



PREPAREDNESS PLANNING: EVALUATING THE QUALITY OF HEALTHCARE DISASTER MENTAL HEALTH PLANS



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BACKGROUND: A key component of healthcare emergency preparedness planning is providing for the mental and psychosocial well-being of the hospital/healthcare facility's community - workers, patients and their families - during a disaster. To date there have been few efforts to measure the quality of these provisions. From 2006-07, The NYC Department of Health and Mental Hygiene evaluated local hospitals' mental health emergency response plans (MH-ERPs). Here we present a promising method for evaluating MH-ERPs, findings and recommendations.

METHOD: In 2005, DOHMH offered funding and guidance to hospitals to develop MH-ERP plans and submit them to DOHMH for review. 29 of 65 NYC Hospitals voluntarily participated in MH-ERP Initiative. Plans were collected over an 18 month period, from August 2005 through February 2007. Table 1 shows characteristics of the 29 hospitals/healthcare facilities that participated in the MH ERP initiative.

Development of The MH ERP Assessment Instrument was guided by Grounded Theory principles (Strauss & Corbin, 1990) and employed a theoretical sampling strategy to examine the collected data (Charmaz, 2006). Researchers reviewed existing literatures on healthcare emergency response planning and conducted semi-structured interviews designed with teams of participating emergency planners from the 29 participating hospitals to elicit ideas on MH ERPs (e.g., What types of actions is your hospital taking to help staff maintain contact with their family during a disaster?). From this work researchers developed the assessment's domains and their attributes.

The researchers used a constantly compared their developing assessment to the submitted MH ERPs. This discursive process was designed to help maintain balance between theoretical concepts and the MH ERP data.

Characteristic	No.	%
Location (City/County)		
New York (Manhattan)	14	48.3
Range (Brooklyn)	9	31.0
Queens (Queens)	4	13.8
Roseton (The Bronx)	1	3.4
Roseton (Staten Island)	1	3.4
Hospital/Healthcare Facility Size*		
Cardiac Beds	27	Range: 61-899
Staff	25	Range: 800-8111

*Researchers constructed 'endpoints' for each attribute; these were anchored at one end by an 'ideal' but achievable aspect of the attribute (e.g., Plan Development) as plan development team with deci-

Domain	Definition
MCI	Recent Community Involvement in Plan Development
MCI1	• Involvement of community members in plan development • Involvement of community members in plan development
MCI2	• Involvement of community members in plan development • Involvement of community members in plan development
MCI3	• Involvement of community members in plan development • Involvement of community members in plan development
MCI4	• Involvement of community members in plan development • Involvement of community members in plan development
MCI5	• Involvement of community members in plan development • Involvement of community members in plan development
MCI6	• Involvement of community members in plan development • Involvement of community members in plan development
MCI7	• Involvement of community members in plan development • Involvement of community members in plan development
MCI8	• Involvement of community members in plan development • Involvement of community members in plan development
MCI9	• Involvement of community members in plan development • Involvement of community members in plan development
MCI10	• Involvement of community members in plan development • Involvement of community members in plan development
MCI11	• Involvement of community members in plan development • Involvement of community members in plan development
MCI12	• Involvement of community members in plan development • Involvement of community members in plan development
MCI13	• Involvement of community members in plan development • Involvement of community members in plan development
MCI14	• Involvement of community members in plan development • Involvement of community members in plan development
MCI15	• Involvement of community members in plan development • Involvement of community members in plan development
MCI16	• Involvement of community members in plan development • Involvement of community members in plan development
MCI17	• Involvement of community members in plan development • Involvement of community members in plan development
MCI18	• Involvement of community members in plan development • Involvement of community members in plan development
MCI19	• Involvement of community members in plan development • Involvement of community members in plan development
MCI20	• Involvement of community members in plan development • Involvement of community members in plan development

sion-making authority), and at the other by the absence or minimal presence of the attribute (e.g., Plan Development: Plan created by one person with no decision-making authority). Researchers then created mutually exhaustive and exclusive categories between these endpoint using a parsimonious categorization strategy to create the fewest possible categories. The categories reflect gradations of detail and specificity in each attribute on a scale of 0 - the attribute's absence, minimal detail or specificity to 4 - most specific and detailed presence of the attribute. The final iteration of the instrument contains 14 attributes distributed across six domains.

Table 3 list the final set of MHP Assessment domains and attributes.

RESULTS: Table 3 presents a summary of MH ERP attribute scores. Planners were best at incorporating MH providers into HICS; 90% of plans included original/tailored Job Action Sheets for MH providers. Regarding involving facilities' healthcare communities' in plan development; planners were unlikely to include key decision makers in planning (60%), provide plan updates (92%) or solicit and incorporate feedback (65%). While planners' provisions for increasing staffing capacity in an emergency were often detailed and specific (65%), there was little in-depth planning credentialing and liability issues. Regarding MH ERP content, 79% had of plans included detailed provisions for meeting staff's basic needs; 55% had plans specific plans for staff with child/elder care issues. A third (34%) had a established hospital plans to support staff with these needs.

Attribute	Mean	SD	Range
MCI1	1.5	1.0	0-4
MCI2	1.5	1.0	0-4
MCI3	1.5	1.0	0-4
MCI4	1.5	1.0	0-4
MCI5	1.5	1.0	0-4
MCI6	1.5	1.0	0-4
MCI7	1.5	1.0	0-4
MCI8	1.5	1.0	0-4
MCI9	1.5	1.0	0-4
MCI10	1.5	1.0	0-4
MCI11	1.5	1.0	0-4
MCI12	1.5	1.0	0-4
MCI13	1.5	1.0	0-4
MCI14	1.5	1.0	0-4
MCI15	1.5	1.0	0-4
MCI16	1.5	1.0	0-4
MCI17	1.5	1.0	0-4
MCI18	1.5	1.0	0-4
MCI19	1.5	1.0	0-4
MCI20	1.5	1.0	0-4

CONCLUSIONS: Measuring MH-ERP quality can illuminate hidden strengths and weakness in the healthcare preparedness efforts and provides government with evidence-based direction for guiding healthcare emergency response planners and targeting funding initiatives. Our work suggest that facilities are strengthening their capabilities to address the MH needs of their healthcare communities. However, they are less successful at involving leaders in planning or making their community aware of MH ERPs.

LESSONS LEARNED and RECOMMENDATIONS: The MH ERP assessment has allowed NYC DOHMH to systematically examine the quality of NYC healthcare MH ERP and to plan evidence-based initiatives to facilitate healthcare ERP planners. The work presented here is an early step. The domains and attributes developed are by no means exhaustive, nor are they 'final'. More work in this arena would be welcomed.

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This project was funded by the Health Resources and Services Administration (HRSA) GRANT No. U3RHS05957

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METHOD: In 2005, DOHMH offered funding and guidance to hospitals to develop MH-ERP plans and submit them to DOHMH for review. 29 of 65 NYC hospitals voluntarily participated in MH-ERP Initiative. Plans were collected over an 18 month period, from August 2005 through February 2007. Table 1 shows characteristics of the 29 hospitals/healthcare facilities that participated in the MH ERP initiative.

TABLE 1: Characteristics of Hospital/Healthcare Facility Submitting MH ERPs

Characteristic	No.	%
Location [County/Borough]		
New York (Manhattan)	14	(48.3)
Kings (Brooklyn)	9	(31.0)
Queens (Queens)	4	(13.8)
Bronx (The Bronx)	1	(3.4)
Richmond (Staten Island)	1	(3.4)
Hospital/Healthcare Facility Size*		
Certified Beds	27	Range: 69 - 8999
Staff	25	Range: 800 - 8911

* New York State Hospital Emergency Response Data

The researchers used a constantly compared their developing assessment to the submitted MH ERPs. This discursive process was designed to help maintain balance between theoretical concepts and the MH ERP data.

Researchers constructed 'endpoints' for each attribute; these were anchored at one end by an 'ideal' but achievable aspect of the attribute (e.g., *Plan Development: a plan development team with decision-making authority*), and at the other by the absence or minimal presence of the attribute (e.g., *Plan Development: Plan created by one person with no decision-making authority*). Researchers then created mutually exhaustive and exclusive categories between these endpoint using a parsimonious categorization strategy to create the fewest possible categories. The categories reflect gradations of detail and specificity in each attribute on a scale of 0 – *the attribute's absence, minimal detail or specificity* to 4 – *most specific and detailed presence of the attribute*. The final iteration of the instrument contains 14 attributes distributed across six domains.

Table 3 list the final set of MHP Assessment domains and attributes.

RESULTS: Table 3 presents a summary of MH ERP attribute scores. Planners were best at incorporating MH providers into HICS; 90% of plans included original/tailored Job Action Sheets for MH providers. Regarding involving facilities' healthcare communities' in plan development; planners were unlikely to include key decision makers

Development of The MH ERP assessment instrument was guided by Grounded Theory principles (Strauss & Corbin, 1990) and employed a theoretical sampling strategy to examine the collected data (Charmaz, 2006). Researchers reviewed existing literatures on healthcare emergency response planning and conducted semi-structured interviews designed with teams of hospital emergency planners from the 29 participating hospitals to elicit ideas on MH ERPs (e.g., *What types of actions is your hospital taking to help staff maintain contact with their family during a disaster?*). From this work researchers developed the assessment's domains and their attributes.

TABLE 2: MH ERP Assessment Domains and Attributes

Domain	Definition
HCI	<p>Hospital Community Involvement in Plan Development: <i>facility's healthcare community's involvement: 1) who was involved in plan's development; 2) arrangements for maintaining the plan; and 3) arrangements for dissemination to and incorporation of feedback from the healthcare facility's community</i></p> <p>Attributes</p> <ul style="list-style-type: none"> • Presence of a Multidisciplinary Team • Maintenance/Updating of Plan • Initial Review and feedback from healthcare community
IHICS	<p>Incorporation into Hospital's Incident Command System: <i>integration of mental health providers into Hospital Incident Command/Management Systems</i></p> <p>Attributes</p> <ul style="list-style-type: none"> • Incorporation of MHP into HEICS • MHP Job Action Sheets
PFA	<p>Psychological First Aid/Mental Health Support Strategies: <i>use and adaptation of science-based mental health support strategies</i></p> <p>Attributes</p> <ul style="list-style-type: none"> • Presence of mental/social health support strategies • Quality of mental/social health support strategies
M/SHS	<p>Healthcare Personnel Support: <i>provisions made for supporting staff and patient's family mental/social health and care needs</i></p> <p>Attributes</p> <ul style="list-style-type: none"> • Plans for basic needs (housing and feeding staff for prolonged periods) • Emergency family support (elder/child care) for healthcare personnel • Hospital has a plan for communicating with staff and their families during an emergency
S/E/T	<p>MH ERP Staff training: <i>education/training on plan for staff</i></p> <p>Attributes</p> <ul style="list-style-type: none"> • Staff MH ERP education materials • Training curriculum on hospital's MH ERP
InSC	<p>Plan to Increase Staffing Capacity: <i>plan to acquire additional mental health staff in an emergency</i></p> <p>Attributes</p> <ul style="list-style-type: none"> • Quality of plan to exceed internal staffing capacity in an emergency • Plan to provide emergency credentialing/liability

in planning (60%), provide plan updates (97%) or solicit and incorporate feedback (65%). While planners' provisions for increasing staffing capacity in an emergency were often detailed and specific (65%), there was little in-depth planning credentialing and liability issues.

Regarding MH ERP content, 79% had of plans included detailed provisions for meeting staff's basic needs; 55% had plans specific plans for staff with child /elder care issues. A third (34%) had a established hospital plans to support staff with these needs.

TABLE 3: MH ERP Domain Attribute Quality Ratings

	N	%		N	%
HCI			M/SHS		
<i>Presence of a Multidisciplinary Team</i>			<i>Plans for basic needs (housing and feeding staff for prolonged periods)</i>		
• minimum development team with no/implied decision-making authority	17	(60)	• no plan to provide basic support needs or preparedness recommendations for staff	6	(21)
• expanded plan development team with decision-making authority	12	(40)	• hospital (-network) wide plans to address staff needs	10	(34)
<i>Maintenance/Updating of Plan</i>			• hospital (-network) wide plans to address staff needs; personal emergency preparedness recommendations for staff	13	(45)
• no indication of update plan or general update schedule	28	(97)	<i>Emergency family support (elder/child care) for healthcare personnel</i>		
• specific plan for updating with approximate dates and staff responsibilities	1	(3)	• no recommendations or support/accommodation plans for staff with child/elder care needs	12	(43)
<i>Initial Review and feedback from healthcare community</i>			• disseminated general recommendations for staff with child/elder care issues but no hospital (-network) -specific plan to support/ accommodate staff with these needs.	6	(21)
• no review by or dissemination to healthcare community; did not solicit feedback	19	(65)	• disseminated general recommendations for staff with child/elder care issues and established hospital (-network) plans to support/accommodate staff with these needs.	10	(34)
• distributed plan, solicited & integrated feedback from healthcare community	10	(35)	<i>plan for communicating with staff and their families during an emergency</i>		
iHICS			• no plans to assist staff in communicating with their families during an emergency	8	(28)
<i>Incorporation of MHP into HICS</i>			• generic plan to assist staff in communicating with their families during an emergency.	9	(31)
• Mental Health personnel not in HICS – ICS structural diagram	7	(24)	• hospital-specific plan but no description of available services or how employees would access them	12	(41)
• MHPs and their roles in HICS – ICS structure diagram	22	(76)	InSC		
<i>MHP Job Action Sheets</i>			<i>Quality of plan to exceed internal staffing capacity in an emergency</i>		
• no JAS for MHPs or JAS wholly from another source (no adaptation)	3	(10)	• generic plan to obtain additional staff; no indication of the specific institution (where) staff would be obtained from and/or the process for obtaining them (how)	10	(34.5)
• original or tailored JAS for MHPs	26	(90)	• plan for obtaining additional staff from within the hospital's network and/or non-networked or external agencies (including where/how staff would be obtained)	19	(65.5)
PFA			<i>Plan to provide emergency credentialing/liability to non-affiliated MHPs</i>		
<i>Presence of psychological first aid/mentalsocial health support strategies</i>			• no plan to address credentialing or liability issues during an emergency OR general emergency credentialing/liability policy statement	18	(65.5)
• no apparent PFA or wholly taken from another source (no adaptation)	5	(17)	• credentialing/liability protocol for staff from within the hospital's network and/or non-network or community providers; protocol specifically includes MHPs	10	(34.5)
• plan for providing PFA to patients but not for staff	8	(28)			
• plan for PFA to patients and staff	16	(55)			
<i>Quality of mental/social health support strategies</i>					
• no PFA planned or ONLY described stress reactions without any instructions on how to address them	6	(21)			
• objective-oriented descriptions of PFA or a general plan for managing pt & staff's stress reactions	11	(38)			
• objective-oriented description of PFA and hospital-specific plans for managing staff and patients stress reactions	12	(41.3)			
S E/T					
<i>Staff education materials</i>					
• no written materials to present plan to staff	1	(3)			
• General PowerPoint-style presentation or education manual	14	(48)			
• Detailed PowerPoint-style presentation or education manual organized into specific sections	14	(48)			
<i>Training curriculum on mental health surge</i>					
• no MH ERP curriculum or training for staff OR curriculum from existing materials (no adaptation)	15	(55)			
• hospital-specific curriculum; written training procedures	13	(45)			

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