BRIEF REPORT

Facilitators and Barriers to Preparedness Partnerships: A Veterans Affairs Medical Center Perspective

Susan Schmitz, MAIDP; Tamar Wyte-Lake, DPT, MPH; Aram Dobalian, PhD, JD, MPH

ABSTRACT

Objective: This study sought to understand facilitators and barriers faced by local US Department of Veterans Affairs Medical Center (VAMC) emergency managers (EMs) when collaborating with non-VA entities.

Methods: Twelve EMs participated in semi-structured interviews lasting 60 to 90 minutes discussing their collaboration with non-VAMC organizations. Sections of the interview transcripts concerning facilitators and barriers to collaboration were coded and analyzed. Common themes were organized into 2 categories: (1) internal (ie, factors affecting collaboration from within VAMCs or by VA policy) and (2) external (ie, interagency or interpersonal factors).

Results: Respondents reported a range of facilitators and barriers to collaboration with community-based agencies. Internal factors facilitating collaboration included items such as leadership support. An internal barrier example included lack of clarity surrounding the VAMC's role in community disaster response. External factors noted as facilitators included a shared goal across organizations while a noted barrier was a perception that potential partners viewed a VAMC partnership with skepticism.

Conclusion: Federal institutions are important partners for the success of community disaster preparedness and response. Understanding the barriers that VAMCs confront, as well as potential facilitators to collaboration, should enhance the development of VAMC–community partnerships and improve community health resilience. (*Disaster Med Public Health Preparedness*. 2018;12:431-436)

Key Words: preparedness, collaboration, health care coalitions, disasters

Public health agencies have improved their emergency readiness by integrating various aspects of public health into emergency management.[1] One aspect of disaster preparedness that has particularly benefited from these improvements is the proliferation and strengthening of disaster coalitions. Participation in community partnerships has been encouraged by funding agencies and is now required by The Joint Commission and the US Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response's (ASPR's) Hospital Preparedness Program.[2] Following the 2001 terrorist attacks in the United States (9/11 and anthrax), the Joint Commission shifted their attention from organizational to community-wide preparedness. It issued new standards requiring health care agencies to have a command structure that linked to the community's command structure and to work cooperatively with community partners to provide mutual aid.[3] ASPR reinforced this shift by financially supporting initiatives that encouraged health care agencies to form coalitions and prepare to respond to emergencies as a coordinated system.[2,4] Nonetheless, creating healthy, functioning collaborative relationships remains challenging.[2,5]

As a federal health care system, the Veterans Health Administration (VHA) combines health and government responsibilities to provide care before, during, and after emergencies. It adheres to the same accreditation emergency management requirements as private hospitals, while additionally being tasked to support the National Disaster Medical System when requested by the federal government.[6] Therefore, VHA requires emergency managers (EMs) at all Veterans Affairs Medical Centers (VAMCs) to prepare their facilities for disasters, including collaborating with local community partners (eg, response agencies, health care facilities, community organizations).[5] Yet, despite national efforts to promote VAMC–community joint preparedness, a perception remains that it is challenging to engage VAMCs in partnerships with their communities.[2,5,7]

In 2012, the Veterans Emergency Management Evaluation Center initiated a study to understand the nature and scope of emergency management collaborations between VAMCs and local non-VA organizations. We explored how the status of VAMCs as federal entities affects collaborative work with local governmental and nongovernmental entities.

Copyright © 2017 Society for Disaster Medicine and Public Health, Inc. DOI: 10.1017/dmp.2017.92

https://doi.org/10.1017/dmp.2017.92 Published online by Cambridge University Press

We sought to understand facilitators and barriers local VAMC EMs face when collaborating with non-VA entities.

METHODS

Of the 152 VAMCs within the VHA, 15 EMs were identified for interviewing by using purposive and snowball sampling techniques. Selection criteria included facility size and representation from each of the Federal Emergency Management Agency (FEMA) regions to include preparation for a range of disasters. Respondents participated in semi-structured telephone interviews lasting 60 to 90 minutes.

Sections of the interview transcripts eliciting information on barriers and facilitators were identified for analysis herein. Two researchers independently coded the first one-third of the transcript portions, then compared and agreed on coding to refine the codebook. They repeated the process for the next two-thirds of the transcript portions. The team reviewed the coded data to identify recurrent and overlapping themes. Themes identified in the analysis were organized into 2 categories: (1) internal (ie, factors from within individual VAMCs or by VA policy) and (2) external (ie, interagency or interpersonal factors).

This study was approved as a Quality Improvement project by the VA Greater Los Angeles Health Care System Institutional Review Board.

RESULTS

Twelve EMs agreed to participate from across the nation (see Table 1 for interviewee characteristics). All interviewees indicated collaborating with at least one non-VA partner on disaster preparedness or response activities.

TABLE 1

Interviewee Characteristics[a]

Urban or Rural	Title	EM Job Role (Full- vs. Part-time)	Non-EM Job Duties
U	Emergency Manager	FT	N/A
U	Safety Program Specialist in Engineering, Emergency Program Coordinator	PT	Safety
U	Chief, Safety & Emergency Management	FT	N/A
U	Emergency Preparedness Coordinator	FT	N/A
U	Emergency Preparedness Coordinator/Emergency Manager	FT	N/A
R	Emergency Manager/Chief of Police	PT	Police
U	Emergency Management Coordinator	FT	N/A
U	Energy Engineer	PT	Engineering
R	Supervisory Green Environmental Management System (GEMS) Coordinator	PT	Facility and Environment
R	Safety & Occupational Health Specialist Safety Officer	PT	Safety
R	Supervisory Occupational Safety and Health Manager	PT	Safety
U	Emergency Management Coordinator	FT	N/A

[a]Abbreviations: FT, full-time; N/A, not applicable; PT, part-time; R, rural; U, urban.

Internal Themes

See Table 2 for illustrative quotations.

Organizational Mission

Facilitators. The VA's "Fourth Mission" underscores the importance of the "community" part of emergency management. (The VA's "Fourth Mission" is to improve the nation's preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to veterans, as well as to support national, state, and local emergency management, public health, safety and homeland security efforts.)

Barriers. The VA's primary focus is on veterans; limited disaster preparedness resources need to be prioritized internally.

Organizational Structure

Facilitators. Regional oversight of activities can provide an incentive to collaborate.

Barriers. Large chains of command (eg, sharing responsibility between the VAMC and its regional EM) can slow or limit collaborative opportunities, sometimes confusing who has certain responsibilities. Hiring requirements and delays can prevent training of new EMs by departing or retiring EMs, impeding continuity of established connections.

Restrictions

Barriers. Clarity is lacking about whether federal funding can support resource-sharing with privately funded partners and vice versa. Questions exist around Memorandums of Understanding (MOU's): what can one legally commit to with community partners? Can they be signed? What can they include? Creating MOUs often necessitates legal counsel, falling outside the expertise of EMs.

Leadership Support

Facilitators. Facilitators included clear communication and active engagement with leadership about potential partnerships and expectations of what is permissible and leadership who emphasize collaboration, support time on collaborative activities, grant sufficient autonomy, authorize hiring full-time or additional staff, and encourage sharing resources.

Barriers. Barriers include leadership who see limited benefits from collaboration or who place lower priority on emergency management. Examples include "inappropriate" job classification or not hiring full-time staff.

https://doi.org/10.1017/dmp.2017.92 Published online by Cambridge University Press

TABLE 2

Illustrative Quotes Demonstrating Factors Affecting Collaborative Relationships[a]

Theme	Quote
INTERNAL THEMES	
Organization	
VA Mission	*Well I think starting out with understanding the mission—the fourth mission of the VA is really important. If you don't know that mission, or are unfamiliar, it just it becomes just another piece…I think that's the most important for an emergency preparedness manager to really understand what that means—the impact that has on the nation at large, and our local community. We've had numerous mega disasters—national disasters since Katrina, and if someone is plugged into what is happening around them, then that mission becomes very clear. And if someone is plugged into the overall mission with what we provide as the Veterans Healthcare Administration, and that we are told that we are told to stay open 24/7 365, no matter what. That's my translation: you will stay open no matter what. And if you have to close it better be for a good reason, and not because you didn't have the right relationship in place.*
Structure	*…all I can do is go to management and say you know what, the hospital down the street has an extra couple of ambulances. Shall I tell them to come here? And it's like, no, let me check with leadership in XX or let me check with the VISN before we get any clear direction*
Restrictions	*…it's confusing, I think, to the outside world to say, well what exactly do you—well we coordinate that. Well, then you got all these private entities that you're coordinating with, yet you don't play in the same sandbox as them.*
Internal Support	
Leadership	*Probably the primary thing is that my bosses, my direct supervisors, comprehend and support the fact that these activities make our particular VA able to maintain its mission….The time that I'm spending off station doing these particular activities, they do consider as important for the most part, as my regular on station things.*
Clarifying Ambiguity	*…when it comes to collaborative work, if the cry goes out for it, but it's not very clear. What do you mean by that? What commitments do we make? How do we obligate the VA? You know, is it just attend meetings and feel good about what may happen?...I don't think it's very clear. It's like do what?* *…online PowerPoint or whatever is not going get the point across. But sitting in a class for a day, understanding how you sell this to your inter-operable or inter-community partners is something you may have to sell to this individual. They may not have the education. They may not have the experience. They may have had speaking classes in the military, or schools, but maybe they don't really have that much practice at it. So those people need to be molded by others to show them some of the examples from successful programs, and how they can better beef them up and get them motivated, so by the time they ever leave that training, they're ready to walk out the door. They feel confident. They're going out there. They're ready to extend that handshake and they're ready to make that sale.*
Resource Allocation and Prioritization	*The one word, "time." If you can work the time in to go do it that's what it takes, time….But it's hard. I mean, it's hard to do it because if you don't have the time, you can't make the time, then you just won't build those kind of relationships.*
EXTERNAL THEMES	
Geography	*…even here…we have XX and they're a small facility and they're part of a much larger organization, which is located in XX. The Medical Center…they also have a much larger facility in XX, so I think when they do their drills, they're not looking to us down the street and saying, oh, XX VA, come participate with us. They might be looking towards their larger sister facility in XX to participate in their drill, as we do with the XX VA….We're not going to go to the smaller hospital down the street when we can go to the much larger VA facility in XX ... that's a part of our organization. So there's no MOUs, [MOAs], you know, commitments to say we're going to back you up and you're going to back us up.*
Community Connections	*…the first barrier is understanding where your community needs are, and the community then understanding who we are. And so it's education, and—that's one. Learning who is in the community—are those community leaders.* *…made it a lot easier, because I wasn't a stranger walking into any of these other units.* *…if you have a hospital association and you're not in it, you need to be. If you have a coalition that's been set up by the ASPR grant program and you haven't been participating with your Department of Health program, you need to get into that so you're a part of that coalition.*
Reputation	*And then the others that have said, "well we've tried to work with your predecessors, but we never got anywhere. So we just wrote you guys out." It's like, "okay, well now we're here, let's talk." So there's skepticism, but you have to overcome that as part of the soft skills. You gotta accept that and say, "okay, that's where we are today, then let's move forward; let me prove myself"* *And more than the training or experience as a barrier would be the concept that we're a federal agency up on a hill. We do what we want, and we're not participating, you know?... And that's where the training and experience comes in, is by having the knowledge and the training and the background to push past that and say, "No. We are a partner. We do want to work with you. If something happens, we are going to work and play together well.*
Common Goal	*Because we collectively put our issues to the table, and collectively, we solve them. There's no nepotism…* *…we all are cognizant that we all won't get that first drop of fuel oil, but we will get a drop of fuel oil. And we have to understand the patience and the prior planning and the importance of truth as we discuss things, not to try to hoard or protect or do those things that will be discovered and then cause you to be in your own sandbox for a long, long time. That's probably the most important philosophical thing I can say to you, because all else falls below that.*
Mutual Benefits	*The priorities aren't so much, "What can you do for me?" but it's more, "Here I have this. How can we use it and can you help me cover this particular back door?" Perception.*
Fostering Relationships	*…everybody realizes that big brother is truly the right person to be leading us, and so when big brother speaks, we listen. And from that, I think everything else works.* *…emergency management officials at all levels tend to be half-full rather than half-empty. You will find, at least in my experience, everybody strives to make that cup half-full go to three-quarters or full-full, and do that in collaborative efforts wherever possible.* *…as John Wayne would say, you gotta have true grit, okay? If you don't have true grit to get out there and be able to show you have the confidence to sell your program or whatever you're selling, period, you're not gonna be successful. But if you believe in your ability and what you're trying to do and what you're trying to get across, you're gonna gain those people that want to help.*

[a]Abbreviations: ASPR, US Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response; MOA, memorandum of agreement; MOU, Memorandum of Understanding; VISN, Veterans Integrated Service Networks.

https://doi.org/10.1017/dmp.2017.92 Published online by Cambridge University Press

Clarifying Ambiguity

Facilitators. Facilitators include a more formal definition of collaboration and clearer guidance on how to actualize collaboration requirements and formalize external relationships. Examples include (1) providing new hires an experienced mentor with whom they can attend community meetings until they feel confident and are seen by partners as sufficiently knowledgeable and experienced, (2) VA regional networks introducing new hires to fellow EMs who can offer them support, and (3) in-person trainings that provide education and can emphasize "soft skills" required for engaging community partners.

Barriers. The VA Guidebook for EMs was characterized as describing what one cannot do but being sparse on "how to do it." It was mentioned that the Guidebook was being revised to include more "how to" details, but that it was currently challenging for even experienced EMs to understand their role in collaborating with other organizations. Restrictions were perceived on the types of commitments and resources that VAMCs can promise to non-VA partners, even with the knowledge that in the midst of a disaster, EMs will likely become the local representative of the federal response in their community and may need to coordinate shared resources.

Resource Allocation and Prioritization

Facilitators. Facilitators included making collaboration a regular part of one's schedule, organizing community events, and providing VA staff time and space to partner agencies. The community characteristics perceived as being more receptive to partnerships and sharing resources included being at risk for a high number of disasters, having had previous disaster experience, and being rural or geographically secluded. Some EMs in rural areas were more likely to identify a larger, "sister" VA facility nearby as a priority partner rather than a small non-VA facility, thus receiving the benefits of a collaborative relationship, while decreasing the need for complicated MOUs.

Barriers. Barriers included time constraints to travel to partner agencies and collaborative meetings (eg, 4-hour drives to community meetings made in-person attendance difficult). Small, rural VAMCs with a single, often part-time EM managing multiple facilities indicated a lack of time, lack of clarity, or little interest in investing extra time in collaboration. These EMs sometimes were resistant to having collaboration become a job expectation.

External Themes

See Table 2 for illustrative quotations.

Community Connections

Facilitators. Facilitators included learning about the community, community leaders, the structure and role of other organizations, and clearly communicating with potential partners. VA colleagues and nonwork friends can provide community contacts, while participation in multiple community groups (eg, local hospital associations, coalitions) offers additional networking.

Barriers. Barriers included not understanding the community's needs or how VAMCs fit with those needs. EMs new to the community, emergency management, or their job may find it challenging to identify contacts and initiate communication without assistance. Partnerships that rely on individual relationships between organizations may be vulnerable as job turnover can interrupt continuity. If past relationships were negative, prior interactions may hinder the development of new relationships.

Reputation

Facilitators. The perception of the VA as isolationist was believed to have decreased over the last few years. EMs articulating VAMC's responsibilities around emergency management at community meetings and emphasizing the desire to collaborate can overcome misperceptions.

Barriers. The VA's reputation of being "aloof" or self-contained, skepticism of the VA's ability to contribute to community preparedness and response, or negative opinions of the VA (eg, negative perceptions of care, EM predecessor was un-collaborative) can cause community organizations to hesitate to include VAMCs in activities.

Common Goal

Facilitators. Facilitators included EMs recognizing "You're part of the community whether you plan to be or not" and all partners believing they will benefit from working together, devoting time to collaboration, contributing to communal coffers, and working together collectively enable the community to succeed as a whole.

Mutual Benefits

Facilitators. Facilitators included approaching collaboration as an asset, rather than looking for what partners can offer; informing partners what each agency can offer and their resource limitations; and sharing resources in a manner that avoids the need for MOUs. For example, hosting partner events (eg, trainings) on VAMC property provides necessary space to a partner and allows VAMC staff to attend a beneficial training. These events provide rich opportunities for partner engagement. Other preparedness activities (eg, providing space on VAMC campus to store emergency supplies for the community) can demonstrate how relationships can be mutually beneficial.

Barriers. Barriers included not knowing the available resources of each partner agency.

https://doi.org/10.1017/dmp.2017.92 Published online by Cambridge University Press

Fostering Relationships

Facilitators. Facilitators included investing time and resources, proactively joining in partner events, having a community group leader or other individual whose dedication to collaboration goes beyond minimum job requirements, not taking criticism of the VA personally, being persistent, and taking the initiative to meet people and contribute to meetings. Some personality characteristics (eg, optimism, flexibility, maturity, confidence, ability to balance work requirements) and interpersonal skills (eg, active listening, asking probing questions, being personable) of EMs and partners are conducive to collaboration.

Barriers. Barriers included confusion around how to maintain engagement with partners.

DISCUSSION

VHA EMs indicated at least a minimal level of collaboration with external regional entities around preparedness and response. Many invested significant effort in community collaboration. Some acknowledged an interest in improving coordination with non-VA entities. Others reported a hesitancy to invest time into outreach and relationship development. The barriers and facilitators of VHA–community collaborations we identified are corroborated by existing literature on collaboration, community coalitions, and emergency management partnerships.[8,9]

Similar to VHA EMs' experiences, other organizations' policies, regulations, and regular duties may sometimes supersede preparedness and collaborative activities.[8] Differences in decision-making and authority structures between organizations may pose challenges for diverse partners.[9,10] Federal or grant funding restrictions may divert time to noncollaborative areas of emergency planning or mission-specific activities rather than those that promote collaboration.[9,10] Yet, we found that collaborative activities can occur without committing financial resources, thereby encouraging collaboration before a disaster.[1,10]

Gaining buy-in from leadership, especially hospital executives, can be challenging.[9,11] But, leadership involvement and support can build organizational investment[12] and lead to sharing lessons from past collaboration efforts,[12] which can better position the organization to continue positive relationships. Many agencies, VA included, face staffing shortages and limited time and resources for emergency management activities, let alone something as time-intensive as collaboration.[2,8] Resources are often prioritized to preparedness efforts for internal facilities rather than external collaborations. Nonetheless, collaboration offers an opportunity to share resources without heavy financial investment (eg, hosting events, providing space to store response supplies) which, in turn, creates the potential for organizations to accrue substantial benefits (eg, better trained staff, easier and quicker access to response supplies).

Smaller institutions may have financial constraints and fewer available personnel, reducing their ability to engage with other organizations.[2,8] Yet rural communities may encourage relationships if the population is tight-knit, where knowing one another can facilitate introductions.[12] Challenges overcoming preconceived notions, territorialism, and working in isolated silos are faced by coalitions as well as EMs.[8-10] However, aligning partner organizations' goals and identifying a shared vision can reduce hesitancy to work together.[1,12-14] In order to provide mutual support, partners must be aware of what each organization is able to do and share.[2,10] Clear communication, internal and external, available learning opportunities, and forthright discussions all help to build and maintain strong relationships.[1] Interpersonal skills and active listening[11] can improve communication, while working together on an ongoing basis and emphasizing reciprocity can build familiarity[14] and trust,[13] key components for strong collaboration during and after a disaster.

This study had limitations. The data are a point-in-time perspective from 2012 and may not be indicative of current experiences of VHA EMs. A larger sample size may be helpful to generate more generalizable information, and future projects may benefit from seeking the perspectives of VHA regional EMs and community-based partners.

CONCLUSION

For disaster preparedness and response systems to be successful, collaboration between private and public entities is invaluable and is often a necessity. Recent disasters have underscored the importance of pre-disaster coordination and communication between public and private entities. Emergency management and public health have made great strides in strengthening the nation's response capabilities. Unfortunately, federal agencies have traditionally faced challenges when trying to engage in local collaborative, community partnerships. Understanding the barriers VAMCs confront, as well as the potential facilitators to collaboration that we identify in this study, should enhance the development of VAMC–community partnerships and improve community health resilience.

About the Authors

Veterans Emergency Management Evaluation Center (VEMEC), US Department of Veterans Affairs, North Hills, California.

Correspondence and reprint requests to Susan Schmitz, MAIDP, US Department of Veterans Affairs, Veterans Emergency Management Evaluation Center (VEMEC), 16111 Plummer Street, MS-152, North Hills, CA 91343 (e-mail: Susan.Schmitz2@VA.gov).

Acknowledgments

The authors thank Deb Riopelle, MSPH, and Rebecca Saia for their support in recruiting and interviewing the participants for this study. This material is based upon work supported by the Department of Veterans Affairs, Veterans Health Administration, Office of Patient Care Services. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the US government.

Published online: September 13, 2017.

https://doi.org/10.1017/dmp.2017.92 Published online by Cambridge University Press

REFERENCES

1. Bashir Z, Lafronza V, Fraser MR, et al. Local and state collaboration for effective preparedness planning. *J Public Health Manag Pract*. 2003; 9(5):344-351. https://doi.org/10.1097/00124784-200309000-00003.
2. Toner E, Waldhorn R, Franco C, et al, Hospitals Rising to the Challenge: The First Five Years of the U.S. Hospital Preparedness Program and Priorities Going Forward. Prepared by the Center for Biosecurity of UPMC for the US Department of Health and Human Services under contract no. HHSO100200700038C. http://www.upmchealthsecurity.org/our-work/pubs_archive/pubs-pdfs/2009/2009-04-16-hppreport.pdf. Published March 2009. Accessed August 10, 2017.
3. The Joint Commission on Accreditation of Healthcare Organizations. Health Care at the Crossroads Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems. http://www.jointcommission.org/assets/1/18/emergency_preparedness.pdf. Published 2003. Accessed April 21, 2017.
4. Rambhia KJ, Waldhorn RE, Selck F, et al. A survey of hospitals to determine the prevalence and characteristics of healthcare coalitions for emergency preparedness and response. *Biosecur Bioterror*. 2012;10(3): 304-313. https://doi.org/10.1089/bsp.2012.0022.
5. Dobalian A. The US Department of Veterans Affairs and sustainable health care coalitions. *Disaster Med Public Health Prep*. 2015; 9(6):726-727. https://doi.org/10.1017/dmp.2015.136.
6. Veterans Health Affairs Office of Emergency Management. http://www.va.gov/VHAEMERGENCYMANAGEMENT/Plans.asp#NDMS. Accessed September 23, 2016.
7. Dobalian A, Callis R, Davey VJ. Evolution of the Veterans Health Administration's role in emergency management since September 11, 2001. *Disaster Med Public Health Prep*. 2011;5(suppl 2):S182-S184. https://doi.org/10.1001/dmp.2011.61.
8. Carrier E, Yee T, Cross D, Samuel D. Emergency preparedness and community coalitions: opportunities and challenges. *Research Brief*. 2012; (24):1-9.
9. Toner ES, Ravi S, Adalja A, et al. Doing good by playing well with others: exploring local collaboration for emergency preparedness and response. *Health Secur*. 2015;13(4):281-289. https://doi.org/10.1089/hs.2015.0003.
10. Dunlop AL, Logue KM, Vaidyanathan L, et al. Facilitators and barriers for effective academic-community collaboration for disaster preparedness and response. *J Public Health Manag Pract*. 2016;22(3):E20-E28. https://doi.org/10.1097/PHH.0b013e3182205087.
11. Gamboa-Maldonado T, Marshak HH, Sinclair R, et al. Building capacity for community disaster preparedness: a call for collaboration between public environmental health and emergency preparedness and response programs. *J Environ Health*. 2012;75(2):24-29.
12. Schoch-Spana M, Selck FW, Goldberg LA. A national survey on health department capacity for community engagement in emergency preparedness. *J Public Health Manag Pract*. 2015;21(2):196-207. https://doi.org/10.1097/PHH.0000000000000110.
13. Thomson A, Perry J, Miller T. Conceptualizing and Measuring Collaboration. *J Public Adm Res Theory*. 2009;19(1):23-56. https://doi.org/10.1093/jopart/mum036.
14. US Department of Education. Collaboration: Key to a Successful Partnership. *REMS* Express. http://rems.ed.gov/docs/REMSX_Vol4Issue1.pdf. Published 2008. Accessed September 30, 2016.

https://doi.org/10.1017/dmp.2017.92 Published online by Cambridge University Press