NCDMPH Workshop Report

General Session: *Enhancing Recovery Through Learning, Education, and Training*

Presenters:
Moderator - Daniel P. Aldrich, PhD, Associate Professor, University Faculty Scholar, Purdue University
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Session summarized and reported by:
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Overall Key Session Points:
1. Effective and timely education and training of those involved in response and recovery is critical.
2. Planning and preparing for recovery before the disaster happens is important.

Session Summary:
The purpose of this panel was to bring together people who had been involved in recovery after large, recent disasters in order to share their experiences. This panel session centered on questions posed by the moderator that asked the panelists to explain different challenges, successes, and lessons learned around disaster recovery.

The moderator asked for the biggest mistakes and the biggest lessons learned after large-scale disasters like Hurricane Katrina and Superstorm Sandy.

Speaker 1 talked about how people with access and functional needs, children, and pets were left behind. She said that reunification in those contexts was a big problem, as well as a large lesson learned.

Speaker 2 discussed the reunification, resettlement, and support of individuals displaced by Katrina. He also noted that after the last two hurricane events, recovery needs to be an important aspect of planning. He also noted that dealing with staff during disasters is also a critical concern; his facility sent staff with the evacuated patients to support continuity of operations. His main lesson learned was to pre-plan and to identify needs ahead of time. Teams from the hospital ensured continuity of operations by setting up mobile clinics and mobile vans. He went on to say these successes were due to training. At his facility, success comes down to training at the individual, as a family member, level. He said that if the worker and their family are prepared, then they are prepared to come in to work at the facility.

Speaker 3 discussed Superstorm Sandy damage in southern Rhode Island. He observed a lack of knowledge of how the health care system handles disaster response and recovery among non-health care groups. Local entities had a major issue in the lack of understanding of how to evacuate and shelter elderly nursing home patients. As a result, they have memoranda of understanding among state nursing homes to facilitate safe evacuations. Additionally, they have taken steps to invite local emergency managers to the state table before a disaster so they know how these procedures are done and so they can better assist in the process. Moving forward, they are talking to facilities to discuss what the state requires from them in recovery.

Speaker 4 discussed how after 9/11, the city set up a "care for the caregivers" program which included faith leaders. His agency also ran a program for disaster case managers and mental health personnel, which provided mental

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health care for those roles as they transitioned out of recovery. His agency recommended that this be repeated in the future, and it was not. This made it a challenge to retain caregivers during the Sandy recovery. Using congregations to check in with elderly or infirm congregants was a success, as it added to community resilience. This program was also not picked up after Sandy, and there were poor outcomes among the elderly. Speaker 4 went on to talk about things that went well. After Katrina, it was a huge help for families resettled into his area to be connected with traditional support networks (ie, faith communities). He mentioned several examples of good relationships between hospitals and faith organizations in disasters.

The moderator asked panelists how these lessons learned have been put into practice for future disasters. Think about your facility's short-, mid-, and long-term plans, and then think about what your community will need in response and recovery. It simply comes down to planning and preparedness. Take what you've learned, put it to process, and make it actionable. Speaker 2 talked about how shelters now have a state team to assess a person with potential access and functional needs. They have started to work with emergency managers to help them understand recovery beyond the immediate "flashing lights" issues. Speaker 3 suggested that a relationship or awareness of national volunteer organizations would be helpful.

The moderator posed a question about decentralized vs centralized approaches to response and recovery. Is decentralized better than centralized? The moderator said that in a large, Katrina-scale disaster, a centralized approach is the only way it would work. However, in most disasters, "local is king" and the community steps up to handle their disasters and ask for resources when necessary. Speaker 2 echoed that all responses start local, and in a home rule state, it can stay local if the municipality demands it. As a result, state organizations aim to build trust with the locals. They aim to be a conduit, and help the locals, rather being a barrier. Speaker 3 said that both happen simultaneously, especially because people trust faith leaders. He noted that after 9/11, people reported trusting religious leaders more than anyone else. He noted a need to know how to interact with religious leaders and work with them.

The moderator then went on to ask what, during a time of budget cuts, we should do with the money we do have. Speaker 1 noted needs for behavioral health, reunification planning, and specific recovery strategies, since recovery often is ignored or forgotten. She also noted a need for greater alignment; human services need to be integrated into emergency management, CMS, Hospital Preparedness Program, and accreditation requirements need to be aligned, and there needs to be coordination among the different departments of HHS. She noted that all health care facilities need a funding base for disaster issues, as well as support in recovery planning. Speaker 1 stated there needs to be the budget for a dedicated public health emergency manager for each health care facility. Speaker 3 discussed a need for care for the caregiver, self-care, disaster case management, and mental health first aid training that communities are "starving for" and that they would trust these materials if they came from a local hospital. He also stated that hospitals could utilize local faith-based organizations in drills and exercises for no additional cost.

The moderator asked how we should be training the new generation of disaster emergency managers and first responders? The moderator stated that behavioral health and self-care training across diverse professions needs to start at the college level for those in medical, first response, and law enforcement fields. She stated that more virtual learning opportunities are important, both to take advantage of current technologies and because travel budgets are decreasing. A clearinghouse is needed for disaster behavioral health, social services, and human services information. Better alignment between ESF6 and ESF8 is also an important need so that emergency managers understand the needs of health care in recovery. He noted the need for health care coalition involvement in pre-disaster recovery planning. Speaker 4 identified the need for training on religious literacy and competency, how faith communities are structured, and how to reach out and work with religious traditions other than your own. If you work with religious organizations and rely on them, your continuity of operations plan needs to extend to them. Social workers, caseworkers, and clergy all need disaster-specific training.

The moderator then opened it up to questions. The panel was asked to identify the vitals of recovery. Speaker 3 said his definition would be every impacted family becoming self-sufficient. Speaker 2 stated that recovery for the health care system was building back stronger. The moderator said that getting back to continuity of operations was the important short-term goal, and in the long-term, the facility and the community need to be sustainable. The moderator then noted that recovery is different for every community.

Supplementary material

To view supplementary material for this article, please visit http://dx.doi.org/10.1017/dmp.2014.141