



# Readiness and Response to Public Health Emergencies: Help Needed *Now* from Professional Nursing Associations

THE TRAGEDY OF SEPTEMBER 11, anthrax attacks, and severe acute respiratory syndrome (SARS) and other recent infectious disease outbreaks have heightened our awareness of the need for health care system readiness and response capabilities. At the same time, the economic realities of our modern health care system are reflected in cost-containment strategies toward low-volume inventories, reduced bed availability, downsizing of staff, and a shift to outpatient services (American Hospital Association, 2002). Decreased reimbursement structures and workforce shortages have diminished the health care system's ability to meet minimum patient demands, let alone the surge of patients that would be expected in a mass-casualty incident. Furthermore, the infrastructure needed for detection and response from the public health sector has been seriously eroded by decades of insufficient funds. Agencies within the Department of Health and Human Services (HHS) have been working to address readiness and response capabilities, but private organizations and professional associations also have a role to play.

In keeping with the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, HHS developed a department-wide strategic plan to delineate its priorities. Within the plan, the Centers for Disease Control (<http://www.bt.cdc.gov>) and Health Resources and Services Administration (HRSA; <http://www.hrsa.gov/bioterrorism.htm>) have strategic activities in education, training, licensure, and credentialing for the public health care workforce and for hospital readiness. The Agency for Healthcare Research and Quality also has strategic activities related to education and training, as well as uses of information technology and electronic communication networks (Phillips,

Burstin, Dillard, & Clancy, 2004; Phillips, Dillard, & Burstin, 2002).

HHS's working definition of health surge capacity is the ability a health care system has to rapidly expand beyond normal services to meet the increased demand for medical care and public health services that would be required to care for patients in the event of a large-scale public health emergency or disaster. Needed resources include beds, personnel to staff the beds, equipment, ability to transport victims and personnel, and the ability to provide ongoing care. All aspects of surge capacity present challenges, but the demand for qualified health care personnel is particularly complex.

Although nursing is not the only health profession experiencing a workforce shortage, nursing is vital to any large-scale demand for care. Nationally, there are 2,694,540 licensed registered nurses, or 808 registered nurses per 100,000 people (HRSA, 2000). These numbers are insufficient to meet current capacity needs and would be woefully inadequate in the event of a mass-casualty incident. A mass-casualty event would require mobilization of additional nurses from outside the affected jurisdiction. Such a mobilization, however, would have to overcome issues of credentialing and licensing. When licensed health care clinicians arrived as Good Samaritans and volunteered after 9/11, hospital administrators turned them away because they did not have the proper credentials.

Nurses must collaborate and coordinate and train for future crises. Issues of competency, standards, and mechanisms for education and training must be approved to certify qualified nurses for mass-casualty events. A major step was taken in March 2001, when the International Nursing Coalition for Mass Casualty Education (INCMCE) was founded to ensure a competent nurse workforce in response to mass-casualty incidents. The INCMCE consists of organizational representatives from schools of nursing, nursing accrediting bodies, nursing specialty organizations, and governmental agencies. In July 2003, INCMCE developed a set of national, consensus-based, validated competencies for all entry-level nurses (INCMCE, 2003).

Nurses must also initiate systems that promote their ability to respond in the next crisis. In 1998, President Clinton signed Presidential Decision Directive/NSC-63 (White House, 1998), which established a national strategy for ensuring critical infrastructure protection, primarily cybersecurity. In 2003, President Bush replaced PDD-63 with Homeland Security Presidential Directive 7 (White House, 2003), which identified the roles of the health care and public health sectors. Specifically, it charged the sector-specific agencies to "collaborate with appropriate private sector entities and continue to encourage the development of infor-

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mation sharing and analysis mechanisms" (PDD-63). Under the directive, HHS established the Healthcare Sector Coordinating Council, which has responsibility for activities such as communicating potential risks, threats, and vulnerabilities to private organizations.

Nurses make up the largest health profession, yet they lack a mechanism that enables them to gather and disseminate nursing-specific information and communicate potential risks, threats, and vulnerabilities. A coordinating group comprising nurses from university, public health, and response settings, with a secure system that would allow collaboration on issues like identifying and providing a roster of volunteers, would be a good national, consistent approach to identifying and addressing vulnerabilities. This group would provide valuable insight to and receive vital information from the Healthcare Sector Coordinating Council and would disseminate that information to nurses throughout the country. Nurses would be better prepared and the country would be safer. It is time for nursing to endorse such an entity and become engaged at this level of strategic initiative.

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