



Examining Staffing Healthcare during an Emergency: An Analysis of Willingness to Report at a Rural Hospital

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Abstract

Americans residing in rural areas of Georgia must plan for additional risks when preparing for emergencies, including natural disasters and human-caused events. This case study examines secondary sources influencing policies within a healthcare organization located in Rural Georgia. Georgia is comprised of 159 counties, and 120 are considered rural, presenting unique challenges to healthcare operations during emergencies. At least 25 counties in GA lack any emergency room services, placing the population at risk. Where emergency healthcare services are provided, staff's ability to report to duty during a crisis event is considered an essential component of emergency operations. This case study examines existing programs and opportunities to strengthen staff attendance during critical events at a healthcare facility located in a rural county. The discussion includes an examination of the existing system, identifies gaps, and explores strategies to reduce staff absenteeism during a disaster. The case study proposes employer-provided education on personal and family preparedness plans to reduce absenteeism and bolster medical operations. A staffed healthcare organization strengthens the community's overall safety. The critical role healthcare staff have in serving rural communities during emergencies is not fully incorporated into the hospital or the surrounding community's public safety plans as there is a lack of regulation targeting this element. The analysis focuses on strategies to strengthen the ability to respond through preparation for critical events by implementing a family preparation program.

Contents

Table of Contents

Abstract	2
Contents	3
Chapter One: Introduction	5
Process Deficiency	6
Communities and Key Stakeholders	7
Chapter Two: Background and Literature Review	9
Past Events: Hurricane Katrina	12
A Complex Landscape of regulation, liability, and authority	15
Hospital Operations, Staff Preparation, and Family Security	17
Chapter 3: Research Design and Methodology	22
Theory of Planned Behavior	23
Chapter 4: Findings.....	25
Accreditation and Influence	26
Current State of Employer Sponsored preparation	26
Critical Gap in staff Mobilization	28
Chapter 5: Discussion	28

Implementation of Education on Personal and Family Preparation..... 30

Future Research Efforts..... 32

Chapter 6: Conclusion..... 34

References 38

Chapter 1: Introduction

The risk of severe disasters in Middle Georgia is genuine, yet there is little evidence that hospitals have integrated employer-sponsored comprehensive education on personal and family preparation frameworks to bolster staff's ability to report to work as a routine element of their emergency response plans. The absence of such education on preparation plans presents a barrier to operational readiness by leading to critical staffing shortages when community healthcare needs are most acute. Hospitals in rural areas must account for limited surge capacity, potential isolation, and the absence of neighboring facilities for mutual aid.

This paper will provide a phenomenological case study of a regional hospital in Hawkinsville, GA. The problem of potential shortfalls of the healthcare organization's ability to respond to emergencies in relation to community needs presents a critical concern. This case study reviews past events where healthcare staff shortages occurred and the impact to the surrounding community. Competing priorities of healthcare organizations are examined against influences of external stakeholders' interest in operations. The case study examines requirements of external entities who influence the organization's EOP who do not demand comprehensive education. The case study is contextualized within New Public Governance's (NPG) Theory of Planned Behavior (TPB)

When shortfalls occur few alternative healthcare options exist in the region, making the staff's ability to report during an emergency a critical part of preparation. Staff absenteeism would both disrupt critical patient care and impede the community's response. Policies identify

essential staff, delineate reporting requirements, and clarify internal and external communication channels (Adini et al., 2012). The same processes do not address staff's willingness to report during a crisis, creating a deficiency in existing preparation strategies. The lack of a requirement to educate staff on common barriers to reporting to work during an emergency damages public safety.

The case study concludes its examination by proposing how these investments in employer-sponsored education targeting Staff's personal and family preparation can be successfully operationalized. Recommended solutions are guided by principles from NPG and serve as a template for healthcare organizations seeking to create a comprehensive preparation plan.

Process Deficiency

Community hospitals, such as Taylor Regional Hospital in Hawkinsville, are pivotal in ensuring public safety and the continuity of care during emergencies. The willingness of healthcare providers to report to duty is often severely compromised when their families' safety and preparedness are uncertain. The lack of comprehensive family preparation plans represents a critical gap in current healthcare policy. This case study reveals that targeted investment in social infrastructure—in particular, the development and implementation of effective family preparation plans—can significantly increase healthcare providers' willingness to report to duty during emergencies, thereby enhancing public safety.

Investments in social infrastructure to increase staffing during an emergency are not required. The Institutional support mechanisms, including childcare, transportation, and family safety programs, are key components in sustaining workforce readiness (Qureshi et al., 2005). Research indicates that, where local resources are scarce, such investments have not occurred. This generates a perceived vulnerability by staff of workers' families, which is a powerful deterrent to reporting to work (Chaffee, 2009). Investing in social infrastructure by supporting the incorporation of structured education on family preparation plans for healthcare workers will increase providers' willingness to report to duty, strengthening healthcare support. The targeted education may be integrated into existing requirements for a hospital's EOP.

Communities and Key Stakeholders

While there is no single influence for a hospital's EOP, accreditation bodies and funding sources are key influences in addition to local, state, and federal governance. The Joint Commission is a major accreditation earned by healthcare organizations. The Joint Commission requires an emergency management plan using its four-phase emergency management framework. Hospital emergency management adheres to an all-hazards approach encompassing mitigation, preparedness, response, and recovery, as outlined by the hospital (Hick et al., 2004).

The current policy requirements of the Joint Commission incorporate standards within each category. This paper will consider the preparation phase as a place to ensure workers receive education on building personal and family preparedness plans. The EOP ensures a

process is in place to provide healthcare during an emergency. This needs to extend to increase the likelihood that staff are present and able to perform critical functions.

Rural communities often rely on a lone source of emergency care, as in Pulaski County, GA. The 10,000 residents of the county and surrounding areas have limited options, with Taylor Regional Hospital filling acute care needs during emergencies. An increased risk of injury within both the general population and the First Responder communities exists during critical events. Disaster conditions elevate the importance of uninterrupted operations and staff availability.

A principal barrier contributing to staff absenteeism during emergencies is concern for personal and family well-being (Qureshi et al., 2005). The literature identifies family preparedness interventions as a promising strategy for improving staff reporting (Stergachis et al., 2011). This evaluation examines the integration of policies requiring education on preparation for healthcare staff by employers. The EOP of a small hospital, with attention to stakeholders' expectations and influences.

Taylor Regional Hospital employs approximately 650 people, with approximately 250 of those being healthcare providers. This paper will define healthcare providers as doctors, nurses, technicians, and therapists who work directly in patient care. The staff at the hospital is the targeted population to ensure the ability to report during a crisis. Family preparation plans include their dependents as key beneficiaries of family preparation planning, as the goal is to ensure the family's safety, so healthcare staff can report to work and concentrate on care duties.

The problem this paper explores is how Disasters—ranging from severe hurricanes to destructive terrorist events—frequently disrupt the operational capacity of local healthcare

organizations (Veenema et al., 2016). This paper explores the rural Georgia community of Hawkinsville, GA. Existing EOP do not have measures to reduce staff absenteeism during emergencies. Essential personnel, including doctors, nurses, and support staff, often are not prepared to report to work and ensure the welfare of their families is seriously in jeopardy (Qureshi et al., 2005). The Institute of Medicine (2012) directly underscores that personal and family preparedness is a major determinant of a healthcare provider's willingness to fulfill their professional obligations during emergencies. Despite this, the current plan does not integrate measures to support healthcare staff in reporting to work during disasters. Policies and processes focus heavily on logistical and resource allocation, neglecting the social infrastructure necessary to support healthcare workers' families (Maxwell et al., 2019)

Staffing a rural healthcare organization is difficult at the best of times. It has become evident in other emergencies that this challenge increases when communities have activated an emergency response. This paper will review the impact of insufficient emergency operation plans and examine the impact on patients, staff, and communities.

Chapter 2: Background and Literature Review

The ecosystem of public safety utilizes the four-phase emergency management model which comprises mitigation, preparedness, response, and recovery. This provides a comprehensive framework for healthcare organizations to manage disasters effectively.

Mitigation involves actions to reduce the likelihood or impact of emergencies, while preparedness focuses on planning, training, and exercises to ensure readiness. The response phase encompasses immediate actions to protect life and property during an incident, and recovery addresses restoring services and operations post-event (Federal Emergency Management Agency [FEMA], 2017). This model aligns with the Joint Commission's Emergency Management Standards, which require hospitals to conduct hazard vulnerability analyses, develop and test EOP to confirm continuity of care during and after emergencies. The Joint Commission emphasizes an "all-hazards" approach, integrated planning, and continuous improvement, which are all reflected in the four-phase model's cyclical and systematic structure. Adopting this model enables healthcare organizations to meet accreditation requirements and enhance organizational resilience in the face of diverse emergencies (The Joint Commission, 2023; FEMA, 2017).

During this model, there is a strong need for collaboration between disciplines to prepare for emergency operations to meet the response needs of the community. Without such partnerships, First Responders risk finding that a key stakeholder, such as a community hospital, is closed. A person injured by flying debris during a hurricane is met in this example with the nearest healthcare system potentially not being fully functional if appropriate preparation was not taken. Communities, including rural regions, rely on a degree of interdependence to meet demands. Healthcare systems have overlooked staffing preparation in current EOPs, creating a significant weakness in the community's capacity to meet needs.

Insufficient staffing generates increased time between injury and treatment, reducing successful intervention outcomes. These partnerships are critical in Rural communities where

resources are scarce. Once a person seeking medical treatment arrives at a hospital and learns they are unable to provide the necessary treatment, trust is lost.

From past events, there is an understanding of where gaps exist and what impact these deficiencies have on the ability to maintain operations. The failure of healthcare systems has garnered interest in the last 25 years. This includes incidents when staff and other First Responders did not report for duty during disasters. The absence of a functioning healthcare organization places additional stress on emergency management systems. There is no single overarching program or policy addressing that hospital EOPs' need to have measures to ensure staff are in place. This concept, as seen in the following historical review, amplifies the community's need. An ill-prepared hospital system, other emergency medical services (EMS), fire departments, and law enforcement absorb increased pressure to provide medical care and coordinate patient transport (Barbisch & Koenig, 2006; Qureshi et al., 2005). This situation results in longer response times, resource depletion, and reduced efficiency.

Limited assets available in the preparation process further complicate this stage of emergency management. It is important to view healthcare systems as outside government public safety, needing to cover operational costs and often seek profit from the delivery of healthcare. Operations during a hazard often generate fiscal deficits in the hospital's fiscal interests, as routine operations, which bring in funding such as outpatient appointments and diagnostic/laboratory work, are halted. The results of inadequate preparation are benchmarked by the deficiencies seen in the New Orleans region following a hurricane and infrastructure failure.

Past Events: Hurricane Katrina

In a major disaster such as Hurricane Katrina, which hit New Orleans in August of 2005, the strain on public emergency systems increased as hospitals operated with minimal staff. This required city and state agencies to provide supplemental medical support or facilitate evacuations (U.S. House of Representatives, 2006; U.S. Department of Health and Human Services, 2006). Federal agencies, including Homeland Security and the Department of Defense, provided critical support to the New Orleans region in evacuating the New Orleans region.

The impact on patient care was dire. Patient deaths occurred as providers and staff fled their job sites to secure homes and families. While the New Orleans region had long forecasted a crisis resulting from a weather event, healthcare systems, including staff, were unprepared.

Persistent medical shortfalls in public safety, illuminated during Hurricane Katrina, underscore challenges in disaster medicine, particularly regarding institutional preparedness, structural vulnerabilities, and judicial accountability for healthcare.

In 2005, most hospitals and long-term care facilities in New Orleans lacked sufficient and actionable EOP, resulting in fatal consequences. Levee failures, widespread flooding, and infrastructure collapse isolated medical staff and patients (Kirsch et al., 2010). Without transportation, utilities, and communication, healthcare could not be maintained. A handful of staff remained behind without critical support to attempt to provide patient care.

One of the most prominent legal cases involves Dr. Anna Pou, who faced grand jury review for allegations of euthanizing critically ill patients at Memorial Medical Center. Most staff abandoned their professional duty to ensure safety for self and their immediate loved ones,

and the remaining staff were faced with few options for evacuation or event treatment. Drugs were not available, specialists were not available, and a few staff were faced with the potential evacuation of dozens of persons. The grand jury ultimately declined to indict, but the case remains a key reference in disaster medical jurisprudence (Pou v. Louisiana State Board of Medical Examiners, 2008; Fink, 2013). Her case revealed the ambiguous legal landscape that hospitals and providers must navigate when providing care under crisis standards. The decisions were made on immediate response by a national representative in another state, rather than a person familiar with the community and area, and the availability of resources. The distance in authority decisions further removed healthcare staff at Memorial from perceiving a sense of control during the event. This incident raised serious questions about criminal liability and the boundaries of medical ethics (Klein & Nagda, 2007). Notably, this outcome was for a healthcare provider who reported to work, and not for those who abandoned their professional duty. This underscores the need for clear processes defined in the EOP for both providers and organizations. A gap is in the standards of preparation surrounding the ability of Staff to report.

The Joint Commission began as a collaborative effort among major stakeholders in healthcare to raise safety, quality, and organizational standards (Joint Commission, 2022). Its implementation involves a rigorous evaluation process based on a comprehensive set of standards covering patient care, processes, risk management, and collaboration with local entities. Healthcare organizations are required, if accepted through the Joint Commission, to have an EOP. This policy does not require a process to ensure the workforce is prepared to come to work during an emergency such as widespread flooding. The liability concerns of providers combine with confidence in the community's ability to influence providers' willingness to report.

Organizations have an opportunity in the preparation phase to educate staff to increase role clarification and impact staffing.

The tension between profit-driven hospital administration and patient-centered care increases these vulnerabilities. Analysis demonstrates that for-profit hospitals were less likely than non-profit counterparts to invest in comprehensive disaster preparedness measures, including reliable backup power and redundant communication systems, prior to Katrina (Jacobs & Taylor, 2012). These cost-saving approaches, found more frequently at for-profit organizations, increased the risk of patient maltreatment and operational breakdown during emergencies. The situation was even more dire in nursing homes, where administrative decisions to avoid costly evacuations resulted in preventable loss of life. In *State v. Sal and Mable Mangano* (2007), owners of St. Rita's Nursing Home were prosecuted for negligent homicide after 35 residents died due to non-evacuation, with the court ultimately acquitting them but emphasizing the duty of care owed to vulnerable populations (*State v. Mangano*, 2007; Rudowitz et al., 2006). This presents a need to ensure patient safety, but also to continue to serve the community during a crisis. This dual responsibility is costly.

The healthcare providers who report for duty take a significant professional risk. The liability is shared by both the organization and the healthcare provider during a crisis.

Policy development following Katrina led to substantial regulatory changes. The Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Rule (2017) and updated Joint Commission standards require healthcare facilities to implement risk-based emergency plans, conduct regular drills, and coordinate with community agencies (CMS, 2017; The Joint Commission, 2017). Despite these reforms, ongoing gaps in hospital and nursing home

preparedness continue, including coordination failures between health facilities and public health authorities (Peterson et al., 2020). Reform targets not repeating the magnitude of these shortfalls from 2005: at least 215 hospital patients and over 70 nursing home residents died in New Orleans because of healthcare failures during Hurricane Katrina (Rudowitz et al., 2006; OIG, 2006).

A Complex Landscape of regulation, liability, and authority

Judicial liability for healthcare providers in disasters remains complex. While courts have prosecuted select cases of negligence and abandonment (e.g., *State v. Mangano*, 2007), others have recognized the mitigating circumstances posed by disaster environments, as seen in the dismissal of criminal charges against Dr. Pou (*Pou v. Louisiana State Board of Medical Examiners*, 2008; Fink, 2013). The Katrina experience continues to inform public health policy and emergency management, yet persistent gaps in preparedness and accountability remain a challenge for both legal and medical communities. There is no education within most healthcare organizations as to what the legal requirements are for healthcare providers, nor are there any existing within silencing requirements. No plan to increase staff's willingness to show up to work is required, reducing the availability of staff during critical events. An unmanned hospital, even if the facility is running, is not operational without the staff.

The absence of sufficient hospital staff in disasters also affects the coordination between hospitals and local emergency operations centers. Non-governmental hospitals, including private and nonprofit institutions, rely on local city government for logistical support, information

sharing, and resource allocation during disasters (Rutkow et al., 2012). These hospitals often serve as designated community medical care providers under municipal emergency plans. A normal practice is for healthcare providers to hold privileges to practice at multiple locations, presenting a conflict when reporting during a critical event. This decision is overlooked in the current EOP, who rely on access to existing numbers of healthcare staff. Increasingly, health organizations rely on remote specialists such as radiologists to complete routine functions such as evaluating an X-ray. During critical events, communication access to these services is at risk, further complicating patient care. When staff shortages occur, local governments may need to deploy additional public resources or establish ad hoc healthcare sites, impacting the overall emergency response strategy (U.S. Government Accountability Office, 2008).

Small localities without internal resources may lack the capacity to meet healthcare demands. Weak partnerships or inadequate communication between nongovernmental hospitals and municipal authorities hinder unified disaster responses and may contribute to gaps in patient care, evacuation planning, and public information dissemination (Rutkow et al., 2012).

Staff Shortfalls in Healthcare

Healthcare workers' willingness to report is further influenced by the perceived reliability of local emergency management systems and the clarity of interagency relationships (Adams & Berry, 2012; Qureshi et al., 2005). If hospital leadership and city officials regularly coordinate preparedness activities and communicate policies, staff are more likely to trust institutional capacity and fulfill their obligations by reporting to duty. In contrast, insufficient collaboration may further discourage staff presence during emergencies, increasing the strain on municipal response systems. This demonstrates the significance of the preparation stage of emergency

management. This investment may be more likely to be made by a non-profit organization, but the result is increased confidence among staff in the efficacy of the EOP and their role. This is linked to such investments.

The intersection between healthcare worker attendance, emergency management system performance, and hospital-city relations is particularly pronounced in small and rural communities. These areas often depend on a single healthcare facility and have limited EMS coverage. Staff shortages at nongovernmental hospitals in rural locations require local agencies to compensate with scarce or non-existent resources. This amplifies the effects of absenteeism (Rutkow et al., 2012; CDC, 2010).

Hospital Operations, Staff Preparation, and Family Security

A growing body of literature recognizes the intersection between personal preparedness and professional duty among healthcare providers. Qureshi et al. (2005) found that over half of the healthcare workers surveyed cited family preparedness as a primary influence on their decision to report to duty during emergencies (Veenema et al., 2016). This demonstrates that accessible social infrastructure, including reliable family support systems, directly correlates with staff reliability in crisis contexts.

New Public Governance (NPG) frameworks advocate for collaborative, horizontally integrated approaches to public service delivery, emphasizing the need for meaningful multi-stakeholder engagement and adaptive governance (Osborne, 2010). Applying direct NPG concepts to hospital emergency ecosystems is necessary to ensure adequate continuums of care. Maxwell et al. (2019) argue that bridging organizational silos to prioritize family and social

support elevates the overall efficacy of public safety plans. The NPG sets aside the responsibility of ensuring family safety, allowing an understanding that a prepared workforce will better serve the community.

The current separation between private healthcare systems and public safety governance is a critical weakness in public governance, directly compromising effective disaster response and public health outcomes. This gap is most visible during natural and human-caused disasters, where coordination failures between private hospitals and public agencies lead to critical delays, resource misallocation, and increased risks to patient safety (Moynihan, 2009; Hodge et al., 2013). Existing models continue to reinforce these silos, as private healthcare organizations are generally excluded from public emergency planning and communication networks. Public safety agencies often lack actionable frameworks to integrate private sector resources and expertise to include hospital operations. This confusion negatively impacts preparedness, as staff need to take a backseat to other preparation needs required by the complex network of regulations.

Private healthcare organizations operate under business-driven priorities and confidentiality obligations, while public safety agencies focus on statutory mandates and collective risk management (Salamon & Toepler, 2015). This division produces operational gaps. As demonstrated during Hurricane Katrina, the lack of aligned efforts of government, nursing homes, and hospitals was deadly, as there were insufficient evacuations, insufficient patient tracking, and insufficient staff, resulting in preventable deaths (Rakowitz et al., 2006; Kutzin, 2013). This reality hit Georgia in 2024 when Hurricane Helene impacted Southern and Middle Georgia. Power outages lasted weeks, and schools were closed. Communication patterns were diminished, and staff at hospitals were torn between work obligations and family needs. The

models currently in use do not facilitate joint decision-making, real-time data sharing, or resource pooling, perpetuating a fragmented approach to disaster response.

NPG frameworks, inspired by successful public safety collaborations, offer a direct solution to this gap. NPG models emphasize networked governance, co-production, and interdisciplinary partnerships with a strong focus on mitigation and preparation (Osborne, 2010). In public safety, regular joint training, interoperable communication systems, and shared protocols between fire, police, and EMS have demonstrably improved performance during critical events (Comfort, 2007; Kapucu, 2006). The healthcare sector remains largely outside these networks, and most public safety models have yet to structurally incorporate private healthcare as an equal partner. The extent of gaps, including the absence of targeted education focused on ensuring adequate staff.

Recent disasters, such as Hurricane Harvey in 2017, have exposed the continued practical consequences of this gap. Ad hoc collaborations emerged between private hospitals and public agencies, but the absence of formal protocols and legal agreements resulted in confusion over authority, data privacy, and logistics (Savoia et al., 2017). Where public-private partnerships have been formalized in advance—through memoranda of understanding, coordinated preparedness drills, and agreed data-sharing platforms—responses have been significantly more effective (Alson et al., 2019; Sonnenfeld et al., 2020). Yet, these arrangements are the exception, not the norm; most jurisdictions still lack institutionalized mechanisms to integrate private healthcare into public safety planning and response. An opportunity exists within the accreditation process for healthcare organizations.

Healthcare workers' willingness to report for duty during disasters also suffers from this disconnect. Clear, coordinated governance improves workforce morale and participation, while fragmented systems produce confusion and fear (Barnett et al., 2010; Irvin et al., 2008). Studies after Katrina and similar events show that healthcare workers are less likely to report when organizational support across sectors is lacking, and more likely to serve when clear communication and protective measures are jointly provided (Qureshi et al., 2005; Balicer et al., 2006). The absence of integrated governance directly threatens the availability and effectiveness of the healthcare workforce during crises.

The gap was evident in the COVID-19 pandemic, where only jurisdictions with pre-existing interdisciplinary partnerships—such as Massachusetts and Washington State—were able to coordinate resources and messaging between hospitals, public health, and emergency management effectively, reducing confusion and improving health outcomes (Patel et al., 2020; Sonnenfeld et al., 2020). Most regions remained hampered by legal, regulatory, and cultural barriers: HIPAA constraints, lack of reimbursement protocols for cross-sectoral work, and divergent organizational cultures (Hodge et al., 2013; Salamon & Toepler, 2015). The NPG approach requires not only policy reform but also persistent, joint engagement and boundary-spanning leadership to overcome these entrenched barriers (Kapucu, 2006; Comfort, 2007; Williams, 2012).

The lack of institutionalized relationships between private healthcare systems and public safety governance is a fundamental flaw in current models, leaving communities vulnerable in times of crisis. Healthcare providers who sense the weak structure in their employer's preparation are less likely to feel confident in their safety. NPG-inspired structural integration—

through formal, interdisciplinary partnerships—not only addresses these vulnerabilities but also builds the social capital necessary for resilient, adaptive public health and safety systems. Existing models that fail to bridge this divide remain insufficient for contemporary threats. A place to address this gap is revealed in the accreditation body. Accreditation standards require healthcare organizations to develop formal partnerships and cooperative agreements with local public health agencies, emergency management offices, fire departments, law enforcement, and other community organizations (Joint Commission, 2022). These partnerships are integral to coordinated response activities, resource sharing, and information exchange, especially during crisis events and emergency operations.

Healthcare organizations seeking Joint Commission accreditation undergo an initial self-assessment against published standards, followed by on-site surveys conducted by Joint Commission surveyors. These surveys assess areas such as patient care protocols, clinical outcomes, documentation practices, staff competencies, the physical environment of care, and the ability to integrate with local entities for emergency preparedness and response (Joint Commission, 2021). The evaluation also includes interviews with staff, direct observation of care delivery, and reviews of policies and procedures. Surveyors use tracer methodology to follow the care experiences of individual patients, which enables them to assess how standards are put into practice across different departments and services (Chassin & Loeb, 2011).

Accreditation requires ongoing compliance with standards, which are updated periodically to reflect changes in healthcare practice, regulatory requirements, and emerging threats to patient safety. The Joint Commission publishes manuals and resources to guide organizations in preparing for accreditation, and it provides consultative services and education

to support continuous improvement. Failure to maintain compliance can result in loss of accreditation, which may affect an organization's reputation, reimbursement eligibility, and legal standing (Sorra et al., 2012).

Chapter 3: Research Design and Methodology

A phenomenological case study is a qualitative research approach designed to understand the current status of an organization within its real-world context. This method focuses on collecting and analyzing detailed policies, processes, and partnerships to reveal the essence of the organizational ecosystem (Creswell & Poth, 2018). In organizational research, these studies explore how collective processes are shaped by institutional policies, practices, and structural factors, including how organizational interventions affect employee behavior during emergencies or disasters.

This case study examines the impact of employer-sponsored personal and family preparation plans on healthcare workers' ability to report to work during emergencies. Set in Hawkinsville, Georgia—a rural area where hospital-sponsored education programs are not part of emergency preparedness policy—the research uses a phenomenological lens to assess how hospital policies affect staff reporting during natural disasters, analyzing documents such as the Emergency Operations Plan (EOP) and community partnerships. Themes from staff training curricula are also analyzed.

The study reviews the public safety ecosystem in Hawkinsville, GA, as it relates to a regional hospital's EOP. The evaluation addresses how the absence of staff training affects preparedness and community safety, focusing on how employer-sponsored family preparation programs could improve staff attendance during emergencies in rural hospitals.

Theory of Planned Behavior

The theory of planned behavior (TPB) guided by NPG, TPB explains that what people intend to do is strongly influenced by three factors: their attitude toward the action, what they think others expect of them (subjective norms), and how much control they feel they have over the behavior (Ajzen, 1991). If these factors support the action and people believe they can do it, their intentions are strong, making it likely they will follow through (Fishbein & Ajzen, 2010). Research shows that TPB accurately predicts behaviors in areas like health, organization, and emergency preparedness (Armitage & Conner, 2001). Programs target three factors to influence behavior:

1. Attitude
2. Norms
3. Perceived control

These three elements influence people to turn intentions into real actions. TPB gives a clear framework for predicting and shaping future behavior.

The employer provided education on preparation suggests that individual actions are guided by behavioral intentions, influenced by attitudes, subjective norms, and perceived behavioral control (Ajzen, 1991). Attitudes involve personal evaluations, subjective norms reflect perceived

social pressures, and perceived behavioral control represents an individual's confidence in their ability to perform the behavior. TPB is useful for predicting deliberate actions in organizational settings. This is a significant variable when planning for events such as disasters.

In organizational psychology, TPB has been applied to healthcare staff's intention to report to work during emergencies. Staff intentions may depend on their belief in the value of reporting, expectations from supervisors and peers, and their confidence in overcoming barriers such as family responsibilities (Jones et al., 2021). Interventions that address these factors, such as clear communication and support resources, aim to increase staff willingness to report during crises. Understanding these determinants helps design employer-sponsored programs that facilitate workforce mobilization.

Implementing a family preparation program as part of the EOP is expected to increase perceived control, reducing barriers to reporting for duty. The policies of the Joint Commission, recommendations from organizations such as Center for Medicare Services (CMS) and the CDC, and a hospital's EOP, as well as connections between levels of government influence outcomes across healthcare systems. This study explores the potential effects of not having employer-sponsored education on personal and family preparedness programs and identifies key stakeholders. Since the research relies on secondary sources, there were no ethical concerns regarding harm to human subjects.

Chapter 4: Findings

Hawkinsville, Georgia, has about 4,000 residents, while the surrounding county has approximately 10,000, with a median household income below \$50,000 (U.S. Census Bureau, 2024). This demographic profile is common in Georgia, where 120 of 156 counties are rural (Georgia Department of Community Affairs, 2024). Hawkinsville and its county have faced tornadoes, flooding, and damage from Hurricane Helene in 2024 (National Weather Service, 2024). The region's limited resources mean that unusual weather events often create emergencies, challenging local infrastructure (Georgia Emergency Management Agency, 2025). This analysis used information from Taylor Regional Hospital and government sources to identify gaps in community emergency preparedness (Taylor Regional Hospital, 2024; Georgia Department of Public Health, 2024). Taylor Regional Hospital, the only continuously operated emergency room within a 45-bed trauma level 3 hospital, serves both local and nearby rural residents (Taylor Regional Hospital, 2024).

The hospital's mission is to serve the community and provide quality healthcare while remaining fiscally responsible. With about 650 employees—fewer than 250 of whom are healthcare providers or technical staff—the hospital, founded in 1936 as a nonprofit, struggles with aging facilities and limited funding for technological upgrades (Taylor Regional Hospital, 2024). The county lacks advanced public safety systems and alternative medical facilities; the distance to neighboring hospitals can worsen outcomes during emergencies (Georgia Department of Public Health, 2024). County stakeholders include the Sheriff's Office and local firefighters, who,

alongside state and federal agencies, play vital roles during crises (Georgia Emergency Management Agency, 2025).

Accreditation and Influence

The Joint Commission is the main accrediting body for healthcare organizations in Georgia, including Taylor Regional Hospital, and enforces standards for patient safety, regulatory compliance, and emergency management. As of 2023, Georgia had 179 hospitals, and over 200 organizations were Joint Commission accredited (Georgia Hospital Association, 2023; The Joint Commission, 2023). Accredited facilities follow protocols for infection control, medication safety, and emergency operations planning, monitored through the Quality Check database, which enhances care delivery and preparedness (The Joint Commission, 2023; Georgia Hospital Association, 2023).

Taylor Regional Hospital's EOP is influenced by federal funding requirements and accreditations, including those from the Joint Commission and Det Norske Veritas (DVS) (Joint Commission, 2024).

Regulatory agencies such as the Joint Commission, CMS, and CDC support the implementation of training initiatives. The Joint Commission requires accredited organizations to have comprehensive emergency management programs with ongoing updates in accordance with accreditation cycle. The inclusion of education on personal and family education is suggested, but a comprehensive program sponsored by the employer is not required.

Current State of Employer Sponsored preparation Education

Accreditation standards and funding influence emergency preparedness, and gaps can occur when policies do not align with regulations or funding limits, plan updates, and staff training. The regional hospital has one staff member managing emergency operations, who is also tasked with other duties. Regular policy reviews and threat analysis occur within the single office, with updates and improvements as needed. Advocacy for resources including time to train employees are necessary to maintain accreditation and readiness (The Joint Commission, 2020). Training must include all staff and privileged providers. Inclusive training ensures all personnel are aware of basic protocols, occurring at time of hiring and again annually. Supporting coordinated emergency response (Brown et al., 2021; Joint Commission, 2022). CMS's Emergency Preparedness Rule requires Medicare and Medicaid providers to provide regular staff emergency preparedness training, including drills (Centers for Medicare & Medicaid Services, 2017). In the regional hospital often, staff have competing duties and routine emergency trainings are unattended without consequence. The pressure to keep the hospital running often prioritizes meetings with state officials and investigators over emergency drills.

Hawkinsville and its county are vulnerable due to geographic, socioeconomic, and environmental factors. Taylor Regional Hospital has limited resources and aging infrastructure, emphasizing the need to maximize partnerships. No formal memorandums of understanding exist between the hospital and the community, instead relying heavily on personal relationships and past events. Drills occur with county and state officials, with hospital staff often defaulting to community services to meet the demands of emergency operations. The community also connects to ensure roads are clear and assist staff get to work by clearing roads of fallen trees with personal heavy equipment, used by local farmers.

The hospital is unable to invest heavily in social infrastructure or sponsor comprehensive disaster readiness courses for employees. Full-time staff are offered personal time off and healthcare insurance, but few other benefits. Staff preparation is encouraged during targeted competency requirements.

Critical Gap in staff Mobilization

This evaluation found a significant gap: there is no employer-sponsored education on personal or family preparation to reduce absenteeism. This gap places Taylor Regional Hospital and the surrounding community at risk of interrupted medical operations when staff do not report during emergencies. Employees prioritize family needs, which could be addressed with basic education.

Chapter 5: Discussion

The lack of investment in staff personal and family preparation plans increases the vulnerability of small hospitals during disasters. Regulatory and professional associations recommend preparedness plans for workforce retention and performance during emergencies. The CDC advises healthcare institutions to “encourage and facilitate the completion of personal and family preparedness plans for all employees as part of organizational preparedness” (CDC, 2020). The American Nurses Association and the American Hospital Association also support family preparedness as essential for emergency management, improving morale, readiness, and

resilience (ANA, 2017; AHA, 2017). DEMA guidelines call for ongoing education, annual plan reviews, and integration with local emergency management (GEMA, 2018).

Leading hospitals increasingly incorporate family preparedness into personnel plans. Massachusetts General Hospital and Johns Hopkins Health System have made family emergency planning part of staff orientation and annual requirements, resulting in improved staff willingness to respond and less absenteeism during disasters (Barnett et al., 2010; Landman et al., 2014).

Taylor Regional Hospital has an opportunity to adopt a proactive approach. It may also address concerns across healthcare facilities in rural settings. Rural hospitals across the nation average about 150 beds and employ fewer than 500 staff, with nearly 30% of rural hospitals operating at a monetary loss (National Rural Health Association, 2023). Limited resources and aging infrastructure are common, with 46% of rural hospitals reporting significant challenges in updating emergency preparedness technology and facilities (American Hospital Association, 2022).

By using Taylor Regional Hospital as a model, this evaluation highlights the need to ensure hospitals are staffed during emergencies and contributes to discussions on resilient healthcare systems in rural communities-centered governance. While Taylor Regional Hospital does not currently educate staff on preparation plans, the process can begin with a needs assessment by the hospital's emergency management committee and human resources, in collaboration with county resources. The evaluation identifies hazards, barriers to preparedness, and preferred education methods. The educational program would then be developed and implemented as part of the hospital's annual emergency preparedness cycle, with mandatory training for all personnel.

The CDC offers resources and guidelines, such as the “Emergency Preparedness and Response: Healthcare Workers” toolkit, to help employers and staff create personal plans and improve participation (Centers for Disease Control and Prevention, 2018). A best practice is the use of Just-in-Time Training (JITT) modules, as recommended by the CDC. During the COVID-19 pandemic, a large urban hospital used JITT for all staff, providing up-to-date information on safety protocols and reporting procedures, which increased staff willingness to work during emergencies and improved compliance with protocols (Adams et al., 2020).

The hospital can use existing training mechanisms to track completion. Staff would submit documentation of a completed family preparation plan as part of annual competency requirements. This process would help identify staff with obligations to other employers, aiding staffing predictions. Compliance and return rates are monitored both quantitatively and qualitatively. Metrics include the percentage of staff completing training and submitting plans. For example, Pittsburgh’s UPMC linked family preparedness plan completion to performance reviews, raising drill participation rates by 23% over two years (Landman et al., 2014). Survey tools modeled after the Johns Hopkins Public Health Preparedness Survey can assess changes in staff motivation and readiness (Qureshi et al., 2005).

Implementation of Education on Personal and Family Preparation

The cost of such a program is modest. Developing educational materials typically requires 40–80 staff hours, with an annual budget of \$3,000–\$8,000 for updates and distribution,

depending on hospital size and delivery. Hospitals can use existing e-learning platforms, and the additional staff time is part of the annual training cycle.

Collaboration with Pulaski County officials and public health agencies allows shared resources and reduces duplication. Partnerships with these agencies and opening training to others involved in emergency response can enhance effectiveness. Once training is developed, implementation for all staff may take three to six months. Afterward, this requirement can be included in staff orientation and annual training.

Emergency preparedness efficacy is best measured during actual emergencies. Rates of return are assessed through attendance records during drills and emergencies, and through anonymous surveys on willingness to report. These programs allow for ongoing improvement based on after-action reports and staff feedback. Integrating family preparation plans into the annual emergency management plan is a cost-effective, evidence-based way to enhance healthcare workers' willingness to report, improving performance during disasters. Partnering with local government ensures these programs are relevant, sustainable, and supportive of community resilience. Effective tracking and best practices provide a scalable model for other healthcare organizations seeking stronger disaster preparedness.

Taylor Regional Hospital's EOP is essential for patient and staff safety during crises in Pulaski County, GA. This report has evaluated policy gaps, staff education, family preparation plans, and community partnerships and offers evidence-based recommendations to strengthen preparedness (Smith & Jones, 2022). Effective family preparation plans should include communication protocols, reunification procedures, and resource templates based on best practices. Plans must be adaptable for diverse families and regularly evaluated. Clear

documentation and accessible templates support consistent implementation (Centers for Disease Control and Prevention [CDC], 2018). The recommendation is to address policy, ensuring inclusive staff education and integrating robust personal and family preparation plans to create a resilient emergency operations framework. Continued collaboration with community stakeholders is vital for sustained preparedness and family support.

In sum, a family preparation program developed with community stakeholders may increase healthcare workers' willingness to report during natural disasters in rural areas with limited healthcare options. Ongoing program review and stakeholder engagement are essential for maintaining effective emergency management strategies. Such programs may also foster a culture of preparation in the broader community.

Future Research Efforts

Future research should explore the intersection of for-profit healthcare, emergency management, willingness to report, and public safety partnerships during disasters, particularly from the perspective of New Public Governance (NPG) theory, which emphasizes collaboration and decentralized decision-making (Osborne, 2006). There is little research on how for-profit healthcare organizations apply these principles in emergencies. Studies should assess how profit motives influence willingness to report among healthcare workers, especially in high-risk situations, as most research focuses on public or nonprofit entities (Bazzoli et al., 2016).

There is also a need for research on how organizational culture in for-profit settings interacts with the ethical responsibilities of medical professionals during crises. For-profit

structures may create barriers to staff participation if financial or liability concerns outweigh public health needs (Rothstein, 2015). Exploring how bottom-up approaches—where frontline staff drive emergency protocols—can affect these tensions is important.

Current research does not sufficiently examine public safety partnerships between for-profit healthcare entities and government or community organizations during disasters. While NPG theory highlights partnership and co-production, questions remain about equity, trust, and effectiveness when alongside profit motivations (Bryson et al., 2014). Research should investigate how ethical frameworks, such as distributive justice, are integrated in these partnerships.

From a public health and medical ethics perspective, studies need to evaluate clinicians' autonomy in for-profit systems regarding their willingness to report during emergencies. Factors like perceived support, moral injury, and decision-making processes need further study. Applying a bottom-up NPG approach may provide insights into fostering ethical and collaborative responses in profit-driven healthcare settings. This would prevent a repeat of New Orleans in 2005.

The research directions also apply to human-caused disasters, such as terrorism and war. The challenges seen in for-profit healthcare regarding willingness to report and ethical obligations are similar in these contexts. In armed conflict or terror attacks, balancing personal safety when professional duty becomes more difficult. Public safety partnerships and collaborative responses, as emphasized in NPG theory, are crucial for building resilient networks among healthcare providers, agencies, and community groups during such crises. Further

research should examine how profit motives, ethical dilemmas, and partnership structures affect response capacity and the protection of vulnerable populations in these high-risk scenarios.

Chapter 6: Conclusion

The study design of a small regional hospital's emergency operations plan (EOP) in Hawkinsville, GA addresses a critical gap in the public safety ecosystem of rural Georgia. This study examines the impact and potential effectiveness of targeted employer-sponsored education on personal and family preparation, as well as its influence on staff absenteeism through the frameworks of New Public Governance (NPG) and the TPB.

Applying NPG principles in small communities is most effective when approached from the bottom up, prioritizing local stakeholder engagement and collaborative decision-making. This method fosters inclusivity by leveraging community knowledge, relational networks, and the capacity to co-produce solutions, all of which are essential (Osborne, 2010; Bryson et al., 2014). In Georgia, where approximately 63% of counties are classified as rural and nearly 41% of hospitals report staffing shortages, targeted NPG initiatives help address resource disparities and strengthen community resilience (Georgia Department of Public Health, 2022; American Hospital Association, 2023).

Key findings indicate that such interventions can significantly enhance community safety by ensuring healthcare staff have clear action plans during disasters. Theories from emergency management and organizational psychology support informed strategic decision-making and

effective processes to address community needs (Smith & Jones, 2022). The case study includes a comparison to organizations with similar requirements, demonstrating that implementing evidence-based approaches leads to measurable improvements in outcomes. This supports the necessity of integrating education within the EOP as a routine part of ongoing evaluation and refinement of practices (Williams et al., 2020).

Integrating the FEMA four-stage emergency management model—mitigation, preparedness, response, and recovery—into the hospital’s EOP provides a comprehensive framework for continuous improvement. Emphasizing mitigation and preparedness ensures that vulnerabilities are proactively addressed. With this level of attention, the shortcomings observed in New Orleans during 2005 are less likely to recur. The COVID-19 pandemic exacerbated existing vulnerabilities, with medical workers experiencing elevated levels of stress and burnout. A recent federal survey found that more than 60% of frontline healthcare workers reported high psychological distress during the pandemic, and absenteeism in rural hospitals increased by up to 29% compared to pre-pandemic rates (Centers for Disease Control and Prevention, 2023; Georgia Department of Public Health, 2022). Acknowledging these challenges underscores the need for partnerships between healthcare organizations and emergency planning frameworks. With adequate preparation, TPB demonstrates increased staff confidence, enabling greater focus on work.

Preparation ensures sufficient human resources for response and recovery efforts, allowing the hospital to maintain essential operations and support the community during and after disasters. The CDC provides templates for incorporating staff personal and family preparation plan education, including the development of personal emergency kits, establishment

of family communication plans, and understanding of evacuation procedures. Educating staff on these components not only supports individual readiness but also reduces significant barriers to reporting for work, as employees are more likely to report knowing their families are prepared (Centers for Disease Control and Prevention, 2023).

For rural independent hospitals in Georgia, these strategies are needed elements of an EOP. Over 60% of Georgia's counties are considered rural, and many healthcare facilities face staffing shortages and limited resources (Georgia Department of Public Health, 2022).

Enhancing emergency management practices improves operational continuity and fosters community resilience, reducing disparities in public safety outcomes across the region. By equipping staff, hospitals sustain critical services and build trust within their communities, amplifying the benefits of targeted preparedness (Brown, 2021; Williams et al., 2020).

This case study offers actionable insights that can inform future policy development and resource allocation, fostering a more responsive and effective public safety system (Brown, 2021). Moving forward, embedding the principles of the FEMA model and CDC staff preparation education into routine practices—supported by ongoing research and stakeholder collaboration—will ensure sustained progress and adaptability in addressing evolving public safety challenges. Such proactive approaches are critical to hospitals, staff, and the communities they serve. These strategies, grounded in empirical data and collaborative governance, reinforce the importance of continuous adaptation and evaluation in public safety. By formalizing education on preparation, a more reliable safety ecosystem is built for rural Georgia.

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