Chapter 36

Government Support

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Contents

Introduction

The need for governmental support for disaster management at all levels is clear and compelling. A limited pool of federal capital is available to fund programs. One can argue until the cows come home about the relative size of the pool of funds dedicated to disaster management, and the priorities to fund the different aspects of counter-terrorism and military conflicts, but the reality is that we will get what we will get. At least the distribution of those funds should be equitable and appropriate. Therefore, the government has the responsibility to intelligently divide this pot of gold and support the various programs that will benefit the system of disaster mitigation the most.

It would be naïve for anyone to think that terrorism can ever be eliminated. It has been a part of history since the dawn of organized society and is a natural outcome of the idiosyncrasies of human behavior, including envy, power, pride, and greed. While not our most shining moment, terrorism and war are totally predictable. Terrorism will always be there as a response to intranational and international relationships, as long as one population has something the other wants and each population feels deserving of possession.

Terrorism, as a tool of diplomacy, will also be around as long as the disenfranchised feel they have been oppressed by another group. It will be fostered by the notion that people are different, and some are inferior, which is a natural, though regrettable, human frailty. It will be there for as long as the intelligence of words is replaced by the substitution of violence.

The most important propellant for terrorism is egoism, not egotism. Egoism is the idea that the world revolves around you. It is the selfishness in considering only one's own needs and feelings, without consideration of the impact on others. Until people can learn to look at events from another person's point of view, there will always be misunderstanding, mistrust, and aggression. Our entrance into the Muslim world has not been perceived as a visit by the benevolent saviors we think we are, but rather as an invasion, domination, and occupation. Naturally, the response back to us will be aggression, not the gratitude we think we deserve.

Unfortunately, some events, once started, cannot be stopped. Extrication from an ill-planned strategy is, at times, almost impossible. It is the old expression of having a tiger by the tail. You cannot let go or the tiger will maul you, but he is still capable of turning around and biting you anyway. Or, using another analogy, once an action is taken, and the beehive has been stirred, one must sit back and accept the stings, trying to end the process as quickly as possible with the least lasting damage.

Another important aspect of international relations is to promote global friendships through mutual respect and common goals. In the event of a threat to the nation, the support of allies can be the only factor that tips the scale in the nation's favor. Alienating the other countries and powers of the world will only succeed in making the country more vulnerable and defenseless.

The effect on the financial, cultural, or emotional well-being of a country will influence its decisions and policies. Isolationism may have been viable in the times of our founding fathers, but it is not practical today. With the global economy, a country needs other allies to assist in detection of terrorism, military assistance in the fight against terrorism, and cooperation and sympathy in the responses to a terrorist event.

Please bear in mind that the statements made are the opinion of the author and are not meant to denounce particular strategies or policies, but are merely observations to show the implications of government position and rhetoric on the progress of terror abatement. Also, the issue of the tenacity of terror suggests that the present climate will continue for the foreseeable future and must be dealt with by protecting the American people as much as is humanly possible.

The relevance of the preceding statements to the acquisition of Government Funding is that the policies of the government and the beliefs that drive an administration define the priorities dedicated to the funding of practical solutions. In other words, whatever is felt by the government to be the most efficient and important areas in combating terrorism, that is where the majority of funds will be directed.

Only by changing the philosophy and priorities of the administration can the funding priorities be altered to provide better protection to the populace in the event of a terrorist attack. If the consideration of mitigation as opposed to detection can be raised only slightly, then the ability to survive a mass casualty event will be greatly enhanced by the freeing of select Government Funding sources.

Methods to Combat Terrorism

Four methods can be employed for terrorist abatement. Each has its own advantages and disadvantages, and specificity for particular situations and target populations. The characteristics of the terrorist group and the relationship, whether real or perceived, between the country and the terrorist organization dictate the most effective methodology for prevention of aggression. These four methods represent the chain of events that leads to a terrorist act. The earlier in the chain the cascade can be averted, the better. However, the initial actions can create new cascades of their own, and care must be taken not to provoke a greater negative response as a reaction to the amelioration attempts.

The first method is Negotiation and Diplomacy. Logic and compromise should always be the first weapons of defense. This form of defense does not require a great outlay of money, nor does it result in death and destruction, or the accompanying emotional toll. Unfortunately, such negotiations are undermined by personal agendas and prejudices. Each group will see a set of circumstances from its own unique vantage point. Rarely do the two interpretations match. Therefore, knowing the mind-set of one's opponent makes for a more successful negotiation.

The second method is Military Action. While often necessary, it should be reserved for only the direst of defensive circumstances and should never be preemptive. War is costly, both in manpower and monetary resources, and can be even more costly in reputation.

The third method is Security and Intelligence. Here, the goal is to discover the terrorist plot before it can be actuated, and to provide security measures to protect the population from such attacks by thwarting the efforts of the terrorists at or before the target zone.

Unfortunately, while also very costly, such measures will not prevent all occurrences. It only takes one gap in the defenses or one missed opportunity for intelligence to provide the access to a target, and the scale of areas to be secured in the United States is so massive as to be impractical to guarantee absolute security. This is not to say that such actions are not vital to the safety of the population, only that

one must not be deluded into thinking that mitigation measures are unnecessary and of low priority because we have security and intelligence measures in place. There are no guarantees of complete protection.

The fourth method is Management and Education. The purpose of this system is to mitigate the effects of a terrorist event to limit impact on the population and the infrastructure. In addition, it is intended to preserve evidence to identify the participants in a plot, to identify system weaknesses and correct them, and attempt, through education and preparation, to provide better responses in the future.

The strategy is two-pronged. The management portion of the method of terrorism abatement is to minimize the loss of life, as well as the damage to infrastructure and systems arising from a successful terrorist attack. The second prong, the education of the population, is intended to provide defensive strategies in the event of an incident. The secondary goal of education is to bring awareness to the importance of disaster management, an equally important though daunting and fleeting task.

While no one wishes the terrorist act to occur, and there is a realization that the mitigation efforts will do nothing for the initial casualties, the reality is that there will be terrorist acts that ignore the negotiations and diplomacy, break through the military defenses, evade the security and intelligence, and will be consummated. Mitigation allows for the greatest survival potential and the ability to continue daily functions or to continue to defend ourselves from future attacks.

Presently, too high a percentage of the financial resources are being spent on the second and third methods: military actions and security. While no one can argue about the need for both categories to be robust, the priority of this philosophy should not negate or prevent the implementation of the first method, negotiation and diplomacy.

Nor should the priority of funding be at the exclusion of the fourth method of management. Suppose the military action is the first action taken, thus precluding or limiting the ability to negotiate; and this action fails to eliminate the entire terrorist organization, and fails to ensure that no second generation of terrorists will arise from the ashes of the first. Then the security measures and intelligence efforts fail to identify each and every terrorist plot and prevent all incursions onto our vast soil. And finally, without management dollars, we cannot adequately protect the citizens from greater harm when that terrorist attack occurs.

Responsibility to the Hospitals

Without governmental financial support and the continuing support of the corporate community, the hospitals most responsible and dedicated to the search for survivors and the care of the rescuers will be in jeopardy of facing financial ruin. Disaster mitigation is an expensive proposition and beyond the scope of most individual institutions. Failure to provide adequate resources to hospitals leaves a weak link in the chain of defense in terror mitigation. Because the chain is only as strong

as its weakest link, the unavoidable weakness of the hospitals will undermine the disaster management efforts, through no fault of their own.

With the quarantine of many of the local residential communities, and the difficulties encountered by patients in reaching the hospital because of checkpoints and barricades, the hospital's financial base will be threatened for a prolonged period. While hospitals outside the disaster area are able to stand down from alert a short time after the disaster, the primary hospital's alert status will continue for some time to come. Therefore, the financial demands will be extensive. Support is also needed in this area to keep these challenged hospitals open, if only in recognition of appreciation for their actions in the disaster.

Areas for Government Financial Support: Pre-Disaster Appeals

There are three separate areas of consideration in the question of government support in disaster management: pre-disaster appeals, concurrent funding, and post-disaster appeals. Each area has its own requirements and challenges. Since the timetable for government action is not always what an organization would desire, the need to be preemptive and strategic in the requests for assistance is essential. Further, the need for supporting documentation and logical argument is key to success in acquiring funding.

The first area of consideration is the Federal or state help requested beforea disaster scenario. This preplanning stage is the most advantageous in disaster preparation because it is a proactive step. The strategy is to upgrade resources before they are needed, thus being more efficient and effective in the future management and mitigation.

The difficulty is that there are no direct precedents upon which to base the arguments for the need for funding. The disaster has not yet happened, and may or may not happen to that particular hospital. Therefore, it is difficult to make the need compelling and immediate in the face of other budgetary priorities that are more concrete and persuasive.

Be aware that preplanning requests are no different than post-disaster responses. Both involve the request for upgrading of systems, infrastructure, or equipment. Both involve the delineation of future risk and the likelihood of a mass casualty event occurring. And both have the challenge of convincing an authority that a need exists when there is no immediate activity to illustrate the issues.

The discussions of both of these areas, therefore, can actually be combined and will augment each other, if not specifically, then generally. However, to avoid redundancy and duplication, there will be an attempt to consider in each section only those aspects most germane to the individual period.

The difficulty arises in that projected need is difficult to codify and quantify, and even harder to justify. It is always difficult to persuade a funding source that

the risks to the institution justify the potential financial contributions requested. If it were easy, everyone would have it. The key is in presentation, logic, and blind luck, though graphs, charts, and tables help with the impact.

The most daunting task is to demonstrate future risk. Presently, the federal government employs a system of hazard mapping to identify the geographic areas with the greatest potential of terrorist targeting. The calculations revolve around the characteristics of a particular geographic area that would encourage terrorist activity and attack. The topic of hazard mapping is discussed in Chapters 20 and 21. Also, the presentation of a slightly different system of target risk score, which is not employed presently by any agency, is presented for comparison and consideration.

However, for purposes of this discussion, it is only necessary to know that such a system exists and, through contact with local senators and congressmen, the scoring of a hospital's location can be obtained. Should that score be sufficiently high, then the potential to obtain funding for mitigation increases.

Unfortunately, while such considerations would seem automatic, meaning that when an institution or area is deemed high risk by the hazard mapping, funding would be funneled in that direction, it does not work that way. The hospital must take the initiative to identify itself as a target facility and use the statistics as a club to acquire the funding. And each hospital must compete with all other hospitals and institutions in the country doing the same.

Bear in mind also that when it comes to seeking funding, veracity is the first casualty. Many institutions have learned the art of stretching the truth better than a worker in a taffy factory. The author does not advocate stooping to that level to gain funding. However, being able to tactfully point out that the arguments of the other hospitals have more holes than Swiss cheese, and that their logic is worthy of a great work of fiction, is an excellent defense. The struggle to place one's hospital at the top of the feeding chain is absolutely an uphill battle.

The second hurdle in the acquisition of federal or state funding for disaster management is the question of predicting potential losses and expenditures in the event of a disaster. Since there is no way to show conclusively what the actual expenditures will be, the hospital must rely upon anecdotal reports from other institutions that have faced such catastrophic situations and extrapolate those figures to their own institution. Supporting documentation must be supplied to justify the calculations of need.

Furthermore, each mass casualty event is very different. Even beyond the obvious categories of concussive, biologic, chemical, radiologic, and nuclear, each scenario will play out differently depending on circumstances surrounding the disaster and cooperation of other agencies and institutions.

Thus, the wisest choice is to present a range of possibilities for the potential utilization of equipment and supplies, as well as the needs for modification of the hospital's present structural elements to adequately care for patients and protect staff in the event of a mass casualty event. Finally, translate that risk into a dollar figure.

It would be wise not to present too great a range. Otherwise, the funding sources will either consider the calculations flawed and imprecise (which, of necessity, they are), or they will assume that the lowest end of the spectrum of need is sufficient to supply the hospital with an adequate defense for most situations, and therefore, let that represent the highest level of their cooperation.

The third hurdle in the acquisition of funds is competition. There are four areas of competition for a disaster fund requests. Each of these areas is unique and presents an obstacle that can derail even the best of requests. The key is to make the plan far more compelling and necessary than other programs, and then to tailor that request to the agendas of the politicians.

The first area of competition comes from other hospitals. As every hospital in the country requires disaster preparation, the competition for the small pot of federal dollars is fierce. Justification for funding and political connections are the two most important factors in securing that funding.

The second area of competition is with other disaster mitigation programs. The usual area of consideration is the traditional first responders: police, fire, and Emergency Medical Services (EMS). Because these institutions have the desired moniker of first responder, unlike the hospital's belittling first receiver label, funding is skewed toward these deserving, but not uniquely deserving organizations, leaving hospitals to scratch for the crumbs.

The third area of competition is with other disaster strategies. The most prominent funding programs are dedicated to security and intelligence strategies, rather than management and education. These preventive strategies are far more appealing and visible than the boring and unattractive task of cleaning up after a disaster. Politicians would prefer to use the rhetoric of prevention and safety rather than admitting that a disaster may occur despite all efforts.

The fourth area of competition is other government programs, including the military, which is currently the highest funding priority. Other areas of nondisaster management are often more closely tied to political agenda and reputation. In addition, the professional and lobbying relationships so rife in government divert funds to pet projects and happy constituents.

Therefore, the requests must also be specific and compelling, and tied to a particular renovation, equipment purchase, or program. No government agency will finance manpower or other ongoing expenses. Every outlay must be for a single event, purchase, or training program. There are few exceptions.

Areas for Government Financial Support: Concurrent Funding Requests

The second area of discussion is the help sought during or immediately after a disaster. While the ability to justify and illustrate need is less of a challenge when events

are unfolding, there is a different obstacle. The amount of resources and manpower that can be dedicated to the exhausting process of requesting the allocations may be drained or simply unavailable. Priority must be given to patient care and safety, as well as stabilizing the facility. This prioritization leaves little room for political junkets. There are, however, several guidelines to consider.

First, it must be remembered that promised assistance is not the same as realized funding. Many elements can intercede during the lengthy process of funding requests and allocations that can derail even the best of a politician's intentions. Several ubiquitous factors play in this process.

The first is political pressure. The manipulations of many special interest groups and powerful lobbies can dwarf the efforts of a single hospital in acquiring grant monies. These groups are well aware of the existing funding programs and have a great deal of experience and resources for tailoring their requests to best fit the criteria desired for the particular funding program, even if the actual proposal is not representative of the spirit of the grant source.

One of the best ways to counter this glaring disadvantage is with the help of a grant writer or a lobbying firm. Their assistance in presentation of the request, and the particular arenas and venues most sympathetic to the cause, will prove invaluable. And they have the experience and resources to offer the strategies and petition the sources that the hospital does not possess.

The other important qualities of the application process are persistence and diligence. The hospital must be dogged in its pursuit of the funding source and relentless in its push to gain access and action. In addition, the hospital must be shameless and unabashed in presenting itself, not only to the funding source area itself, but also to local politicians or other influential parties who can help propel request through the red tape and bureaucracy of the grant process.

Finally, the hospital must be prepared for the illogical reasoning that will preclude it from accessing the funding desired. The roadblocks can be political or legislative. Whole programs can disappear from the table by the sweep of a pen in a distant office. The decisions may appear arbitrary, and often are, but it is the reality of the process and must be considered with flexibility and resolve.

On the other hand, the reasons for cancellation of a program may be far more concrete, and, yet, insidious. The funding of military actions may take priority over other domestic issues, and so the monies will be diverted there. Never underestimate the power of the military to be persuasive enough to influence the distribution of funding.

The ability to describe horrific scenarios to illustrate the need is unparalleled in any other organization, and these poignant and provocative epithets and illustrations go far in convincing the politician of the need for funding. As we have seen with the conflict in Iraq, the expense of military conflict in manpower and dollars is staggering.

For reasons that may not be clear to the general public, priority to rebuild the infrastructure of a foreign country may take precedence over rebuilding the

infrastructure of locations within the United States. Anyone from New Orleans can attest to that skewed distribution system.

Despite the feeling that the logic for particular decisions is flawed, the reality is that such strategies are omnipresent. Knowledge of the idiosyncrasies of the process will allow the hospital to navigate a tortuous path toward the desired goal and avoid the quagmire of competition within programs that would prove futile. Therefore, efforts can be directed where the highest potential for success exists.

Even without the military consideration, multiple simultaneous events may be competing for the same monies. In such a case, it is important for the hospital to determine what makes its cause unique and compelling, and how can attention be diverted from these other competitors to its own cause. The more graphic the description, grotesque the examples, or poignant the stories, the more successful the pitch will be.

In a different, but related scenario, there may be a single event, the one that has propelled the hospital to request funding, that engenders the competition. That event has affected several institutions, agencies, or groups simultaneously. These other participants are applying for the same funding pool that the hospital desires. The trick here is to make one's hospital the most worthy in the eyes of the politicians. This stature can be achieved by sympathy, pride, patriotism, or shame. Regardless of the vehicle, the effect is the same.

When discussing the issues that make a proposal more compelling than others, it is important to realize that there are two distinct modes of presentation: a positive spin and a negative spin. Each is equally successful, but great care must be taken not to mix the two elements because such combinations fragment the proposal and blur the rationale that the proposal is unique and superior to the others. In actuality, the two opposing viewpoints have the effect of canceling each other out.

The positive campaign focuses on the achievements of the hospital, the pride in the accomplishments, the patriotism that surrounds it, and the positive press it can generate for the politicians and agencies involved. This type of campaign is the easiest to mount and the least risky. However, as circumstances become more competitive, the requesting agencies become similar, limiting the impact of each individual campaign. As the lines between the applications blur and the outcome looks less promising, the decision may be to change strategies to the negative campaign.

Once again, bear in mind that the two campaigns must not coexist or they cancel each other out. The positive campaign must be terminated and completely abandoned before embarking on a negative campaign. This type of strategy is far more risky since it can alienate the funding source and cause many undesired repercussions. In short, it should be reserved for only the most dire of circumstances, which, frankly, during or immediately after a disaster, may be exactly the case.

A negative campaign is not to be misinterpreted as a threat or an attack. Such tactics would only result in the funding source digging in its heels and becoming intransigent to all persuasions. Rather, such a campaign is aimed at an embarrassment

factor. It is geared to shame the politicians into complying with the request to avoid negative publicity or perceptions by their constituency, or worse, an investigation or expose.

Nothing creates more angst to a politician than the reporting in the press of an unfair or unappealing situation. Such is the nature of politics: public sentiment and perception. The desire to avoid the negative coverage can be a more powerful stimulant to action than a slew of positive motivations.

Or the strategy can be simply to make the managers of the fund feel badly about the treatment of the hospital so, out of sympathy and charity, they award the grant. The latter approach is usually far less successful. Politicians are not that gullible, and the stakes for public perception and political affiliations far outstrip the desire for sympathy.

The truth is, the three most motivating factors to a politician are: whether the proposal fits in with their political agenda, whether it will engender political affiliations and connections, and whether it will make them look good to their constituency. This statement is not meant to belittle the politicians. It is not to insinuate that politicians are shallow or devious, but merely to point out that they are elected officials and must be constantly aware of their perceptions by their constituents if they wish to be elected again. It's their job description.

There has to be a selling point to the proposal, a sort of quid pro quo. If the hospital is cognizant of this fact, then the presentation can be modified to point out the advantages to the politicians by securing this grant and the positive publicity it could generate with their fellow politicians and their constituencies.

There are also times when all of these questions are moot. For certain allocations, priorities for distribution of resources and funding have been locked in since the inception of the bill. Many times, the very fate of the grant itself is dependent upon the assertion that it is linked to particular parties or charities to be ratified and funded. Therefore, any competition for the funds is a moot point; it has already been earmarked for another destination. A lobbyist can help sort out these challenging issues so that the hospital does not waste its time tilting at windmills and can dedicate its resources to achievable goals.

Sometimes the problems center around the principles or the very nature of our government. The cumbersome framework of our political process can deflate a proposal for many reasons. Delays and postponements can cause a strategy to wither on the vine. The fact that most grants involve multiple levels and organizations means that dissention in only one of those areas can sabotage even the most sophisticated plan. Often, these roadblocks cannot be predicted, but a good lobbying agency may be able to assist the hospital in steering around these obstacles.

The most frustrating development is when funds that have already been approved suddenly evaporate for no particularly understandable or even discernable reason. There are precedents where extremely large grants have been presented with great flair to many institutions, such as after September 11th, only to be withdrawn almost immediately after, quietly of course, for no apparently logical reason. It is not always

clear to where that funding was diverted, though guesses can be made by looking to the priority-du-jour, such as the military.

In a completely different category, the speed of acquisition of federal support, particularly from FEMA, during a disaster can be very frustrating. The examples of Hurricane Katrina response and the rescue efforts of September 11th, demonstrate that the government response to a mass casualty event will likely be delayed at least 72 hours. These responses are due to resources and manpower. The funding requests are even more delayed.

Bear in mind that hospitals usually don't qualify for the small business loans that are provided to disaster area businesses. The size of the hospital staff is too large to qualify as a small business. Therefore, assistance can only come from three sources: private donations, corporate philanthropy, and government support.

Aware of these facts, there may be the ability to ask the government to provide emergency funding to the primary hospital and the rescuers for the initial time frame until the FEMA response can be mobilized, and that ploy could save the institution. Unfortunately, while mobilizing cash should be more rapid than mobilizing resources and manpower, there is no precedent for this practice, so it is unclear if this funding would ever be procured in such a timely fashion

If there would be any hope in gleaning any financial support from the government, the request must come from the local senators or representatives who can apply the amount of pressure to achieve the unusual request. Again, all of the usual strategies, positive or negative, must be employed to convince the politicians, at all levels, to support the hospital in its request.

Unfortunately, with even the most concerted of efforts, the likelihood is that the hospital will suffer catastrophic losses that will never be reimbursed. As ridiculous as it sounds, the reward for dedicated participation in the life-saving task of disaster management will likely be bankruptcy for the institution. This situation must be changed.

Areas for Government Financial Support: Post-Disaster Appeals

The third area of concern is the request for help during the post-disaster recovery period. As mentioned above, the process and parameters of this process shares many of the same characteristics and strategies as the pre-disaster requests. However, there are two very distinct differences, one negative and one positive.

On the negative side, the need is more acute and desperate since the damage to the infrastructure and systems has already happened and the hospital needs funds to continue to operate. The needs are far more time sensitive because ongoing expenses must be covered to keep the hospital open. The facility does not have the luxury of shutting down for a vacation while waiting for the funding to come

through. The other issue is that the resources available to pursue the funding are probably far less available than they would be during the pre-disaster phase.

However, on the positive side, the events of the disaster serve as justification and corroboration of the request for assistance. The needs are no longer estimates or approximations; they are tangible realities. In the long run, the post-disaster period is the most likely and advantageous time to secure funding. This tragic period should be utilized and capitalized upon to the limit that manpower and financial resources will allow.

The first task is the need to justify the request for federal subsidy by evidence in several categories. This evidence must be gleaned and organized to present the most convincing argument. Some of the items are retrospective, and some are prospective.

While all of the elements of the need are evident and present, they must be organized into a concise, complete, and compelling program to convince the politicians of the overwhelming need. Hospitals shouldn't hesitate to ring the bell of patriotism or service. It is not egotistical or prideful. Most people involved in a disaster downplay the importance of their contribution. Most do not realize that they are the heroes that they are viewed to be by the rest of the nation.

The hospital must stress the loss of services: electric, telephone, etc. This is the easy aspect of the proposals. While it is easy to document these losses, the difficulty arises when the hospital attempts to show the damages that resulted from these losses. Some effects are easy to document, such as the expenses for the generators. Others are more difficult, such as the manpower resources used to overcome the shortages or the strain on other systems used to bypass the lost utilities.

The second category of loss is the manpower expenses consumed at the hospital during the disaster. The physicians, nurses, and ancillary staff that returned to the hospital to assist in the disaster care. Similarly, the calculation of the expenses for the supplies and equipment exhausted in caring for the victims in the hospital and in the neighborhood must be carefully assessed.

In a related topic, the third area is the compensation to the private physicians who gave up their private practices to assist in the disaster. These physicians are probably also suffering from losses to their own patient population. While there are provisions for small business in the post-disaster atmosphere, often, and for a variety of reasons, the private practices do not qualify for such aid. Petitioned alone, these offices may not have much of a chance to secure funds; when combined with the hospital application, there is more impetus for funding agencies to comply with the requests.

The fourth area of loss is the diversion of supplies and equipment to the triage centers at the warm zone of the epicenter of the disaster. With the delay in government assistance and FEMA support for the first 72 hours of the disaster, the hospital must frequently step up to supply and staff the triage centers. Thus, credit must also be provided for manpower assistance to the triage areas.

The fifth area is the temporary loss of the patient population from obstacles to access such as checkpoints and barricades. These obstacles typically persist long after the original disaster has passed. The losses can only be demonstrated by comparison of patient load to the same time period the year before, or to graph the pattern of usage to show the persistence of the drop in volume. This area of loss is, typically, the most profound and costly.

In a related topic, the sixth area is the loss of the patient base from death or relocation. Depending upon the type of disaster, the local devastation may be extreme. It is conceivable that there would be no local population left to frequent the hospital.

The return of a population is a slow process, and it may be years before levels will be reached that approach the pre-disaster totals. In some instances, those levels are never reached because the area has been so devastated as to be undesirable or, as in the case of September 11th, there is concern over the air quality and future safety from terrorism. In such a case, the hospital should be requesting the funds to relocate to a new area.

The seventh area is the damage to the physical plant of the hospital. Part of this damage is directly from the events of the disaster. Another, and often, larger part of this expense is the wear and tear on hospital equipment and physical plant. The requested funds are earmarked to return the hospital to the pre-disaster status or, hopefully, better.

The eighth area is a related topic. Where the seventh area is repair of the damage to the physical plant and the resources necessary to return the hospital to normal function, the eighth is the amount of resources necessary to upgrade the physical plant to a superior functioning level. Specifically, the request is to provide the resources to manage mass casualty traumas.

The standard areas of the emergency department are the areas upgraded to provide improved care, as well as adjunct areas of the hospital that support the emergency response. As mentioned in the chapter on the Physical Plant, the upgrades may need to be extensive. It is important to know, in advance, the extent and types of renovations that will be required to meet the challenges of a mass casualty event, especially if the hospital is in an area where future terrorist or natural disasters are likely.

In addition, funding can be requested to upgrade the ability to handle disasters involving weapons of mass destruction. These funds are used to construct decontamination areas and mass isolation units. These resources may be the easiest to procure because of the stigma of a chemical or biological terrorism. However, concrete plans must still be provided to set the limits for the funding requests.

One of the difficulties in providing justifications and corroborations for the proposals is that many incidents are unprecedented. There is no ability to compare to live scenarios as no similar circumstances may exist. Thus, there must be some extrapolation to provide a framework to assess need.

Several adjuncts to proposals for funding also may be helpful. The first is that the hospital must seek federal, state, and city recognition for the achievements of the hospital. The positive press will assist in promoting the hospital as a deserving institution. In addition, the more known the hospital is, the more likely the positive press to the politician who assists the hospital in securing funding.

The hospital must solicit continued press coverage even after the remainder of the hospitals in the area have stepped down from alert status. As long as the hospital remains in the press, the impetus to provide aid remains. Once the positive press stops, the attention span of the public can be very short, as is the attention span of the press in covering the story. Politicians seem to have the same attention span issues.

In summary, the proposals for government grants and funding are difficult and resource exhausting. The process must not be entered into without planning and consideration. The hospital would do well to consult a lobbyist agency and a grant writer to assist in the request procedure.

Quick Look Resource

1. Policies of government and the beliefs that drive the administration define funding priorities.
2. Government needs to be dedicated to the funding of practical solutions in disasters.
3. Limited pools of federal funds are available for disaster management; there are many priorities to serve.
4. Four methods to combat terrorism, each with its own advantages and disadvantages.
5. First: Negotiation and Diplomacy: best method, using logic and compromise.
6. Second: Military action can be effective if swift and decisive and backed with sound logic.
7. The problem is that military strikes can engender fierce patriotism, resistance, and martyrdom.
8. Reserve military aggression for most dire circumstances; too risky to be presumptive.
9. Third: Security and Intelligence: two goals at opposite ends of terrorist action.
10. First goal is to discover and thwart terrorist plot before it is actuated (most desired).
11. Second goal is to thwart the terrorist efforts at or before the target zone.
12. Can lull the public into false sense of security that mitigation funding not necessary.
13. But it only takes one opening for terrorists to succeed in a terrorist plot.
14. Fourth: Management and Education: mitigate effects of a successful terrorist attack.

15. Two prongs of strategy: both areas needed to be successful in disaster management.
16. Management deals with mitigating the effects of a disaster.
17. Education of the public on disaster management is necessary for compliance.
18. Funding is unfortunately greatly skewed to Military, also Security and Intelligence.
19. Needs to be reprioritized to include Management and Education funding.
20. Disaster preparation in hospitals is too costly to maintain without government support.
21. Remember, every hospital must be brought up to the minimum standard of preparedness.
22. Hospitals can't easily move; can't predict which will be involved; all must be prepared.
23. Failure to provide resources will leave hospitals as the weak link in the disaster chain.
24. Hospitals lose great sums of money during disasters for a variety of reasons.
25. Three considerations: Pre-disaster appeal; Concurrent funding; Post-disaster appeal.
26. Upgrade hospital resources before they are needed.
27. Problem is that there is no precedent, so it is hard to convince funding sources of need.
28. Competition: other hospitals, from disaster or not, seeking disaster upgrades.
29. Competition: other first responders, take precedent because hospitals not considered.
30. Competition: other disaster aspects, particularly military and security and intelligence.
31. Competition: other unrelated proposals; often due to political agendas and associations.
32. Concurrent funding requests are important to keep the hospital functioning.
33. The manpower to prepare proposals is difficult to find during a disaster; staff is doing other tasks.
34. Process for requests and proposals must be simplified.
35. Grant writers and lobbists are beneficial for breaking through red tape and political favoritism.
36. Proposals can fail for any number of reasons, mostly illogical.
37. Post-disaster appeals are similar to Pre-disaster appeals.
38. Simpler, because the needs and losses are more easily corroborated and justified.
39. However, circumstances are more desperate and the appeal is much more time-sensitive.
40. Service losses, facility damage, manpower, supply, and equipment must all be addressed.

41. Revenue losses, practice losses, facility isolation, and patient death or relocation must be covered.
42. Upgrading the facility (physical plant, equipment, and programs) might only occur now.
43. Funding doesn't pay for manpower or ongoing programs (no one operates new toys).
44. Hospital must seek positive press and accolades to promote cause for funding.