

Superstorm Sandy: Lessons for Optimizing Limited Training Resources for Local Impact

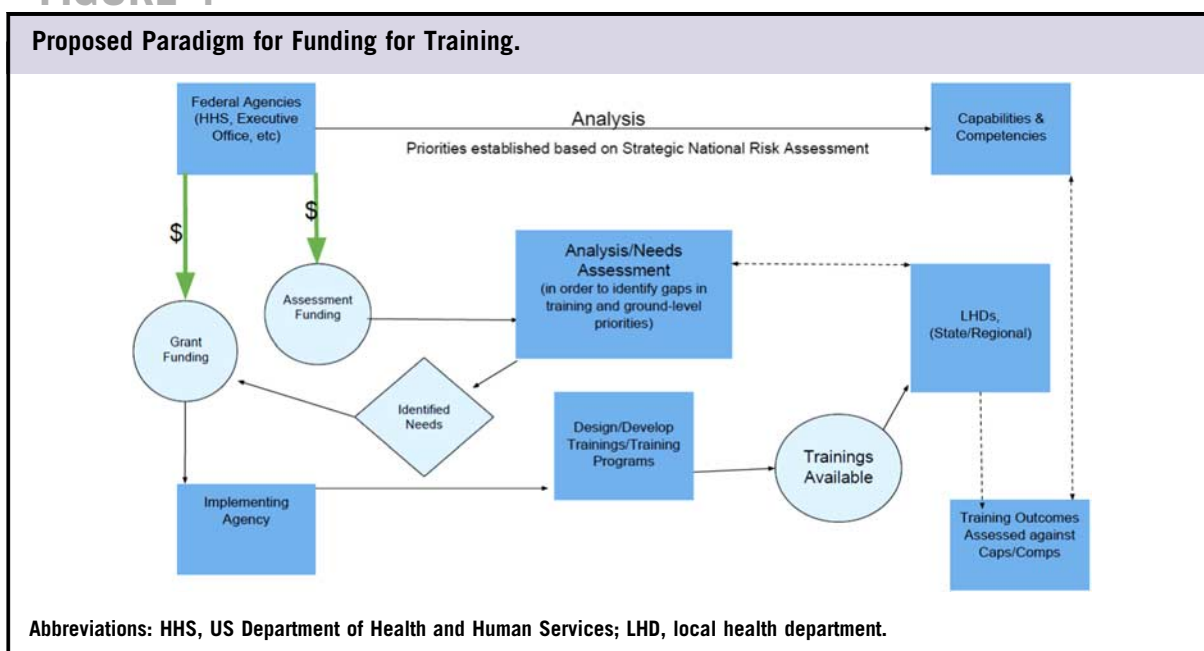
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Professional training development, whether for a classroom, work environment, or other setting, typically follows a validated instructional design model that includes an assessment of learner needs before the development of a training.¹ This foundational principle is integrated into federal guidance documents for emergency preparedness training.^{2,3} That said, local preparedness resources are sometimes in misalignment with this principle. Funding tends to favor nationally defined priorities as a proxy for the assessment of local needs. For example, the guidance for the 2015 Public Health Emergency Preparedness (PHEP) and Hospital Preparedness Program (HPP) funding application requires “justification” that “all training is purposefully designed to close operational gaps and sustain jurisdictionally required preparedness competencies.”⁴ Beyond such vague references, there are no robust training needs assessment requirements. Additionally, many of the recommended and freely available preparedness trainings for public health personnel are not specific to public health and are instead based on a national-level view of preparedness needs that may not fully accommodate local requirements.

During the response to Superstorm Sandy, local public health departments had to carry out disaster response tasks based in part on federally funded trainings developed over years of investment in public health preparedness. To understand this further, we analyzed field data collected as part of a research study on the public health system response to Superstorm Sandy, based on key informant interviews and focus group discussions with lower New York State county health officials and first responders.

As noted in our findings, staff from the affected health departments had to operationalize previous trainings by implementing disaster management systems, ensuring the continuity of essential functions, and embracing the emerging requirements of the storm. We also noted that nationally prioritized trainings, such as those focused on the Incident Command System (ICS)⁵ and Unified Command, were strongly emphasized in 2012, before the storm struck. However, this focus on the inter-organizational integration distracted some from developing intra-organizational knowledge, skills, and abilities that were necessary for a local response to Superstorm Sandy. It was also

FIGURE 1



Letter to the Editor

acknowledged by the study participants that funding is influential to how trainings are prioritized.

As a result of our current preparedness paradigm, public health preparedness trainings have a tendency to “happen to” public health personnel rather than being driven by locally identified needs. Our analysis of the response to Superstorm Sandy suggests that the problem is not simply that available trainings don’t meet local needs. In many instances, they do. However, we offer that the paucity of end user input into federal emergency response trainings has resulted in an incomplete set of curricula for local health departments.

Realigning preparedness funding to simultaneously fund needs assessments and training development could foster more locally based programs. Figure 1 represents a proposed restructuring of the current preparedness funding paradigm to create a two-part training funding source to ensure dedicated resources for local needs assessments. More locally relevant trainings and other experiential learning opportunities for public health staff will be critical to properly prepare public health staff to perform to their full potential in the midst of uncertainty.

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