting patients if necessary; managing security and safety during an emergency including collaboration with local security agencies; and managing hazardous materials and waste.
- ❑ An Emergency Operations Plan that describes how the hospital will manage staff during emergencies, such as defining staff roles and responsibilities; managing staff needs (such as housing and transportation); managing staff family needs (such as child care and communication); and training employees for their assigned emergency roles.
- ❑ An Emergency Operations Plan that describes how the hospital will manage utilities during emergencies, such as alternative means of providing electricity, water and fuel.
- ❑ An Emergency Operations Plan that describes how the hospital will manage patients during emergencies, such as a plan for keeping patients on the premises or evacuating them if the facility is not safe; how the hospital will manage scheduling, triaging, assessing, treating, admitting, transferring and discharging patients; and how the hospital will manage an increase in demand for services, patients' personal hygiene and sanitation needs, mental health needs, and mortuary services. In addition, the Plan must include how the hospital will document and track patients' clinical information.
- ❑ An Emergency Operations Plan that describes how the hospital will grant disaster privileges to volunteer licensed independent practitioners and volunteer practitioners during emergencies, such as a process of granting privileges once the Plan has been activated, how volunteer providers will be distinguished from hospital staff and how their performance will be overseen.
- ❑ An annual evaluation of the effectiveness of the hospital's emergency management planning activities, including an annual review of the hospital's hazard vulnerability analysis, the objectives and scope of the hospital's Emergency Operations Plan, and the hospital's inventory.
- ❑ An annual evaluation of the effectiveness of the hospital's Emergency Operations Plan, including, but not limited to:
 - Activating the Emergency Operations Plan twice a year;
 - At least one annual exercise that includes an influx of simulated patients;
 - At least one annual exercise that includes an escalating event in which the local community is unable to support the hospital;
 - At least one annual exercise that includes participation in a community-wide exercise; and
 - Monitoring of the hospital's performance throughout the drills and modifications to the Emergency Operations Plan based on the exercises.

Source: *The Joint Commission's Comprehensive Manual 2010 Standards. The Joint Commission.*

leaders. In the 2009 American College of Healthcare Executives' annual survey, only 1% of CEOs selected disaster preparedness as one of their top three issues. Not surprisingly, among the top issues selected were financial challenges, health care reform implications, care for the uninsured, and patient safety and quality. While it is understandable that these issues are top of mind for health care leaders, being prepared in a disaster has implications in all of these areas— if a disaster does strike, being prepared can make or break an organization's financial viability, health care reform requires that hospitals are prepared to care for the insured and uninsured alike during a disaster, and a hospital's ability to provide comprehensive, coordinated care during a disaster has far-reaching implications on quality and patient safety.¹¹

Preparing Before Disaster Strikes

"When a community is afflicted with a disaster, citizens don't run to the police or fire station, they run to the hospital. The hospital becomes the beacon and a source of fortitude to the community...disaster preparedness should rise fairly high on the board's priority list of hospital responsibilities, right up there with quality of care and safety to the public," says Joe Cappiello.

Preparing for a disaster is more than simply developing a written disaster plan. It requires working collaboratively with local and regional community organizations, including potential competitors, to ensure a comprehensive plan is in place. And like any other plan, it requires practice to ensure that all the key players know what they should be doing and are comfortable with their role before they are placed in a high pressure situation.

Is The Big One Coming?

America has experienced terrorist attacks, hurricanes, flooding, and much more first-hand over the past decade. But what we haven't encountered is a big earthquake. The recent earthquakes in Japan, Haiti and Chile are a reminder of the devastation they can cause, and the critical role that hospitals and health care organizations play in such a disaster.

According to Dr. Marcia McNutt, a geophysicist and director for the U.S. Geological Survey, it's not a matter of if a major earthquake is going to strike in the U.S., it's a matter of when. Although the quake hitting the U.S. might not be as large as the 8.9-magnitude quake that hit Japan in March 2011, it will likely be just as devastating because of population density.

More than 10,000 people died in the Japan quake and tsunami, despite Japan being well-prepared with good building codes. Some of the biggest challenges after the earthquake and tsunami in Japan was the impact on its nuclear power plants, housing and transportation infrastructure. This should be a wake-up call to the U.S. because of the fragile state of our infrastructure. In a 2008 report the U.S. Department of Transportation found that nearly 14% of the nation's bridges are "functionally obsolete," with another 12% "structurally deficient."¹²

Hospitals must be proactive in forming the necessary partnerships and conduct drills to ensure their community is prepared. Michael Leavitt, Former Secretary, Department of Health and Human Services, recently clarified this responsibility when he said "Any family or community that fails to prepare for the worst, with the expectation that the federal or state government will come to the rescue, will be tragically wrong."

Board and Administration Roles. The board's initial role is to help ensure the proper disaster preparedness plans are both in place and fully funded. Board members and hospital leaders work together to emphasize the importance of planning for potential emergencies, dedicating the time and resources necessary to adequately prepare.

The board's role is high-level, focused on policy, strategy and ensuring appropriate resources, while hospital leaders work on the details. To start, hospital staff leaders will develop or update the emergency plan, while board members familiarize themselves with its every aspect. Similarly, hospital staff leaders order the equipment, supplies and other materials necessary to carry out the plan, while the board must make certain sufficient

funding is in place for the purchases, as well as any additional staffing that needs to be funded. In addition, the board may be asked to help raise outside funds for specific disaster preparedness projects, leveraging their connections within the community.

Staff leaders are also responsible for arranging and coordinating drills and community-wide disaster simulations. The board is responsible for ensuring that all of this happens, and may be asked to participate by discussing the outcomes, and assessing and scoring the hospital's response, as well as the response and coordination of other participating community organizations.

Board Review of the Plan. In reviewing their hospital's disaster readiness plan, board members should look for the existence of three key elements:

- Threat identification;
- Detailed planning; and
- Adequate drilling.

Identify Logical, Likely Threats. Every hospital should begin its disaster preparedness plan by conducting a "hazard vulnerability analysis" to determine the types of emergencies

most likely to occur. For example, while hospitals along the Gulf Coast face a significant risk of hurricanes, those in California will be more concerned about earthquakes. Hospitals and communities in the Midwest may be concerned about flooding or severe winter storms, and hospitals near chemical plants will focus more on hazardous materials spills, burns and injuries that can occur from inhalation of fumes.

In addition, hospitals need to be prepared for man-made worst-case scenarios. Although they seemed unrealistic until recent years, the threat of school shootings, bombings and terrorist attacks are today all-too real.

Assess Threats, Create an Action Plan. Once all potential hazards have been determined, organizations must develop plans to address each emergency. The planning process should include as many disciplines as possible, representing all key players within the hospital family and the surrounding community. Working across traditional departmental and agency boundaries should strengthen communication among all segments of the hospital and its community.

In addition to developing plans to respond to identified potential disasters, hospitals must ensure their facilities and equipment are prepared to withstand the effects of a disaster. For some hospitals, this may mean preparation for hurricane winds; for others it might be upgrades to meet new earthquake structural standards.

Simulate the Disaster, Practice the Response. Developing an emergency plan will not successfully prepare a hospital for any disaster or terrorist attack unless it is practiced. Simulating a disaster not only helps the key players understand their roles in the emergency plan, it also helps identify flaws in the plan, which may be amended before a

real disaster strikes. Performing at least two practice drills a year is a requirement of Joint Commission accredited hospitals.

What Should Be Included in the Disaster Plan?

It would be nearly impossible to develop a detailed plan for all potential disasters a hospital could face, so experts recommend developing an “all hazards” planning approach. While hospitals do want to have part of the plan designed to respond to the types of emergencies they determine are most likely to occur (by conducting a hazard vulnerability analysis), a general all hazards approach will help the hospital be prepared for a range of scenarios, whether it is a computer system crash, an earthquake, a terrorist attack or some other threat.

The plan should include guidelines for when it will be activated, and what will happen once it is activated—ranging from communication to supplies to physician credentialing. This level of comprehensive planning may seem “over-the-top,” but recent terrorist

attacks, hurricanes and earthquakes across the globe have proven that it is not. Hospital trustees must expect the unexpected, taking responsibility to ensure that their organizations are prepared for the worst.

Communication. It is no surprise that the ability to continually communicate and coordinate throughout any disaster is critical to ensuring a successful response. That need has been proven time and again in recent disasters. After the September 11 attacks on New York City, so many people used their mobile telephones that the city's network was overloaded. In addition, radio communication was spotty between incident commanders and emergency responders at the World Trade Center. A similar problem occurred after Hurricane Katrina hit New Orleans, with downed cell towers causing the city to be isolated from the outside world.^{4,5}

To be as prepared as possible hospitals should have redundant communication systems in place, such as land lines, mobile telephones and devices, computers using the Internet, and 800

“Tweeting” in a Disaster

The rapid increase in and use of social networking sites is a trend that hospitals can take advantage of when they need to communicate to large audiences simultaneously before, during and after a disaster. In fact, hospitals have used social networking sites such as Facebook and Twitter in recent disasters. According to *HealthLeaders*, some examples from 2009 include:¹⁰

- Scott & White Hospital in Temple, TX provided Twitter updates on shooting victims after the mass shootings at Fort Hood, TX on November 5. The hospital received 10 shooting victims, and gave updates such as the operating status of the hospital's ER and wait times for volunteers to give blood.
- Sts. Mary & Elizabeth Hospital in Louisville, KY used Twitter to keep the public and employees updated on their patient evacuations and building conditions after massive flooding in August.

In its August 2009 *Environment of Care News*, The Joint Commission said that social media sites are a good strategy for emergency communication. As a board member, do you know if your hospital has a Facebook profile? Does someone at your organization “tweet”? As communication strategies evolve, hospitals have an opportunity to not only use these new methods to communicate during a disaster, but also to communicate current issues and build trust and confidence with the community before a disaster strikes.

megahertz radios or satellite phones. In-person human messengers should be built into the plan as a last-ditch effort if no other communication equipment is functioning.

To ensure that key individuals are in contact with one another, a "contact tree" should be established in advance. It should specify all critical individuals to communicate with and their contact information, including their physical addresses. And in case the hospital or its Intranet system is not accessible, key individuals should have access to a separate online or hard copy maintained off-site.

In addition, hospital leaders should think creatively about how technology can be used in times of severe disaster. For example, Twitter and Facebook may be two of the best ways to reach large numbers of people all at the same time.

Board Communication. In addition to communication between hospital leaders, caregivers, disaster responders, the media and the community, communication with and between hospital trustees must be planned for as well. As the organizational leaders who are responsible for providing high-level guidance, support and direction to the hospital, trustee communication is essential. But it is often overlooked in the disaster planning process.

When Hurricane Katrina hit, Richard Culbertson, Ph.D., was a board member of New Orleans' Touro Hospital, as well as a member of the American Hospital Association's Committee on Governance. In an interview with *Trustee Magazine* he recalled the board's lack of preparedness, saying "After Katrina, we were scattered across the country. We had to track everyone down, determine how we were going to conduct a meeting and what would constitute a quorum. Not only that, the National Guard was now guarding our parking lot, and we had no

official identification to get into our building."

A critical part of preparing for a disaster includes how hospital boards will communicate and conduct vital meetings during a disaster. Culbertson recommends considering identification badges for board members, and how communication to local and national media will be handled. In addition, at Touro Hospital, board members now have mobile telephones that use an area code outside the city in case local phone lines and towers shut down.¹³

Security. Challenges following Hurricane Katrina have led many organizations to re-think their disaster plans, whether they are at risk for a hurricane, tornado, earthquake, or some other form of disaster. In an interview with *Hospitals & Health Networks*, Cynthia Hare, Vice President for Performance Improvement at VHA Southeast in Tampa, Florida, says that in a time of disaster "if your facility isn't secure, no one will feel safe and your staff will leave." Hospitals' disaster plans should include collaboration with local police and security agencies and a contingency plan to call on the National Guard if necessary to ensure that all entrances are guarded. It should also include a plan for how security personnel will direct patients and people seeking food and shelter.⁵

Power, Fuel and Supplies. Electricity will likely be one of the first things to go in the event of a disaster. As a result, power backup should be a top priority. This includes having extra generators and fuel supplies in strategic locations,



such as out of flood water levels and/or in earthquake-safe areas. Back-up systems should have enough capacity to power medical equipment, heat and air conditioning, if necessary. In addition, back-up plans should prepare for the potential for generator failure, with redundant systems in place and repair parts on hand.

In addition to power needs, hospitals will also need supplies, including medical supplies, medications, and food and water. In a worst case scenario, not only will hospitals not be able to receive new shipments of supplies, but they will have an increased demand for medical needs as well as people simply seeking food and shelter. This combination can deplete supplies quickly; The Joint Commission mandates that accredited hospitals be able to survive without outside help from the community for up to 96 hours after a disaster. As the recent earthquake in Haiti demonstrated, 96 hours without outside assistance can be long and painful. The more prepared hospitals are for those first days, the better off the community will be.^{5,8}

Information Technology Back-Up. Natural and man-made disasters both have the potential to temporarily disable or damage information technology systems. Hospitals should have an off-site back-up of all patient and employee records should this happen. It is best for

Hospital Survivability and Responsiveness in a Disaster

According to Joe Cappiello, past vice president of Accreditation Field Operations for The Joint Commission, six critical elements of a disaster plan impact hospitals' ability to successfully survive and respond to a disaster:¹³

- ❑ **Communication.** The ability to communicate internally with doctors, nurses and staff, and externally with the community, including other local hospitals and federal agencies.
- ❑ **Resources.** Access to adequate resources to deliver and sustain care for a hospital's own patients and those who may arrive later in order to obtain materials and supplies.
- ❑ **Security.** The ability to maintain safety and security for the facility, staff and patients.
- ❑ **Power and Supplies.** Adequate backup power and water supplies.
- ❑ **Policies.** Organizational policies that ensure clinical and ancillary staff can come to work to provide care.
- ❑ **Stability.** The capability to continue to provide for the basic clinical needs of the community should other health care facilities and clinics shut down.

the back-up system to be located in an area that doesn't face the same threats as the hospital—ideally in another state.

The backed up data will allow patients that have been evacuated or are seeking care elsewhere to have continuity of care, and will enable the hospital to pick up where it left off once the system is restored. In addition, it will help displaced employees get credentialed so they can work elsewhere if the hospital or medical facility is closed for an extended period of time.⁵

A Plan for Meeting Employee Needs.

In the event of a disaster hospitals cannot respond to community needs without their employees. From

administrators to caregivers, every person plays a key role. But employees may find it difficult to come to work if their basic needs aren't met.

Hospital disaster plans should include provisions for meeting employee needs, such as living space for staff and their families, including pets. Hospitals should also be prepared to pay employees advances on their paychecks in cash if banks and ATMs are closed, and may consider an in-house "general store" to help employees get necessities such as cleaning supplies and dry goods.

Following Hurricane Katrina, Touro Hospital in New Orleans compensated employees working after the hurricane struck with advance pay for four weeks to ensure that all employees had the resources they needed to support their families.^{5, 13}

An Assigned Disaster Team.

Hospitals should create a disaster team and a back-up disaster team that can be called on in an emergency. The teams should be comprised of employees committed to responding to a

disaster and staying at the hospital as long as necessary to respond. Having two teams in place allows for one team to relieve the other once recovery begins.⁵

Hospitals should also have a plan for identifying and contacting volunteer health care professionals. If the hospital's surge in patients cannot be met by the assigned disaster team, having a list of qualified volunteer health care professionals will help the hospital more effectively respond to community needs.⁹

Emergency Physician Credentialing Plan.

In addition to having a disaster team in place and volunteers on hand, hospitals should be prepared to bring in additional needed providers. Physician credentialing is a board responsibility, so having an emergency credentialing plan makes sense. For example, there should be a policy for bringing in physicians who practice at competing hospitals.¹³ And while extra help during a disaster can be crucial, board members and hospital leaders must also ensure that the quality of care provided by the additional caregivers meets the organization's quality standards.



Health Care Reform Establishes Ready Reserve Corps

The health care reform legislation establishes a “Ready Reserve Corps” for service in times of national emergency. The Act specifies that the purpose of the Ready Reserve Corps is to “fulfill the need to have additional Commissioned Corps personnel available on short notice (similar to the uniformed service’s reserve program) to assist regular Commissioned Corps personnel to meet both routine public health and emergency response missions.”

The presence and role of the Ready Reserve Corps should be integrated into hospitals’ disaster plans. In addition, hospitals should be prepared for disasters across the country impacting their base workforce needs if a significant number of hospital staff are a part of the Corps and are called to assist in a disaster elsewhere.

The Institute of Medicine recognized the challenge that hospitals face in disaster situations when it convened the Committee on Guidance for Establishing Standards of Care for Use in Disaster Situations to guide state and local public health officials in disaster situations under scarce resource conditions. One of the Committee’s recommendations was for governments to “authorize appropriate agencies to institute crisis standards of care in affected areas, adjust scopes of practice for licensed or certified health care practitioners, and alter licensure and credentialing practices as needed in declared emergencies to create incentives to provide care needed for the health of individuals and the public.”⁶

An Evacuation Plan. For disasters that may provide some warning (such as a hurricane or potential flood), hospitals should have an evacuation plan in place. This includes having policies in place for when patients should be evacuated and when they should remain where they are. As Hurricane Katrina demonstrated, sometimes keeping patients in the hospital rather than moving them is not the best option.⁵

In addition, patients may need to be relocated if the facility is unstable or unsafe, or to free up space for disaster victims. Hospitals should have a plan with criteria and time frames for when patients should be relocated to increase capacity for incoming victims.⁸

Community Coordination. Because people tend to migrate to the hospital during a disaster even if they don’t need medical attention, coordinating with community organizations that can provide assistance in an emergency is essential. Although not all communities have shelters and sophisticated disaster response organizations, with time to plan community leaders can work together to creatively develop appropriate solutions to potential challenges. For example, people coming to the hospital looking for food and shelter can be redirected to schools and other community organizations with the ability to house and feed residents temporarily.⁵

In addition, if the surge of patients needing care is too much, neighboring hospitals need a plan for patient overflow—this means the ability to send patients to a nearby facility if needed, or to accept patients from neighboring areas that have been harder hit by the disaster.⁵

Empowered Leadership. When a disaster does strike, the leadership team must be empowered to make on-the-spot decisions. A national survey of 350 hospital executives and managers conducted by CHA, Inc., it found that the most important factor in successfully responding to hurricanes is to create leadership teams that are empowered to make decisions to meet unanticipated demands.⁵

Recovery Plan. When the critical phases of the disaster are past, the hospital’s work has just begun. Planning for recovery should be part of the hospital’s disaster plan—for example, leaders should know the hospital’s insurance coverage, and have an inventory of their building and equipment assets. The organization should also be prepared to help employees transition to both post-disaster recovery at the hospital, as well as in their own lives.

In addition, there is a good chance that after experiencing a disaster it will face a variety of financial challenges. Boards may consider business interruption insurance to help the hospital survive the loss of revenue during a shutdown or period of reduced operations. Trustees may also need to use their influence to help the hospital secure emergency lines of credit.

A plan should also be in place for ongoing hospital operations, such as resolving hospital financial commitments to suppliers and maintaining patient records. And if the disaster is large enough to warrant significant federal help, trustees should expect the presence of government agencies such as the Federal Emergency Management Administration (FEMA).¹³



Funding the Plan

Developing and implementing a disaster plan can be expensive. While federal funds have been available in the past, and there is the potential for funding through the recently passed health care reform legislation, boards must also be prepared to look for other resources to ensure funding for hospital readiness.



A Critical Board Responsibility. “As members of a not-for-profit hospital board, we represent the community, and we will be held accountable in the event of a disaster,” said Karen Luke, board member of St. Anthony/SSM Health Care of Oklahoma, Oklahoma City in a recent interview with *Trustee Magazine*. “Therefore, it is our responsibility to ensure that our hospitals have a plan, the resources and the budget to be prepared. This needs to be a priority and, in some cases, may have to take precedence over other areas when it comes down to budget allocation.”¹

Being prepared means funding the components of the plan, such as equipment and supplies needed, as well as having a financial plan in place for paying employee salaries and care expenses while not receiving any income. In addition, maintaining a plan means ongoing expenses related to improving community response systems, ensuring up-to-date communication technology, conducting drills annually, and staff training. In light

of recent terrorist events and natural disasters on a large scale (like Hurricane Katrina) as well as on a smaller scale (such as flooding or power outages), hospitals should include disaster preparedness as a necessary component of doing business.¹

Prioritize. Allocating the necessary resources to respond to an emergency is a critical board responsibility, but if boards were to prepare their organization for every imaginable disaster the cost would be astronomical. Part of trustees’ responsibility is to ensure that the most important efforts are addressed first. Trustees should refer to the hazard vulnerability analysis, which helps the board understand the most pressing threats and vulnerabilities the hospital faces. Once the board knows where the organization is most at risk, it can focus its resources on those areas.¹³

In addition to understanding the greatest risks, boards must consider the size of their organization and the community they serve. A small community hospital is not expected to make the same investment as a larger hospital, and each organization should set its expectations accordingly. For smaller organizations, it may be best to develop an all hazards or “scalable approach,” which is a less disaster-specific approach that establishes a capacity to respond to a disaster and can be modified depending on the situation.¹³

Leverage Community Connections. Despite the importance of disaster planning, many hospitals are already facing tight margins and

pressures to increase community benefit activities while dealing with inadequate reimbursement. Fully funding disaster preparedness efforts solely with hospital funds may not be realistic.

However, once hospital leaders have identified the potential threats and a plan to prepare for them, some funding is available through public sources and federal grants included in the health care reform legislation. In addition, trustees have an opportunity to leverage their connections to build support for the hospital’s efforts. Local organizations and private donors committed to the hospital’s disaster plan can help make the plan a reality.

Developing and Leveraging Community Partnerships

A coordinated response from local and regional community organizations is essential in ensuring the most efficient and effective response to an emergency. Community-wide emergency planning is stressed in The Joint Commission’s standards, a concept that is common-sense to ensure services aren’t

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duplicated and resources are maximized in an emergency. But partnering with local community organizations is more than an opportunity to strengthen the community’s response to a disaster. It is also an opportunity to strengthen community relationships, form mutually beneficial partnerships, and build community trust and support for the hospital.

Institute of Medicine Vision: Regionalized, Coordinated and Accountable Care. In June 2006 the Institute of Medicine (IOM) released three reports about the

Future of Emergency Care in the United States Health System, focusing on hospital-based emergency care, pre-hospital emergency care, and pediatric emergency care. It recognized that despite significant efforts to address emergency preparedness, many challenges remain, including:

- Widespread emergency department crowding;
- Frequent boarding of admitted patients in emergency department hallways;
- Diversion of inbound ambulances due to lack of capacity;
- A serious worsening shortage of on-call specialty coverage; and
- Financial challenges.

Because of these challenges and others, one of the central recommendations that emerged from the IOM was that the

nation should develop a "regionalized, coordinated and accountable system of emergency care." The IOM believes that regionalized systems will encourage cooperation among competing local providers and ensure that "emergency patients receive the right care at the right place at the right time."

To help achieve its vision, the IOM's Committee on the Future of Emergency Care recommended the establishment of a "lead federal agency" within the Department of Health and Human Services (HHS) to provide coordination of federal activities to strengthen emergency care. In January 2009, then HHS Secretary Michael Leavitt signed a charter establishing the Emergency Care Coordination Center (ECCC) within DHHS. Since then, the ECCC has worked with a variety of federal agencies to strengthen hospital-based emergency care, and the IOM has conducted additional workshops to examine the

U.S. emergency care system and progress made in coordinating care systems.²⁰

Who Should Hospitals Partner With?

Ideally, when a disaster occurs community organizations will already have well-established relationships and be prepared to work together in a collaborative manner. To ensure a comprehensive response, hospitals should consider partnering with the following organizations, among others:

- Police, fire and emergency services;
- Public health organizations;
- Local and regional hospitals;
- Pharmacies and suppliers;
- Physicians;
- Epidemiologists and laboratories (particularly in the event of a bioterrorism event);

Government Studies: Progress Has Been Made, But Hospitals Are Still Not Prepared

In 2008 the Government Accountability Office (GAO) determined that following a mass casualty event that could involve thousands or tens of thousands of injured or ill victims, health care systems would need the ability to "surge," or care for large numbers of patients or patients with unusual medical needs. Following that report, the GAO conducted a study of state efforts to plan for medical surge needs in the event of a catastrophic event. The results, presented to Congress in January 2010, found that many states had made efforts related to three of the four key components of medical surge that the GAO identified: 1) increasing hospital capacity; 2) identifying alternative care sites; and 3) registering medical volunteers. At the same time, fewer facilities were prepared for the fourth recommendation: planning for altering established standards of care.¹⁴

In addition, in 2007 the U.S. Department of Health and Human Services (HHS) contracted with the Center for Biosecurity of UPMC to conduct a comprehensive assessment of the HHS Hospital Preparedness Program. One of the study's key findings was that "while much progress has been made in healthcare preparedness for common medical disasters, the U.S. healthcare system is ill-prepared to respond to catastrophic health events (CHE), and there is as yet no clear strategy that will enable an effective response to such an event." The study defined a catastrophic health event as "an event that could result in tens or hundreds of thousands of sick or injured individuals who would require access to healthcare resources." In its January 2010 report analyzing the current system for a national response to catastrophic health events, the Center for Biosecurity of UPMC identified several major challenges:¹⁵

- Many hospitals and other healthcare organizations do not yet participate in fully functional healthcare coalitions, which are necessary to CHE response.
- Most existing coalitions do not yet have the ability to share information, resources, and decision making with neighboring coalitions during a CHE.
- There are inadequate systems to perform the necessary triage, immediate treatment, and transport of patients outside of the immediate area stricken by a CHE.
- Existing plans and resources for patient transport are grossly inadequate for moving the expected numbers of patients.
- There is not enough guidance on the crisis standards of care that will be necessary throughout all stages of a CHE.
- There is no plan that sufficiently outlines healthcare roles, responsibilities, and actions during the response to a CHE.

- City manager or mayor;
- Chamber of Commerce;
- County commissioners;
- Schools and shelters;
- Security agencies; and
- Mortuary services.

Staying in the Loop. Without a doubt hospitals provide a critical role in disaster situations. However, if hospitals aren't forthcoming enough, they may be excluded from disaster planning in their community.

For example, although some are more sophisticated than others, many communities have some type of emergency operations center that helps coordinate responses to emergencies. But often hospitals aren't included in the organization's planning efforts.¹

Being involved in community disaster planning efforts is the hospital's responsibility, and it requires being proactive with other community organizations. This is particularly true for small community hospitals who may get left out of planning efforts even when larger hospitals and medical centers are included. Although the resources available from small organizations during a disaster may be less than a larger facility, they still play a critical and valuable role in responding to local disasters, and should be included in planning efforts to ensure that their contribution is maximized.

Crisis Communications Plan. In addition to including a communication component in the hospital's disaster preparedness plan, the hospital should be part of a shared community-wide crisis communication plan. Having a plan in place that links all the key players together ensures that critical minutes aren't wasted during the emergency. Community leaders should form a task

Lessons Learned from the Icelandic Volcano: Preparing for the Unexpected

As hospital leaders prepare for disasters they are likely to consider locally predicted events, such as an earthquake, tornado, hurricane, chemical spill, etc. But the recent chain of events that occurred as a result of the volcanic eruptions at Eyjafjallajökull in Iceland highlight the importance of preparing for the unexpected.

When the Icelandic volcano erupted most were not prepared for the far-reaching implications of the event. The eruption began on April 14, 2010, and led to most European flights being cancelled until April 20th. According to a recent story in *HealthLeaders*, although hospitals were not directly impacted, it is a good reminder about the importance of planning for the unexpected, and for "escalating incidents." The combination of the atmospheric conditions created by the eruptions, coupled with political debate and decision-making, escalated the incident beyond its initial expected impact, a common challenge when disasters occur. Conducting a disaster drill that includes an "escalating incident" at least once a year is a requirement of The Joint Commission.

The fact that passengers were stranded at airports across Europe due to flight delays and cancellations is also a reminder about the challenges a disaster may pose to getting staff members to the hospital during an emergency. Whether it's grounded flights, flooded roads or a collapsed bridge, hospitals must plan to take unusual steps if an emergency prevents employees from getting to the hospital by traditional methods.

Finally, hospitals should be prepared for the financial impact of a disaster. It is reported that airline carriers lost up to \$200 million a day during the Icelandic volcano crisis. Large-scale emergencies can devastate business operations, particularly for hospitals that face a two-part challenge of the expense of caring for patients during the disaster while simultaneously cancelling scheduled patient care.²

force to improve their collective responsiveness during a disaster, coordinating in advance how they will work together to best meet community needs. Components the task force should consider addressing include:¹⁶

- Developing a roster with current contact information for all stakeholders;
- A detailed media plan to follow during a disaster;
- A definition of events that call for notifying authorities, and how to do so; and
- A discussion of worst-case scenarios, and how the group would respond to each.

Leveraging Partnerships for Community Benefit. Forming partnerships with community stakeholders under the umbrella of disaster planning gives all the players a

shared goal around which to unite. It is also an opportunity for the hospital to form lasting relationships with community organizations, governmental agencies, and individual leaders in the community that can help strengthen community trust and support for the hospital in the long-term.

It is a chance to tell the hospital's story, and to look for ways the hospital can form mutually beneficial relationships in the community. It is also an opportunity to identify new ways that the hospital can meet community health needs that may have otherwise fallen below the radar screen.

Conducting Drills

The Joint Commission requires accredited hospitals to conduct disaster response drills twice a year. At least one of the drills conducted must include an influx of simulated patients, and an "escalating event" in which the local



community is unable to support the hospital. In addition, one of the two drills must include participation in a community-wide exercise. Finally, drills should include monitoring of the hospital's performance through the exercise, and make modifications to the hospital's plan based on the drill's outcomes and findings.

Live Drills vs. Tabletop Exercises. Drills can be conducted as live, in-person drills or through "tabletop exercises." Tabletop exercises are a facilitated analysis and discussion of an emergency situation. They allow the key players to come together and discuss preparations for a specific situation in an informal, stress-free environment. The informal setting of tabletop exercises allows participants to discuss in-depth scenarios and problem solve without time constraints; they provide a valuable opportunity for community stakeholders to coordinate and problem-solve together.

Testing Information Technology Systems. Information technology (IT) has become an integral part of the way patient care is delivered today, and can cause care to come to a screeching halt if providers are not prepared. For example, rather than waiting for test results to appear electronically, a nurse may have to designate a "runner" to deliver and retrieve test diagnostic and

laboratory test results. In addition, providers may have to record patient charts and reimbursement information manually and then re-enter it into the system at a later point in time.

According to SunGard Availability Services, a Pennsylvania-based company that provides IT disaster recovery assistance and

managed IT services, hospitals should keep the following in mind when conducting IT drills:⁷

- Conduct at least two drills a year to make staff more comfortable with response plans.
- Push the envelope with unexpected scenarios—make sure nurses know how pharmacy operates if there is an IT failure, IT techs understand the impact of down time on computer-aided diagnoses, etc. Like clinical drills, think about escalating scenarios that can occur with an IT system down.
- Encourage communication between clinical and IT departments so that IT professionals understand what is most critical. For example, nurses need to explain at what point printouts of records may be necessary (such as for patient evacuations).

The Board's Role in Disaster Drills.

While boards of trustees are not responsible for the details of the drills, they should hold hospital leaders accountable for ensuring that they take place, and expect a report of major findings. Because the board is ultimately responsible for the organization's response during a disaster, whether the organization conducts drills and how it responds and makes adjustments based

on the drills' outcomes should be important to the board. The board should also be committed to ensuring that hospital leaders have the resources they need to conduct drills and training exercises.

Practice Pays Off. The importance of practice and post-emergency assessment was apparent to hospitals in Arkansas, Oklahoma and non-coastal areas of Texas when first Hurricane Gustav, then Hurricane Ike threatened the Louisiana and Texas coasts in late August and early September of 2008. According to Health and Human Services (HHS) reports, more than 1,000 patients were evacuated by air from hospitals in Louisiana and Texas in the wake of these storms, and hospitals in neighboring states took them in. Having practiced for flights, ground transportation, triage and reception of the patients, the receiving hospitals entered "disaster preparedness mode" as soon as National Disaster Medical System (NDMS) alerts were activated.

Gustav and Ike also caused NDMS hospitals in many other states, including Mississippi, Alabama, Tennessee, Kentucky, Kansas and Iowa to be on alert, ready to receive patients if necessary. Mississippi and Alabama did experience some in-state patient transfers to hospitals out of the storm's path. These evacuations were done by ambulance and other means of ground transport.

Because of lessons learned following the 2005 Hurricane Katrina disaster, plans for timely patient evacuations were developed and coordinated from the federal level all the way through to local hospitals or health care facilities. The many NDMS drills, conducted with the help of the Departments of Defense and Veterans Affairs (for assistance with air evacuations), truly paid off.

Information Technology May Prove Invaluable

Information technology improves quality of care in everyday care settings, and care in a disaster is no different. In fact, it can play an even more important role in a disaster. In many cases patients may be interacting with a provider or health system they have never used before, and their medical history may be unknown. In addition, technology can aid in communication between providers coordinating care, help families locate missing loved ones, and aid in insurance billing after the event is over.

After the catastrophic earthquake hit Port-au-Prince, Haiti in January 2010 emergency medical care meant life or death for many people. According to an NBC *Nightly News* report, within 48 hours after the earthquake, the Israeli Army landed two 747 aircraft with medical providers and supplies, and set up a temporary hospital not reliant on outside aid. The goal of the hospital was to provide the best field medicine available, using a comprehensive model for disaster response fine-tuned by the Israeli Army that, unfortunately, is all too accustomed to responding to disastrous medical needs. The self-reliant hospital included:³

- Photographing patients when they were checked in;
- Using the digital photo and any other information available to establish an electronic medical record;
- The ability to add digital images to medical records at any time and send the information to a specialist anywhere in the world for assistance; and
- A psychiatrist and an ethics committee to help make difficult decisions around life, death, amputation, and other care decisions.

Not all hospitals in the U.S. have the capacity or the funding to house such a sophisticated IT system, nor are they expected to. However, organizations should be prepared to leverage everything they have. For board members, this means ensuring that the hospital's information technology system will be robust during an emergency, is backed up in an off-site location, and has been a key component in disaster drills. Board members should also encourage the organization's IT leaders to look for new and innovative ways that technology can be used in times of emergency, and test the technology extensively to ensure IT staff is prepared to maximize its impact during an emergency.

Learning From Your Successes and Failures: Conducting a Post-Emergency Assessment

The board's role in a disaster does not end once the disaster has passed. When things are beginning to "return to normal," the board should be actively involved in assessing the hospital's response to the disaster. As with any crisis, some things will have gone according to plan, and some will not. The board should work with administration to weigh what additional resources are needed to aid the hospital as it updates and upgrades its disaster readiness plan, and seek ways to adequately fund these necessities.

The Benefits of Being Prepared: More Than Your Response During the Disaster

The process of ensuring a successful disaster response plan results in more than a hospital that meets Joint Commission requirements and can respond to immediate community needs during an emergency. Thorough disaster planning also results in:

- **Board fulfillment of their fiduciary responsibility** to ensure that the hospital is able to care for the community in the event of a disaster;



- **Improved quality and patient safety**, as the hospital's ability to respond to a disaster in the most organized and prepared manner possible ensures that the quality of care provided throughout and immediately following the disaster is top-notch. In addition, in times of minor snafus (such as a power outage or broken water pipe), the hospital is prepared to continue providing the same quality of care with little or no disruption to patient care.
- **Strengthened physician credentialing process**, which includes a plan for identifying additional qualified physicians that can assist in a major or minor disaster response without being credentialed by the hospital.
- **Greater financial stability**, as the hospital's financial position and long-term viability is strengthened because of its preparation.
- **Additional funding** that may be raised from private donors and/or state and federal grants to fund the hospital's disaster plan.

- **Improved public trust** on multiple fronts. The process of partnering with key stakeholders throughout the community instills trust and support for the hospital as it strives to meet community needs. If and when a disaster does strike, the public will look to the hospital as a safe place that is prepared to handle any kind of emergency. A hospital's response during a disaster can cause public trust to swell or recede.
- **Demonstrated community benefit**, as the hospitals' response to a disaster and ability to care for all regardless of their ability to pay is a basic community benefit expected

by the public, lawmakers and the media.

- **Improved community health and wellness.** Not only is it the hospital's responsibility to care for those in need during a disaster part of their expected community benefit, but depending on the disaster it may also be essential to maintaining the community's health. For example, the hospital may need to quarantine patients to prevent the spread of a highly contagious disease, respond quickly to air or water quality concerns, or promptly care for trauma victims.

Although it may seem unthinkable, disasters can happen anywhere, anytime. Regardless of the size of the organization, every hospital and health system will play a critical role when disaster strikes their community. It is ultimately trustees' responsibility to not only ensure that their organizations are prepared, but to initiate the preparation process in a way that partnerships are maximized, internal systems are improved, and quality of care and community benefits are strengthened as a result.

Questions for Boards: Hospital and Community Disaster Readiness Check

As you evaluate your organization's disaster preparedness plan, consider the following questions:

- When was the last time you asked members of the management team whether your hospital is adequately prepared for local threats or disasters that pose the greatest risks to your community?
- Has your hospital conducted a "hazard vulnerability analysis" to determine what types of emergencies are most likely to occur, and should be included in your disaster plan?
- Does your hospital have a written disaster preparedness plan, and has it been reviewed by the board?
- Does your disaster preparedness plan focus on a general "all-hazards" approach, providing an adaptable framework for a variety of crisis situations?
- Has your hospital or another community leader convened the local health care infrastructure for disaster preparedness discussions?
- Is your hospital part of the National Disaster Medical System? If so, is there a plan in place for who to contact and the organization's role?
- Has your hospital determined the scope and resources for the emergency management plan and implementing the plan?
- Does your hospital have an organizational-wide commitment to communicate effectively and openly during times of crisis?
- Does your hospital have a separate crisis communications plan in place? Has it been developed in collaboration with other local community leaders?
- Does your hospital have back-up communications capabilities in place in the event that traditional forms of communication are either slowed or not functioning altogether?
- Does your hospital have plans in place to rapidly expand clinical and non-clinical staff in the event of a disaster?
- Have staff members been oriented in their roles and responsibilities within the command structure?
- Is there a plan for supporting the families of staff members in the event that they are needed at the hospital? Does the plan cover all bases, from assurances that family members are safe, to child care, elder care, and pet care?
- Has your hospital determined how critical supplies will be obtained and allocated in the event of an emergency?
- Is your hospital prepared to potentially be "on its own" for up to 96 hours, as required by The Joint Commission?
- Does your hospital have a simplified patient registration procedure in the event of a large number of patients and/or casualties?
- Are your information systems backed-up in an off-site location with recovery capabilities?
- Does your hospital have a security plan in the event that the hospital needs to limit access to the facility, and a plan for where to redirect people that come to the hospital seeking assistance for non-life-threatening needs, such as food, water, shelter, electricity or counseling?
- Does your hospital conduct drills annually, and if so, do they include other local health care organizations and key stakeholders?
- In the aftermath of a disaster, is your hospital prepared to review the documentation and debrief key personnel in order to prepare a comprehensive report describing the crisis and evaluating the process undertaken?
- Has your hospital determined which key audiences need ongoing, follow-up communication about the crisis and its aftermath and the hospital's recovery?
- Are your hospital leaders prepared today to talk to the community and its leaders, lawmakers and key stakeholders about how the hospital is prepared to deal with a disaster or emergency situation?

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