

Leadership

The Five Dimensions of Meta-Leadership: Application to US Public Health Leadership During the Onset of H1N1

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Introduction: In April 2009, the United States Centers for Disease Control and Prevention (CDC) learned that a novel and seemingly lethal strain of H1N1 was present in Mexico and was spreading into US border states. The majority of senior CDC leaders were trained in meta-leadership, a strategy for emergency preparedness and response developed at the Harvard University National Preparedness Leadership Initiative. This study reports on an analysis of senior leaders involved in that response.

Methods: Senior CDC leaders involved in the H1N1 response between 22 April and 22 May 2009 were interviewed using a structured interview tool and a qualitative analysis of their responses.

Results: Given the short time since the onset of the event, research still is in progress. However, preliminary interviews confirm that senior CDC leaders, including Acting Director, Dr. Rich Besser, were knowledgeable in the five dimensions of meta-leadership and were intentionally practicing and applying the strategy. A public opinion survey indicated an 83% approval rating for public health leaders managing the event.

Conclusions: The five dimensions of meta-leadership are: (1) the leader; (2) situational awareness; (3) leading one's silo of responsibility; (4) leading up to one's boss; and (5) leading intra-agency and cross-agency connectivity. When adopted across the government and out to the private sector, meta-leadership provides three important advantages: (1) a strategy of action designed to advance coordinated planning and response to major emergencies; (2) a conceptual framework and vocabulary that encourages intentional networking and cohesion to connect the purposes and work of different public and private stakeholders; and (3) a practice method that both instructs and guides multi-dimensional problem-solving. By deploying the skills and abilities of meta-leadership, positive outcomes were achieved during the early phase of the H1N1 outbreak in the US.

Keywords: H1N1; leadership; meta-leadership; public health

Prehosp Disaster Med

Relationship of Hospital Leadership to Regionally Coordinated Disaster Response: Applying a Standardized Assessment to Hospitals in the Aftermath of Hurricanes Katrina and Rita

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Introduction: The US National Response Framework is grounded in the perspective that disaster preparedness

responsibilities stem from local, to state and national planning levels. The Hospitals Preparedness Program, prompted by the 11 September 2001 terrorist attacks, continues to emphasize the value of developing coordinated response capabilities by community leaders. In the aftermath of the catastrophic 2005 Gulf Coast hurricanes, this study examined the hospital emergency preparedness coordinators' leadership style and applied leadership theory to Louisiana planners. It further assessed priority planning areas among nine in-state regions for the purpose of exploring the relationship of leadership styles to coordinated planning priorities and proximity to ground zero of Katrina and Rita.

Methods: Three hospital groups participated, representing 135 hospitals: 22 Designated Regional Coordinators at acute care facilities, 73 Designated Hospital Coordinators at acute care facilities, and 40 Designated Hospital Coordinators at non-acute care facilities, e.g., psychiatric, and rehabilitation. Four professional positions at each hospital participated in this 360° assessment. Two survey tools were used: the Multifactor Leadership Questionnaire (Bass, 1995) and the Emergency Preparedness Indicator Tool.

Results: Transformational leadership, the dominant leadership style, had a positive association with hospital performance cohesion scores. Planning priorities varied considerably between regions, but not between hospital licensed bed size or profit structure.

Conclusions: These results have significance in understanding more about how experienced hospital responders implement effective programs and how that implementation can be examined across other local, state, and national disaster response systems.

Keywords: disaster; hospital; Hurricane Katrina; Hurricane Rita; leadership; response

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Healthcare Preparedness for Disasters: An Update on US Federal Government Resources and Preparedness Activities

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This update for healthcare leaders will present US federal resources and programs available to medical and public health communities to augment the nation's capacity and capability to respond to bioterrorism, infectious disease outbreaks, local and national disasters and mass-casualty incidents, and other threats to the public health. The vast funding provided to the states over the past decade by the US Department of Health and Human Services (HHS) drastically has improved the capabilities and resource capacity of our healthcare system to prepare for, respond to and recover from disasters. A number of programs are and will continue to be critical to local-level healthcare leaders

as we move forward in strengthening our response capabilities. These programs are sponsored by the HHS's Office of the Assistant Secretary for Preparedness and Response (ASPR), which provides Federal guidance and policy direction; the Agency for Healthcare Research and Quality (AHRQ), conducting research and evidence-based guidance for the US healthcare system; the leadership of the Office of the US Surgeon General (OSG) in supporting and encouraging volunteer medical and public health response teams to augment local healthcare; and US Department of Homeland Security (DHS) training for healthcare staff, leaders, and executives offered at its federal training facilities. This presentation also will summarize public health and medical preparedness synchronization in current and future Federal planning and funding initiatives. The most recent findings relating to integration of hospital and public health preparedness activities, in light of the recent H1N1 outbreak, also will be addressed. This critical update presents current efforts at the US national, state, and local level for hospital and healthcare preparedness activities and how these issues affect each healthcare leader. **Keywords:** disaster; funding; government; health care; preparedness

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Disaster Preparedness in America

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Introduction: After 11 September 2001, the threat of further attacks on America soil stimulated the recognition of the need for improved preparedness. Since that time, >100 organizations, Federal and private, were created to produce guidelines for disaster planning and response. About eight billion dollars have been spent in preparing the nation for disasters caused by manmade or natural hazards.

Objective: The goal of this study is to identify the most important lessons learned related to disasters preparedness over the past eight years.

Methods: This study consisted of a systematic literature and Internet review.

Results: The medical responses to the Minneapolis bridge collapse and to Hurricane Gustav showed improved population evacuation, prehospital response, and hospital deployment. Nevertheless, many areas are still of concern and require immediate attention. Hospital funding has decreased, there is no unified and standard approach for surge capacity planning, there are no standard hospital plans to manage sudden mass-casualty events, and there is a lack of realistic drills at the prehospital- and hospital-level. In May 2008, a survey was presented to the US House of Representatives named "Hospital Emergency Surge Capacity: Not Ready for the Predictable Surprise". It concluded that neither the hospitals nor the trauma centers at seven major US cities would have been able to manage the number of victims during an incident similar in magnitude to the train bombing in Madrid.

Conclusions: After eight years of planning and preparedness and eight billion dollars in spending, there still are major gaps in disaster preparedness in America.

Keywords: guidelines; preparedness; response; standards; United States

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Control of Patient Flow during Wartime

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Introduction: Overcrowding of emergency departments (EDs) and increased patient volumes affect the ability to provide quality care. Optimization of patient flow can alleviate such overcrowding. During the 2nd Lebanon War, the MOH issued a directive ordering patients to go to specific EDs in a large metropolitan area. Admissions to all general hospitals were classified as: (1) medical; (2) childbirth; (3) civilian trauma; and (4) war-related trauma.

Objectives: To analyze the impact of the Ministry of Health (MOH) decision to control the patient flow to EDs during the 2nd Lebanon War.

Methods: Classified admissions to the various EDs during the 2nd Lebanon War were evaluated daily and graphs were created to help identify trends and determine the need for further intervention.

Results: Significant differences were found between the following ED admissions, before and after the notification: medical admissions in all hospitals; non-war trauma admissions, in all hospitals; births in one hospital; and war casualties admissions in one hospital.

Conclusions: It is possible to impact on the flow of patients to EDs and rationalize the use of resources, in order to direct patients to the ED best able to care for them. While this paper dealt with the patient flow during a period of armed conflict, the findings may be relevant to other situations in which control of patient flow is deemed necessary. Direct communication with the public is recommended in order to minimize delay between the issuance of a directive and its effective implementation.

Keywords: emergency department; hospital; patient flow; resources; war-time

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Who Responds to Emergency Preparedness Messages: The Story of Lions, Lambs, and Lone Wolves

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Despite a considerable investment of US federal funds directed at increasing individual preparedness since the 2001 terrorist attacks, overall population preparedness barely has increased. In trended US survey data collected between 2003 and 2008, the National Center for Disaster Preparedness (NCDP) has found that the proportion of