Redefining the Mission: The Mercy Model as a Leadership Approach for Public Health Systems and Population-Based Programs

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As evidenced by the Indian Ocean tsunami of 2004, Hurricane Katrina in 2005, and Hurricanes Ike and Gustav in 2008, the aftermath of natural disasters all too often leaves previously functioning public health infrastructures damaged, fragmented, or completely destroyed. Additionally, the effects of war, famine, and other natural and manmade crises similarly impact fragile or developing public health systems.

U.S. Public Health Service (USPHS) Commissioned Corps officers charged with responding to these large-scale events have often been faced with chaotic environments characterized by high levels of need and very limited resources. They have had to sort through a wide range of relief agencies that have demonstrated only marginal capability to coordinate their collective efforts and intended services.

Additionally, as targets of intervention, host systems of care often seem overlooked by responding guest organizations or viewed by them as secondary to the needs of the individual victims. Increasingly, in these situations, responding USPHS officers, usually numbering fewer than 10, face a critical operational question: How can only a few officers effect maximal benefit in such environments where they neither control the resources nor the response systems, but are positioned to offer support to the indigenous systems of care, rather than the individual victims? Answering this question led to the development and implementation of what is now known as the Mercy Model (hereafter referred to as the Model).¹

Taking its name from the U.S. Navy Ship Mercy during relief operations performed by USPHS officers in Banda Aceh, Indonesia, the Model is a framework for leading rapid health infrastructure evaluation and recovery or rehabilitation. The Model is guided by a set of precepts describing facilitation, organization, and leadership methods for supporting damaged systems following disaster.

At its most basic level, the Model represents a public health leadership approach, not a program or a product. The Model capitalizes on the unique strategic and tactical strengths that USPHS officers bring to catastrophic

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situations. Leading the leaders of damaged health systems to develop or regain the operational capacity of their systems is at the Model's foundation. Properly implemented, such targeted interventions have provided large-scale, population-based services that only systems-level interventions can produce. This innovative approach is characterized by a specialized knowledge set, attitude, and collaborative style that guide diplomatic efforts to create collaborative teams and, in turn, support system recovery programs that may vary in scope from local organizations to international macrosystems. The Model helps to mobilize systems far larger than the coordinating team itself to create large-scale, system-level, and population-based recovery programs.

A STRATEGIC LEADERSHIP APPROACH TO CHANGE

The Model assumes a disaster response environment in which particular responding organizations neither completely control, nor have sufficient resources to effect, unilateral system rehabilitation, which is virtually always the case in a USPHS response. Thus, working with others is the most effective strategy to optimize change. The immediate goal then is to form effective coalitions with other agencies, thereby harnessing the combined forces of nongovernmental organizations (NGOs), international agencies and, as the case may be, nations to increase response impact across systems of care. Systemic interventions may include:

- Providing essential health system leadership, not direct service support;
- Addressing, first and foremost, public health and systems-level interventions;
- Conducting rapid assessment to identify system needs, strengths, resources, and potential to increase and sustain capacity;
- Seeking and promoting collaborative, coordinated responses, not unilateral action; and
- Performing continuous analysis and targeting of systemic interventions to ensure optimal matching of limited resources to the highest value targets.

SHIFTING PARADIGMS AND TARGETS

The Mercy Model shifts from the familiar "individual as patient" paradigm to one that views the system as patient. By emphasizing systems as treatable entities, practitioners of the Model have a tested strategy to increase the systematic, system-wide, and sustainable

capacity of systems, from moderately sized agencies to vast organizations, to deliver services to their constituent populations.²

In Indonesia, where the Model was initially developed, seven officers used it to help coordinate relief agencies and the Indonesian government's disaster relief efforts to provide specific infrastructure and program support for children's services. Through this effort, an array of population-based health and human services was created in the post-tsunami relief environment. The services that were developed were eventually delivered to all 200,000 school-aged children in Aceh Province. Equally important, the approach taught local agencies methods to independently develop and deliver their own programs without outside support. Those programs, and the methodologies used to develop them, remain operational today.

The Mercy Model has been distilled into 10 precepts that guide leaders toward successful systemic change and provide the necessary foundation for further evidence-based interventions to be introduced. The precepts are:

1. Define your role as supportive to the existing systems of care. As systems-level disaster responders, practitioners of the Model are focused, virtually exclusively, on capacity enhancement. Thus, practitioners begin by attempting to experience the world through the eyes of those who have been directly affected by the disaster. It is important to note that the disaster responders must be included in this group at the outset.³
2. Wherever and whenever possible, motivate and encourage resident agency/system staff for their dedication and capabilities in the face of daunting challenges. Integrate and foster relationships with key staff deferring to the wisdom and guidance of the host nation/system. To identify their goals and to suggest others, obtain an official invitation from the host nation/system to function as peers on their team.
3. Develop a working knowledge of the organizational structure of the host nation/system. To the extent possible, learn their political, organizational, and cultural history.
4. Study and assimilate, to the extent possible, the organizational culture, recognizing system strengths and weaknesses and identifying key staff members and organizations with potential, as teammates, to achieve the greatest benefit.
5. Observe the management style of the existing organization(s), evaluating the impact of their efforts on the overall goal.

6. Frame the relationships among the various agencies as integral to a successful effort.
7. Building upon their current assets, guide all partners to as tangible a view of their future capacity as possible. Develop a long-term vision that is community-focused and wellness-based as part of a coordinated health system.
8. After developing the long-term vision, refocus the team from that long-term vision to immediate needs as a starting point for planning. Guide all partners to accept that immediate solutions must be designed to “plug and play” with the long-term vision and the larger system of which they are a part.
9. Guide the leaders to practice coordination, cooperation, and communication as essential to reaching their common goal. Encourage coordinated efforts, not unilateral efforts.
10. Promise ONLY what can be delivered.

A DYNAMIC AND ADAPTABLE MODEL

In the post-Katrina recovery effort, the Model was used to help the Louisiana Department of Education regain its operational footing in less than 10 days and create a statewide system of behavioral health interventions for students and families affected by the hurricane. In Indonesia, the process, from initial conception to implementation, was completed in just nine days. There were only seven officers directly assigned to population-based operations in Indonesia; there were only four officers assigned to the Louisiana Department of Education.

In the summer of 2007, the USPHS, Office of Force Readiness and Deployment (OFRD) conducted field training and included the Mercy Model as one of its training components. Officers learned to effectively broaden their view of potential mission possibilities beyond that of the individual disaster victim to the systems and populations affected by the disaster. Subsequently, OFRD has used it as part of its training for health diplomacy missions in South America, Asia, and the Pacific Region.

During the winter of 2007 and spring of 2008, the Model was also employed to assist the Afghanistan Ministry of Public Health in developing its national mental health strategy. Developing that strategy required working with the Ministry and more than 30 donor nations, international organizations, NGOs, and other agencies and organizations, including the Substance Abuse and Mental Health Services Administration, to craft a vision for national services, as well as a means and method to

achieve it. The Afghan/U.S. team developed a highly successful collaboration that articulated and initiated a sustainable system for delivery of critically needed services that could also be supported by a larger international community. Such a system had not previously existed in Afghanistan.

In September 2008, the Mercy Model was applied in partnership with the Texas A&M Health Sciences Center, Texas A&M University, and the Texas A&M Corps of Cadets in response to Hurricane Ike. The USPHS officers were asked to “stand up,” staff, and operate a 300-bed field medical station (FMS) for special-needs patients who had been evacuated from the Texas Coast.

In the first 18 hours of operation, the FMS received more than 250 patients, many of whom were of such high acuity that staff, equipment, and supplies were significantly tested. A very close collaboration with Texas A&M Health Sciences Center volunteers, including medical, nursing, public health, and physical therapy students and faculty, acted as a significant force multiplier. In addition, student and faculty volunteers from across the Texas A&M campus, including their Corps of Cadets, supplied 20 volunteers every four hours as additional resources to do, in their own words, “whatever is most needed.” USPHS officers provided the volunteers with just-in-time training and paired them in teams that were managed by USPHS officers. The community volunteers conducted their assigned duties effectively, thus allowing the USPHS officers to undertake activities that only licensed individuals could perform.

USPHS officers employed the Model to augment the university community’s willingness and capabilities to support the FMS, thereby increasing the quantity and quality of services delivered. For example, utilizing just-in-time training for volunteers from the various programs, USPHS officers created treatment teams employing medical, nursing, physical therapy, and public health students. These volunteers performed a variety of skilled tasks. In so doing, they created the operational support needed by licensed health professionals to conduct those activities requiring a licensed practitioner.

CONCLUSION

The Mercy Model is an effective leadership tool, guided by a precept-based methodology. The Model has proven to be useful many times in recent years, even under the most difficult of circumstances. Properly implemented, the Model has been demonstrated to create essential partnerships and productive collaborations within large and complex systems.

The power of the Model is based, in large part, upon its force multiplication effect and the impact that disparate systems working together on a response—that is owned by no one, but worked as an integrated team—can have when limited resources are brought together strategically to address potentially overwhelming demands.

The formation of essential partnerships through skilled application of the Model is often very quick, but long lasting. The products of such partnerships may begin to manifest themselves in a matter of days, yet they continue to manifest for years to come. Thus, the Mercy Model leads to long-term, sustainable improvement in the infrastructure, capacity, coordination, and productivity of public health systems.

From international health diplomatic efforts in Indonesia and Afghanistan to domestic macrosystem interventions in Louisiana and other venues, and from large-scale psychosocial applications to management of disaster medical systems, the Mercy Model has changed the scope of practice and impact for USPHS officers. Regardless of professional specialty, USPHS officers bring essential leadership skills that are critical to response success. In fact, the Model seems now to be

breaking down traditional misconceptions about the definition and reach of mental health professionals in general. Now, large systems and their constituent components are patients, too. Now, treatment progress must be measured on a population scale and the Mercy Model team can be considered a standard asset for any deployment to global crisis points where people and systems are in need.

The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of Health and Human Services or the United States Government.

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