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The Early Years: Shaping a National Stockpile for Preparedness

By Greg Burel



Podcast: Opioid Epidemic & Narcan's Unintended Consequences

Moderated by Andrew Roszak



The Value of Crisis Communications

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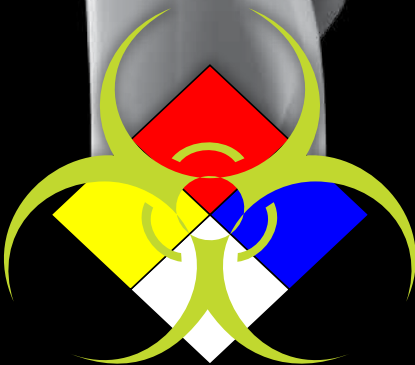
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Pictured on the Cover: (top row) Burel, Source: Strategic National Stockpile; Roszak, Source: ©iStock.com/Tomlw (second row) Mangeri, Source: ©iStock.com/AlexLMX; Gibson, Source: ©iStock.com/Kieferpix



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Overcoming Healthcare Challenges & Finding Solutions

By Catherine L. Feinman



The healthcare industry presents many challenges for emergency preparedness professionals. The planning process for a major crisis involves numerous stakeholders, each with their own plans and procedures. Emergency medical services and hospitals, in particular, are tasked with managing dynamic, ever-changing environments that are difficult to predict. A medical surge could easily lead to shortages in critical resources if mutual aid agreements, healthcare coalitions, and other collaborative efforts are not already in place before disaster strikes.

The opioid epidemic is one crisis that has escalated over time. As solutions were sought, Narcan was introduced to counteract the effects of opioids. Despite saving many lives, this solution has also led to [unintended consequences](#) that have put some patients and responders at further risk to life and health.

For disasters such as biological attacks or other low-frequency, high-consequence events, having antidotes and other resources in place and available when needed introduce logistical challenges. To combat this challenge, the [Strategic National Stockpile](#) (SNS) is able to store and track resources that can be deployed to communities that have depleted their supplies and medicines.

Like the SNS, hospitals understand the importance of resource management, as they often face challenges even during routine operations. The continual turnover of patients and staff throughout a single day can disrupt operations and deplete resources. However, hospital staff have a duty to react regardless if they have all the supplies and resources they need under ideal circumstances. As such, hospital leadership must find ways to overcome the various [challenges within the hospital preparedness](#) process.

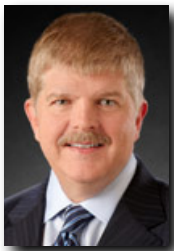
Of course, leadership and communication are key at every stage of a disaster. Identifying the challenges and creating solutions to them require careful planning and extensive collaboration. [Crisis communications](#) is a valuable component of such planning and collaboration. Providing the community with a message that is unified, concise, and easily understood can speed recovery and mitigate unintended consequences.

Emergency planners, responders, and receivers have a choice when it comes to helping or hindering a crisis response. Collaborative planning, streamlined resource management, experienced leadership, and effective communication lay the foundation for mitigating the direct or indirect consequences that can manifest when responding to a crisis. The good news is, like the authors in this edition of the *DomPrep Journal*, there are many people out there who strive every day to overcome challenges and find solutions they can share with their counterparts around the world.

The Early Years: Shaping a National Stockpile for Preparedness

By Greg Burel

In today's emergency response landscape, public health jurisdictions across the United States rely on the Strategic National Stockpile (SNS) when incidents prove large enough or severe enough to deplete medicines and supplies needed to protect communities. In just 20 years, the SNS – now managed by the U.S. Department of Health and Human Services' (HHS) Assistant Secretary for Preparedness and Response (ASPR) – has grown to a \$7 billion enterprise poised to respond to a variety of public health threats. These threats include anthrax, botulism, smallpox, plague, tularemia and viral hemorrhagic fevers, as well as emerging infectious diseases, pandemic influenza, natural disasters, and other chemical, biological, radiological, and nuclear incidents. Although predicting the future of any program is challenging, the SNS has evolved from humble beginnings to a formidable component of national security.



Early discussions about establishing a federal stockpile of medical products centered around planning for the year 2000 – commonly called Y2K – amid fears of terrorist attacks significant enough to cause healthcare facilities to run short on supplies. In January 1999, Congress charged HHS and the Centers for Disease Control and Prevention (CDC) with creating a repository of medical countermeasures (MCMs) for use in the event of a chemical or biological terrorist attack on U.S. civilian populations.

This repository was initially named the National Pharmaceutical Stockpile.

Building the Stockpile Piece by Piece

With a \$51 million appropriation and a handful of public health professionals quietly housed in CDC's National Center for Environmental Health, the program expanded systematically to meet Congress' intent to protect the American people. Within one month, the stockpile was augmenting the National Medical Response Team's inventory by providing funds to HHS to procure and forward-position treatments and antidotes for up to 10,000 individuals if a nerve agent release occurred. This effort ultimately became today's CHEMPACK program, a far-forward-placed stock of medicines to respond to chemical nerve agent attacks or incidents involving organophosphorus pesticides.

Using the 1999 HHS Anti-Bioterrorism Operating Initiative as a starting point for which threat agents to address, stockpile personnel developed concepts for the 12-hour Push Package – a broad spectrum of medicines and supplies for an unidentified threat – and vendor-managed inventory. They began meeting with external subject matter experts to review potential threats and recommended treatments. At the same time, CDC hosted a similar meeting with its Bioterrorism Preparedness and Response Program concerning biological threat agents. From these meetings, stockpile personnel initiated the development of the

early formulary and the medical materiel requirements deemed necessary to protect the United States from a growing list of threats. By September 1999, the stockpile finalized its first total requirements list. Then, on 27 December 1999, the stockpile readied its first 12-hour Push Package to respond to a potential Y2K terrorist incident.

The one-year mark proved a busy time for the budding stockpile. The program established transportation contracts to move stockpiled assets, if needed, and created its Program Planning, Response and Training Team to work with HHS emergency

coordinators in the field to ensure planning efforts were well-coordinated and integrated with activity at the state and local levels. Personnel were writing and establishing initial development contracts for new smallpox and anthrax vaccine and new botulism antitoxin to include in the stockpile, and they served as project officers for the development of these pharmaceuticals.

Over time, stockpile staff continued to adjust the formulary and build and configure the 12-hour Push Packages. They worked with warehouse vendors and transportation partners to establish some early processes and procedures that have been tested and refined for use by the SNS today. In September 2000, the Food and Drug Administration (FDA) granted approval for the stockpile to participate in the FDA/Department of Defense (DoD) Shelf-Life Extension Program (SLEP). Originally, SLEP was viewed simply as a method to save money. Today SNS continues to use SLEP to maximize returns on investment by holding MCMs for as long as possible while ensuring stability and potency. SLEP also allows the SNS program to build up stock over time to reach the full quantities needed to protect Americans. This benefit is especially important because some stockpiled products are produced in such low quantities and have such short shelf life that otherwise would prevent the program from meeting its overall preparedness goals.

Testing Stockpile Response Capabilities

One of the stockpile's first collaborative efforts with emergency response planning was working with the New York City Department of Emergency Operations and the Federal Aviation Administration. On 11 September 2001, one month after the three organizations



Cargo containers specially designed for SNS products in the stockpile's early years are still in use today. The shape allows for better configuration for air cargo transport (Source: Strategic National Stockpile, date unknown).

staged their first full-scale exercise, an early morning attack on the World Trade Center and the Pentagon confirmed the country's worst fears. The stockpile was called into action as part of the government's immediate response to the deadliest terrorist attack on U.S. soil. Within seven hours of the order to deploy to New York City, the stockpile delivered by both ground and air cargo a 12-hour Push Package of medicines and supplies as well as ventilators, ancillary supplies, and burn-and-blast supplies. The delivery was met by a response team of stockpile experts called a Technical Advisory Response Unit, which was able to deploy to New York via chartered aircraft. On that day, the only other non-military flight in U.S. airspace was Air Force One.



Aside from Air Force One, the only other aircrafts in U.S. airspace following the 9/11 attacks were flights to NYC to deliver stockpile medicines, supplies, and personnel (Source: Strategic National Stockpile, 2001).

On the heels of 9/11, the stockpile was called upon again to respond to a series of anthrax attacks and subsequent inhalation anthrax cases in the United States. Using its vendor-managed inventory capability, the stockpile responded to 65 separate drug requests for post-exposure prophylaxis, all of which were filled within an average of five hours from initial contact to delivery.

The events of 2001 shed light on the need to strengthen national public health preparedness and response efforts. Immediately

following these two responses, the stockpile rapidly expanded with both inventory and appropriations. The HHS secretary directed the stockpile to increase its capacity to provide full post-exposure prophylaxis for anthrax for up to 12 million people. The number of 12-hour Push Packages grew from eight to 12. Congress appropriated \$643 million for the stockpile in FY 2002 to fund these initiatives as well as to run a state preparedness grant program, to establish packages of chemical nerve agent antidotes and antibiotics, and to grow the program to a team of 79 personnel.

Expanding the Stockpile for an All Hazards Approach

During the next two years, the stockpile developed and solidified partnerships across the federal interagency community as well as with private warehouse and transportation organizations. The program was granted responsibility for the transport of existing and future supplies of botulism antitoxin and anthrax vaccine as well as for storing and transporting the nation's current and future supplies of smallpox vaccine. Stockpile experts were looking to improve speed and efficiency and worked with private sector partners to design the first specialized cargo containers for the 12-hour Push Package. In this timeframe, the stockpile

also created a pilot program called CHEMPACK, which placed federally owned and managed nerve agent antidotes in forward locations selected by local authorities to integrate with their hazardous material response plans. Fast forward 20 years and the SNS remains ready today to respond to chemical nerve agent incidents through CHEMPACK, which has forward placed more than 1,900 containers of antidotes at more than 1,300 locations across the United States and its territories.

While the stockpile was expanding its mission and role in storing and transporting critical products for national health security, staff was developing a comprehensive training and exercise program to ensure state and local health jurisdictions were ready to receive, distribute, and dispense these products in an emergency. Internally, the program was implementing a professional inventory and financial tracking system to provide a real-time capability to manage SNS assets and mission readiness. With continual updates, this system is still used by the SNS to integrate financial and inventory information and to ensure inventory accountability, reconciliation, and financial reporting.

On 1 March 2003, the Homeland Security Act of 2002 took effect, and the stockpile was transferred from HHS to the Department of Homeland Security (DHS). At the same time, the National Pharmaceutical Stockpile was renamed the SNS to reflect its evolving formulary to store more than just pharmaceuticals, but also medical supplies and devices earmarked for public health emergencies. Additionally, formulary governance in the early years was established by the stockpile via the creation of the Intragovernmental Committee, chaired by CDC's associate director for science and made up of members from various federal organizations including HHS, CDC, FDA, DoD, and DHS.



Specialized cargo containers were designed for the 12-hour Push Package to improve delivery speed and efficiency (Source: Strategic National Stockpile, date unknown).

By the close of 2003, the stockpile program had increased staffing to 120 employees and contractors. The staff grew with specialists in public health, emergency response, and, importantly, now professional medical logisticians. The annual appropriation hovered around \$300 million, there were a dozen 12-hour Push Packages in 10 sites across the nation, and the stockpile was positioned to provide up to 12 million people with a full 60 days of post-exposure prophylaxis if faced with a large-scale anthrax response. Also, the stockpile added

400,000 doses of antiviral drugs to its formulary in preparation for a pandemic influenza. This was the first procurement for the formulary beyond the original mission focused on terrorist incidents and represented an entirely new and different scope.

When Project BioShield – a program to expedite late-stage development and procurement of next generation vaccines and other MCMs against a range of potential terrorist weapons – became law on 21 July 2004, the SNS returned to HHS. Under this new legislation, the SNS was designated as the procurement and storage partner for Project BioShield and would manage the delivery of products in a bioterrorist attack or other emergency. The SNS remains with HHS today, although the program transferred from CDC to its current place in ASPR in October 2018.

In the program's first five years, the SNS grew from a small organization with a modest budget and a handful of staff to a robust and critical piece of federal preparedness and response. Real-world incidents tested the stockpile's capabilities, and state and local jurisdictions worked in concert with stockpile experts on major planning initiatives. These early achievements set the course for the next 15 years as the SNS evolved to broaden its focus to serve as the nation's resource for protecting the public's health.

Greg Burel is director of the Strategic National Stockpile, managed by the Department of Health and Human Services' Assistant Secretary for Preparedness and Response. As head of the nation's largest stockpile of medicines and supplies available for emergency use, he is a leading expert on medical supply chain management in the United States. With more than 35 years of civil service, he has risen through the ranks of the federal government, beginning his career at the Internal Revenue Service and serving in leadership roles in both the General Services Administration and the Federal Emergency Management Agency. In 2006, he assumed the helm of Strategic National Stockpile operations. He was awarded the Samuel J. Heyman Service to America Medal for Management Excellence and selected as a National Academy of Public Administration fellow in 2016.

Significant contributions to this article were made by:

Steve Adams is the SNS deputy director. He joined SNS at its inception in January 1999 and has played an integral role in the assisting state and local jurisdictions in planning for and implementing responses to large-scale public health emergencies. Prior to joining SNS, he held roles at CDC providing direct assistance to the states for STD/HIV prevention and control efforts and managing environmental research projects to quantify the health impact on humans during the Cold War nuclear weapons production era. He holds a bachelor's degree in economics/political science from The Ohio State University and a Master of Public Health from the University of North Carolina at Chapel Hill.

Susan E. Gorman is a licensed pharmacist and board-certified clinical toxicologist who serves as associate director for science and chief of the SNS Science Branch. An original staff member of the SNS, she oversees the formulary and provides technical and scientific advice on all SNS pharmacological and toxicological issues. She earned a Bachelor of Science in pharmacy from Duquesne University, a Doctor of Pharmacy from the University of Maryland, and completed a postdoctoral residency in emergency medicine and toxicology at the University of Illinois at Chicago. She also earned a Master of Science in biosecurity and disaster preparedness from the St. Louis University School of Public Health. Prior to joining the SNS, she was assistant director for the Georgia Poison Center where she continues to serve as a toxicologist. She is actively involved in the American Board of Applied Toxicology and is a fellow of the American Academy of Clinical Toxicology.

Stephanie M. Bialek is the SNS Stockpile Communication Services Section chief. She has 20 years of public relations and communications experience in government, academia, and health sciences and joined the federal government in 2010 to provide communications expertise and strategy for the SNS. She holds both a bachelor's and master's degree in journalism and mass communications from the University of Georgia.

Opioid Epidemic & Narcan's Unintended Consequences

In 2017, the U.S. Department of Health and Human Services declared a public health emergency related to the [opioid crisis](#). Indeed, overdoses and deaths from opioids have skyrocketed over the past decade. In 2017, deaths from opioids were six times higher than in 1999. Opioids impact the quality of life and longevity, as well as have tremendous social and economic impacts on communities throughout the United States. The Centers for Disease Control and Prevention has stated that the total economic burden of prescription opioid misuse costs over \$78 billion per year.

In addition to the financial toll, deaths from opioids have been increasing steadily and have overtaken deaths due to motor vehicle crashes. Approximately 130 Americans die each day from an opioid overdose and around 68% of drug overdose deaths in 2017 were opioid related.

Communities have been actively looking at ways to reduce the impact of opioids and curb these upward trends. One solution that several jurisdictions have embraced is providing Narcan (naloxone) to members of the public. Narcan is an opioid antagonist and, when administered, it can cause the complete or partial reversal of an opioid overdose.

Although emergency medical services (EMS) agencies have been giving Narcan for years, the introduction of this drug to untrained citizens is a relatively new approach. Experienced EMS providers understand that administering Narcan is certainly not without risk. Individuals suffering from an overdose that are treated with Narcan undergo rapid withdrawal, which can lead to erratic behavior and violence.

Sadly, a recent example of this [danger occurred in Appleton, Wisconsin](#) – where a firefighter was killed and a police officer shot after an unconscious individual suffering from an opioid overdose was treated with Narcan. After administering two doses of Narcan, the man regained consciousness. EMS crews attempted to persuade the man to be transported to the hospital for follow-up treatment and evaluation. The man became agitated and pulled out a 380-caliber handgun from concealment. This incident serves as a stark reminder of the dangers faced by first responders each day, and has caused some departments to [rethink or institute policies](#) regarding searching unconscious victims prior to Narcan administration.

This podcast, recorded on 24 September 2019, includes EMS professionals with decades of experience. This podcast explores the issues surrounding the opioid epidemic, explains how EMS is handling this new public health crisis, and discusses the possible unintended consequences of making Narcan available to citizens.

[Click](#) to listen.

Andrew Roszak, Moderator, Executive Director, Institute for Childhood Preparedness

Matt Wiggins, Paramedic

Elizabeth (Liz) Fiato, District Chief of EMS and Emergency Preparedness, Donaldsonville Fire Department



The Value of Crisis Communications

By Anthony S. Mangeri

The role of the emergency management systems is to bring calm to chaos. The role of the public information officer (PIO) is to disseminate information that is credible, accurate, and reliable. It is a critical component of the initial response to meet the informational needs of residents – trusted, credible information aids in bringing calm.



The internet has created new distribution systems for information that include subscription services, e-mail lists, blogs, and social media. All these sources of media have the ability to manipulate the community's perception of what is and is not important.

Communication systems are the essential tool to provide the public an understanding of what is occurring and how to react to a threat. Today's PIOs must work with several media systems to ensure that the public is kept informed. It is now necessary for agencies to be able to provide information across multiple platforms.

Some communications researchers believe that people interact with media sources to create their own meanings out of the images and messages that they receive. The internet and other modern technologies allow individuals to play a more active role in determining the news and information they receive. In some instances, individuals subscribe to sources and control the news they see, hear, or read. In other cases, technology observes the readers' patterns of interests to deliver aggregated news of interest to the reader based on an algorithm.

Defining Mass Media in the 21st Century

Popular news media is a form of mass media designed to distribute news and information to the mass population. Historically, news media has included print media such as newspapers and magazines. It also includes broadcast media such as radio and television.

In today's world, it is content that drives media. Securing content that is of interest to targeted readers allows the sale of advertising and sponsorship of content. However, popular media is no longer the sole source for information. An overwhelming majority of the population now receive news through online sources, making today's mass media very different than even 10 years ago. The internet is full of content, which also can steer the community's perceptions, attitudes, and sense of what is and is not important.

Media in the 21st century includes more options than just print or broadcast media to provide news to individuals. Individuals increasingly receive news from sources that have other content that interest them. In addition to traditional sources, news content is now available via the internet, blogs, social media, and even internal agency channels. All of it now is pushed to the receivers via cellphone or tablet.

According to the [Pew Research Center](#), more Americans get their news from social media than print news. Television remains the most consumed news but is rapidly losing ground to

online sources. Also, according to Pew Research, adults of all ages are increasingly receiving news via mobile devices. As a result, news today is being disseminated and received quicker and consumers are far more mobile than in previous years.

The Role of Media in Disaster Management

It is necessary for emergency management agencies to quickly and effectively communicate strategies and inform the public during times of crisis. In order to effectively manage the dissemination of information, emergency managers must acknowledge the value of mass media – including blogs, local news media, and social media sources – as partners in informing the public. These sources strategically are an important part of providing guidance on preparedness, creating risk-reduction strategies, and securing the reputation of an emergency management organization.

The role of the news media is to secure the content necessary to tell a story that is relevant to the audience. The role of a public information organization is to provide factual verified information. Therefore, it is beneficial for emergency management agencies to use news media as a force multiplier to aid in disseminating needed information to the community.

Reporters are neither a friend nor an enemy. Their job is to tell the story. Reporters are expected to behave in a manner that is professional and balanced in their reporting. However, it is the PIO's role to engage and inform reporters of validated information to tell the story for emergency management. Simply put, PIOs need to work to control the narrative and tell the story of emergency management.

To ensure understanding and to build trust, responses to questions from the public, including news media, should never be casual or cavalier. It is important for agency representatives to follow through in a timely manner if they tell a reporter that they will get the requested information back to them.

Telling the Story

Generally speaking, stories have common elements to form the storyline. Know what information will be needed and be prepared to gather validated information to support your statements. Like all good stories, the basic formula for most news stories has a victim, a rescuer, and a villain. A good emergency manager or public information officer needs to keep the storyline in mind when telling their story to the media.

To develop trust and credibility, emergency management and public safety agencies need to build relationships with news media before an incident. They should conduct workshops with local media and the community to inform them of emergency management programs, planning efforts, and mitigation activities.



When information is scarce, community emotions can run high. Gossip and speculation may interfere with credibility and may lead to fear, anxiety, and a loss of trust in the agencies attempting to respond and aid those in need. It is critical to stay on message, be first to report, be accurate, and be credible. Leading the discussion with empathy and openness also builds trust and confidence.

When planning to communicate with the public and the news media, PIOs should ask themselves the following questions:

- What information is crucial to convey in initial messages in order to prompt appropriate public responses after a crisis?
- What messages need to be delivered prior to, during, and after an incident?
- What obstacles interfere with communications and how can they be minimized?
- What opportunities for effective communications exist and how can they be maximized?
- What questions can be anticipated from the public in these risk situations?
- What are the news media's responsibilities and how can PIOs help reporters meet them?

The one phrase that may significantly impact an organization's credibility is "No Comment." Since this phrase denotes a potential lack of transparency and candor, it should almost never be used in time of crisis. When responding to questions that have no clear response, PIOs should offer to research the topic and provide information later.

Planning for Communications in Times of Emergency

In order to manage public information, the first step is to create an inventory of potential emergencies that can occur. Many governments have already completed a Hazard Identification and Risk Assessment as part of building their emergency planning strategies. At a minimum, the PIO should develop a strategy to address the most common questions as they relate to the top five most likely incidents based on probability of the incident and the potential for damage in the community. The PIO function should be included in all exercises.

A good emergency manager or PIO has a thorough understanding of what information is needed to motivate appropriate community action. The emergency management agency must then provide credible and accurate information as quickly as possible. The benchmarks of a solid public information effort include news reports that are: accurate, informative, timely, open, and empathetic.

Anthony S. Mangeri, MPA, CPM, CEM, has more than 30 years of experience in emergency operations and public safety. He served his community as a volunteer firefighter and an Emergency Medical Technician (EMT) for more than 25 years, ultimately earning the rank of assistant chief/safety officer and serving as the fire department's health and safety officer for many years. Currently, he is a consultant focusing on emergency management, planning, training, and exercising. He is also on the faculty in the School of Security and Global Studies at American Military University. He serves on several professional committees, including the ASIS Fire and Life Safety Council, and the International Association of Emergency Managers (IAEM) USA Board of Directors. He earned a Master of Public Administration from Rutgers University. He is a Certified Public Manager and has received the IAEM's designation of Certified Emergency Manager.

Overcoming Challenges of Hospital Preparedness Plans

By Stephen Gibson

Transitioning from public sector emergency management for a large city to emergency management for a private sector hospital is not easy. The fundamentals of emergency preparedness are the same, but the hospital setting has unique challenges. Each day, there are different numbers of people within the hospital. Some days, the occupants exceed hospital capacity during normal operating conditions. There is no set vulnerable population as the demographics of the population changes hourly. Having a large turnover of people in the hospital because of appointments, outpatient surgeries, visitors, and vendors makes preparedness efforts more challenging.



As performed in the public sector, hospitals must identify their hazards by conducting a hazard vulnerability analysis (HVA), which is like a threat and hazard identification and risk assessment (THIRA). Hospitals need to identify hazards, provide context, and prioritize which hazards make them most vulnerable. The THIRA from the public-sector agencies should be taken into consideration when preparing the HVA as some of the threat to the community will affect hospitals as well. The whole community is needed to prepare for any disaster within a hospital setting.

After identifying hazards and vulnerabilities, the next step is to update the emergency operations plan (EOP). This must be updated annually as local hazards and vulnerabilities may have changed. This is where hospital preparedness gets challenging. Once the EOP is up to date, staff must be trained on the updates and exercise the EOP.

Training can be much more difficult than in the private sector due to budgetary concerns that most hospital emergency managers have to manage in an active hospital. All the services provided at the hospital are revenue generating, which is important for the hospital budget. As such, it is difficult to interrupt surgeries, appointments, laboratory work, and administrative duties to conduct exercises on the EOP. Technology has assisted with this process by having online learning requirements within a health care system. However, online learning only does so much.

Exercising, Resourcing & Informing

Exercising the plan is the difficult part of preparedness. Continuing active patient care complicates conducting exercises in the hospital setting. Patient safety must be considered when planning the exercises and having post-op patients, non-ambulatory patients, and mental health patients requires significant additional resources especially with regard to evacuations. The public information component is also very important especially if conducting a security threat exercise. It is essential that outside agencies are included in the exercise process. Sometimes it is easy to live in the bubble of the hospital building, but there is a community outside the front doors that needs to be included in the preparedness efforts.

Establishing and maintaining quality relationships with the community facilitates conversations about including them in exercise programs. Involving the community on a regular basis will start to build those relationship and build their trust in the hospital. This



should be done through community outreach events, public forums, involving them in developing the HVA, or having their input on EOP development. Once the community understands what the hospital is doing, they will be more willing to exercise the plans and ensure the hospital and the community are resilient to any threat or hazard.

The priority should be ensuring the hospital staff is always prepared. Having them understanding the EOP and exercising the EOP is essential for hospital resilience.

Hospital emergency managers will need to enhance or change the culture of leadership to focus on preparedness efforts. Some executives do not need any convincing, but others still need to understand why preparedness is so important. In general, leadership wants to see qualitative and quantitative data that supports why preparedness is so important. By demonstrating that actions can save lives and provide continuity of operations, hospitals can build support for the preparedness program. The type of data presented is important. Ensure that the data represents a hospital of comparable size and services to make the exercise realistic and less likely for the results to be questioned.

In addition, the hospital staff should be prepared at home and the emergency manager at the hospital should take considerable time to make sure they are. During significant local incidents or disasters, it is natural for people to protect their homes and family. If emergency managers work with hospital staff to be prepared at home, then it is more likely that the staff will report to work because they feel that their families are taken care of. Hospitals need their staff during times of disaster to provide essential services to the community. A couple of ways to assist with home preparedness efforts is to attend department huddles. This offers face-to-face time with all department members to express the importance of the program and discuss which preparedness items and plans they should have in their homes. Wall readers with colorful creative designs in areas where staff may sit frequently (break rooms, bathrooms, and staff cafeterias) will grab attention and offer significant exposure. However, wall readers should be changed monthly to avoid becoming “invisible” over time.

Ensuring a Resilient Community

Hospitals have an obligation to provide emergency and essential services to the community regardless of what is happening inside or outside the hospital setting. Hospitals need to ensure their facilities and staff are prepared for all types of hazards they may face. Safety, budget, logistical, and legal concerns are necessary for meeting preparedness goals, but emergency managers must also exhaust all efforts to ensure a prepared and resilient facility.

Stephen (Steve) Gibson is currently a coordinator–emergency management with a surgical and rehabilitation hospital where he has developed a comprehensive training and exercise program to expand their preparedness efforts. He specializes in emergency management with over 20 years of experience in public safety, serving as a fire officer and emergency management specialist. He consistently aims to further his knowledge of emergency management best practices by working with federal and state partners. He has been assigned to two presidential declared disasters around his home state. Outside of work, he enjoys volunteering with an international mission team to improve the quality of life of those in Central America.

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