

Chapter 3

Developing and Maintaining an Emergency Operations Plan

Developing an emergency management plan is a lot like acquiring an insurance program for a business.¹ The hope is that plan implementation will not be needed, but if it ever is, the plan allows staff to function effectively during a disaster. A successful emergency operations plan outlines a realistic approach to ensuring that the organization's customers will experience minimal disruption in services provided. Emergency management planning should be viewed as an investment. This notion is much more common in industries beyond health care. In fact, some manufacturing firms include their disaster planning process in marketing efforts that identify competitive advantages.¹ This chapter describes how health care organizations can ensure the development of an effective "all-hazards" emergency operations plan (EOP).

Sidebar 3-1 details the Joint Commission's requirements for developing and maintaining an EOP.

Developing and Maintaining an EOP

The standard requiring an EOP describes it as a document that helps guide an organization in its emergency response and recovery efforts. A successful response to an emergency relies upon planning around the management of six critical areas: communication, resources and assets, safety and security, staff responsibilities, utilities management, and patient clinical and support activities. It is important for organizations to develop a comprehensive EOP as documentation to help guide the organization in its emergency response and recovery efforts. Although the EOP can be formatted in a variety of ways, it

Sidebar 3-1.

Applicable Emergency Management Standard

The organization develops and maintains an emergency operations plan.

This standard requires the following:

- The organization develops and maintains a written emergency operations plan (EOP) that describes an "all-hazards" command structure for coordinating the six critical functions (discussed in Chapter 1) within the organization during an emergency.
- The EOP establishes an incident command structure. Hospitals and critical access hospitals must integrate this into their processes and ensure that it is consistent with the surrounding community's command structure.
- The EOP identifies to whom staff report in the organization's incident command structure.
- The EOP identifies the organization's capabilities and establishes response efforts when the organization cannot be supported by the local community for at least 96 hours in the six critical areas. Acceptable response efforts could include the following:
 - Conservation of resources (for example, alternative bathing procedures to save water)
 - Curtailment of services (for example, cancellation of elective surgeries)
 - Supplementing of resources from outside the local community
 - Total evacuation
- The EOP identifies alternative sites for care, treatment, or service that meet the needs of its patients during emergencies.

BE PREPARED TIP

Structuring the Plan

Organizations should consider structuring their plans to state how the items listed in the elements of performance are met within the organization. The plan should include appropriate policies and procedures to respond to likely hazards, as defined in the hazard vulnerability analysis (HVA) described in Chapter 2.

must address these six critical areas to serve as a blueprint for managing care and safety during an emergency. The EOP replaces previous Joint Commission requirements for an emergency management plan and requires organizations to assemble the policies and procedures necessary to respond to emergencies.

Some emergencies can escalate unexpectedly and strain the organization and the entire community. An organization cannot mitigate risks, plan thoroughly, and sustain an effective response and recovery without preparing its staff and collaborating with the community, suppliers, and external response partners. Such an approach will aid the organization in developing a scalable response capability and in defining the timing and criteria for decisions that involve sheltering in place, patient transfer, facility closings, or evacuation. By describing an “all-hazards” command structure for coordinating the aforementioned six critical functions within the organization during an emergency, the plan further gives an organization the tools necessary to meet the challenges of an emergency.

The EOP itself should be a self-contained document. Some organizations might divide the document into major sections covering internal and external emergencies. These sections can begin with the all-purpose EOP, followed by subsections dealing with specific critical areas and with most-likely scenarios. In other words, how would the organization respond to specific types of events? Some organizations then further break down each subsection with entries for defined areas such as departments, formatted with a common template. This makes it easier for the average employee who is not familiar with the entire plan to figure out what he or she should do. (More about staff responsibilities can be found in Chapter 7.) Steps that could be used as a starting point to building an emergency operations plan appear in Table 3-1 and Table 3-2 (page 29).

The EOP also should be written in clear English. Staff should define all terms at the beginning and avoid using too many

acronyms or abbreviations. A clearly marked glossary at the back of the document should define any acronyms or abbreviations that are used.

Incident Command Structure and Identifying Staff Reporting

The Joint Commission requires that the EOP establish an incident command system (ICS) for emergency management. For critical access hospitals and hospitals, the standard further requires that the ICS is integrated into and consistent with its community’s command structure. The ICS requirement should be familiar to organizations from previous accreditation standards. A successful ICS, which should be thought of as an “all-hazards” command structure, includes the following characteristics:

- Flexibility—the structure must be adaptable to a wide variety of situations, including those that the hospital or long term care organization might not have anticipated.
- Clarity—all individuals within the organization, from clinical to clerical staff, must clearly understand their roles and responsibilities.
- Community integration—the organization’s command structure must be coordinated with that of the community responders, such as emergency medical services, as well as the police and fire departments; local, state, or federal emergency management agencies; and other local health care organizations.

An ICS is a standardized incident management concept designed specifically to allow all types of emergency responders to adopt an integrated organizational structure equal to the complexity and demands of any single incident or multiple incidents without being hindered by jurisdictional boundaries.

BE PREPARED TIP

Developing the Plan

Organization staff should review every issue that is addressed by the elements of performance for the Emergency Operations Plan standard because each must be covered in the plan. However, simply restating the intent in the emergency management plan is not enough. The plan should discuss the organization’s method of compliance in enough detail to allow the reader to understand the process and procedures, but not so detailed as to make the plan too voluminous.

Table 3-1. Steps to Building a Customized Emergency Operations Plan

1. By conducting a hazard vulnerability analysis, as described in Chapter 2, identify the risks that can potentially affect the health care facility.
2. Add issues and assess compliance related to the Joint Commission requirements and other agencies and unlisted regulatory issues.
3. Briefly describe compliance with each requirement.
4. Cross-reference to more detailed policies and procedures.
5. Establish and document the process for information collection and evaluation.
6. Determine the content and establish the process for staff orientation and education.
7. Develop the appropriate emergency response procedures.
8. Identify appropriate performance monitors based on actual or potential risk.
9. Establish the process for annual evaluation of the plan.

Source: Joint Commission Resources: *Guide to Emergency Management Planning in Health Care*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2002.

Table 3-2. Developing a Disaster Plan

The Agency for Healthcare Research and Quality (AHRQ) recommends the following steps for developing a disaster plan:

1. Assemble an interdisciplinary team of key stakeholders for disaster planning.
2. Review current resources, strengths, and weaknesses.
3. Develop a detailed written disaster response plan.
4. Disseminate and practice the plan through education and drills.
5. Evaluate the adequacy of knowledge, skills, and resources.
6. Revise the plan based on objective data and lessons learned.
7. Modify education and training as needed to target areas of weakness.
8. Continuously repeat these steps.

Key components of the plan, the AHRQ says, should include an incident command system, system integration, logistics, security, clinical care, human resources, and public relations.

Source: Agency for Healthcare Research and Quality (AHRQ): *Bioterrorism and Health System Preparedness: Disaster Planning Drills and Readiness Assessment*. Rockville, MD: AHRQ, Jan. 2004.

Emergency Operations Plan Checklist

- Surveillance and epidemiological process
- Identification of command structure and authorized personnel
- Notification process
- Activation in stages (alert, standby, callout, stand-down)
- Response plan by department
- Command center location, equipment, staffing, and alternative locations
- Communications systems if all usual lines and methods fail (radios, runners, and so forth)
- Local/regional coordination plan
- Security plan to control access and egress
- Internal traffic flow and control
- Media management and response
- Reception of casualties and victims (identification, triage, stabilization, admission or transfer, transport)
- Meeting care/communication needs of specific populations (non-English-speaking, elderly, pediatric)
- Volunteer plan
- Information sharing plans
- Facility evacuation
- Relocation of care recipients and staff
- Decontamination, isolation, or quarantine
- Assessment of equipment, facility, and laboratory supplies
- Availability of pharmaceuticals

BE PREPARED TIP

Incident Command System Structure

The incident command system (ICS) typically puts one individual (the incident commander) in charge of the emergency and decision-making process. Other positions or roles in an ICS, depending on the size and complexity of the organization, include public information officer, safety and security officer, liaison officer, liaison chief, planning chief, finance chief, and operations chief. Which of these positions is activated depends on the extent and type of the emergency encountered.

An “All-Hazards” Command Structure

An effective command system takes an “all-hazards” approach, with the following characteristics:

- A flexible structure for response to a variety of emergencies
- Clear delineation of staff roles and responsibilities
- A predictable chain of command
- Accountability for staff involved
- Prioritized response checklists
- The use of common terminology to reduce miscommunication
- The ability to be integrated into a communitywide plan

Source: Joint Commission Resources: *Are You Prepared? Hospital Emergency Management Guidebook*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2006.

In the early 1970s ICS was developed to manage rapidly moving wildfires and to address the following problems²:

- Too many people reporting to one supervisor
- Different emergency response organization structures
- Lack of reliable incident information
- Inadequate and incompatible communications
- Lack of structure for coordinated planning among agencies
- Unclear lines of authority
- Terminology differences among agencies
- Unclear or unspecified incident objectives

Although the EOP standard does not require a specific system, community integration itself is considered critical. Several models exist, including the National Incident Management System (NIMS), the Hospital Incident Command System (HICS), and the Fire Service Incident Command System. (See Figure 3-1 (pages 31–35) and Sidebar 3-2 (pages 36–38) and the scenario presented within it for more information on HICS and NIMS.) The HICS is probably the most well-known command structure model used in health care organizations throughout the country, defining staff responsibilities and reporting channels and using common terminology.

One of the reasons for the popularity of the HICS is its flexibility. This system provides a temporary organizational structure that enables individuals to be rotated into various roles as time and circumstances dictate. The command staff includes the incident commander, liaison officer, public information officer, safety officer, and medical technical specialist. The medical technical specialist is a role that can be filled depending on the type of event, such as a specialist in pediatric or biological or infectious disease. Beyond the command staff, the HICS further defines roles related to operations, planning, logistics, and finance/operations.

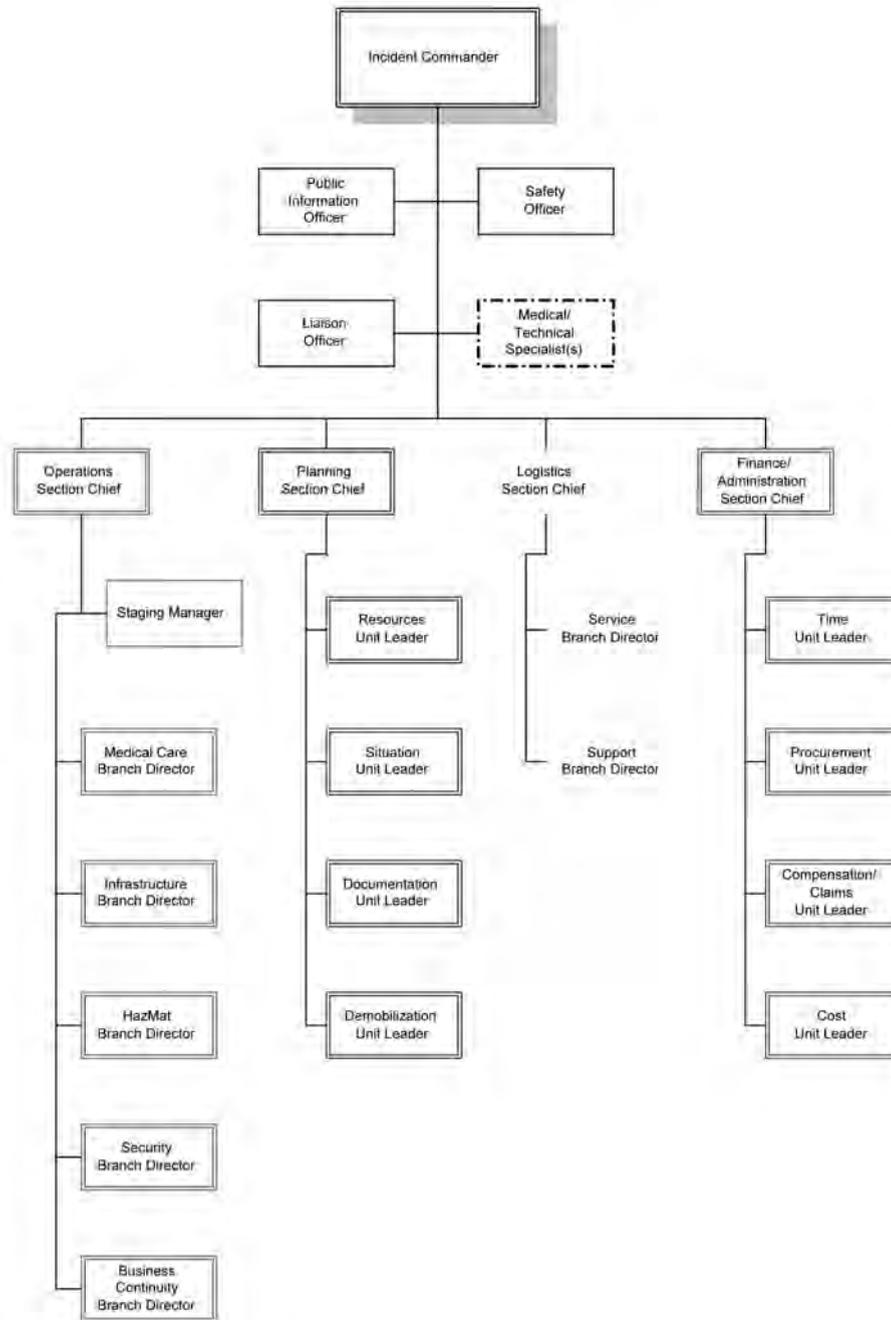
The HICS’s use of an organizational chart is useful in clearly delineating the roles and responsibilities of staff members and leaders during an emergency. In addition, the HICS can be easily integrated into an organization’s EOP and fits well with communitywide emergency efforts because of its standardization of roles and use of common terminology.

It is worth noting that no fixed model, whether it is the HICS, the NIMS, or another model, should be adopted in totality without intensive consultation with the involved community agencies. Modifications will undoubtedly be required to adapt to the given health care organization.

For any ICS to be successfully implemented, staff must understand to whom they report. This is important because emergency situations are likely to result in a reporting structure different than what staff are accustomed to, and staff must be not only ready to work, but cooperative in working toward a common goal.

Figure 3-1. Hospital Incident Command System Examples

This Hospital Incident Command System (HICS) incident management team chart depicts the hospital command functions that have been identified and represents how authority and responsibility are distributed within the incident management team.



Source: Reprinted from HICS IV "Hospital Incident Command Guidebook," Aug. 2006. California Emergency Medical Services Authority. Available online at <http://www.emsa.ca.gov/Dms2/download.htm>.

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Figure 3-1. Hospital Incident Command System Examples, *continued*

This Job Action Sheet (JAS) is an incident management tool designed to familiarize the user with critical aspects of the Incident Commander position. There are many JASs listed within the HICS guidebook, distributed among the categories of "Command," "Medical/Technical Specialists," "Operations," "Planning," "Logistics," and "Finance/Administration."

Job Action Sheet COMMAND

INCIDENT COMMANDER

Mission: Organize and direct the Hospital Command Center (HCC). Give overall strategic direction for hospital incident management and support activities, including emergency response and recovery. Authorize total facility evacuation if warranted.

Date: _____ Start: _____ End: _____ Position Assigned to: _____

Signature: _____ Initial: _____

Hospital Command Center (HCC) Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	Time	Initial
Assume role of Incident Commander and activate the Hospital Incident Command System (HICS).		
Read this entire Job Action Sheet and put on position identification.		
Notify your usual supervisor and the hospital CEO, or designee, of the incident, activation of HICS and your HICS assignment.		
Initiate the Incident Briefing Form (HICS Form 201) and include the following information: <ul style="list-style-type: none"> • Nature of the problem (incident type, victim count, injury/illness type, etc.) • Safety of staff, patients and visitors • Risks to personnel and need for protective equipment • Risks to the facility • Need for decontamination • Estimated duration of incident • Need for modifying daily operations • HICS team required to manage the incident • Need to open up the HCC • Overall community response actions being taken • Status of local, county, and state Emergency Operations Centers (EOC) 		
Contact hospital operator and initiate hospital's emergency operations plan.		
Determine need for and appropriately appoint Command Staff and Section Chiefs, or Branch/Unit/Team leaders and Medical/Technical Specialists as needed; distribute corresponding Job Action Sheets and position identification. Assign or complete the Branch Assignment List (HICS Form 204), as appropriate.		
Brief all appointed staff of the nature of the problem, immediate critical issues and initial plan of action. Designate time for next briefing.		
Assign one of more clerical personnel from current staffing or make a request for staff to the Labor Pool and Credentialing Unit Leader, if activated, to function as the HCC recorder(s).		
Distribute the Section Personnel Time Sheet (HICS Form 252) to Command Staff and Medical/Technical Specialist assigned to Command, and ensure time is recorded appropriately. Submit the Section Personnel Time Sheet to the Finance/Administration Section's Time Unit Leader at the completion of a shift or at the end of each operational period.		
Initiate the Incident Action Plan Safety Analysis (HICS Form 261) to document hazards and define mitigation.		



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(continued)

Figure 3-1. Hospital Incident Command System Examples, *continued*

Job Action Sheet Command
INCIDENT COMMANDER
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Immediate (Operational Period 0-2 Hours)	Time	Initial
<p>Receive status reports from and develop an Incident Action Plan with Section Chiefs and Command Staff to determine appropriate response and recovery levels. During initial briefing/status reports, discover the following:</p> <ul style="list-style-type: none"> • If applicable, receive initial facility damage survey report from Logistics Section Chief and evaluate the need for evacuation. • If applicable, obtain patient census and status from Planning Section Chief, and request a hospital-wide projection report for 4, 8, 12, 24 & 48 hours from time of incident onset. Adjust projections as necessary. • Identify the operational period and HCC shift change. • If additional beds are needed, authorize a patient prioritization assessment for the purposes of designating appropriate early discharge. • Ensure that appropriate contact with outside agencies has been established and facility status and resource information provided through the Liaison Officer. • Seek information from Section Chiefs regarding current "on-hand" resources of medical equipment, supplies, medications, food, and water as indicated by the incident. • Review security and facility surge capacity and capability plans as appropriate. 		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		
Intermediate (Operational Period 2-12 Hours)	Time	Initial
<p>Authorize resources as needed or requested by Command Staff.</p> <p>Designate regular briefings with Command Staff/Section Chiefs to identify and plan for:</p> <ul style="list-style-type: none"> • Update of current situation/response and status of other area hospitals, emergency management/local emergency operation centers, and public health officials and other community response agencies • Deploying a Liaison Officer to local EOC • Deploying a PIO to the local Joint Information Center • Critical facility and patient care issues • Hospital operational support issues • Risk communication and situation updates to staff • Implementation of hospital surge capacity and capability plans • Ensure patient tracking system established and linked with appropriate outside agencies and/or local EOC • Family Support Center operations • Public information, risk communication and education needs • Appropriate use and activation of safety practices and procedures • Enhanced staff protection measures as appropriate • Public information and education needs • Media relations and briefings • Staff and family support • Development, review, and/or revision of the Incident Action Plan, or elements of the Incident Action Plan 		
Oversee and approve revision of the Incident Action Plan developed by the Planning Section Chief. Ensure that the approved plan is communicated to all Command Staff and Section Chiefs.		
Communicate facility and incident status and the Incident Action Plan to CEO or designee, or to other executives and/or Board of Directors members on a need-to-know basis.		

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Figure 3-1. Hospital Incident Command System Examples, *continued*

Command
INCIDENT COMMANDER
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Job Action Sheet

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Ensure staff, patient, and media briefings are being conducted regularly.		
Review and revise the Incident Action Plan Safety Analysis (HICS Form 261) and implement correction or mitigation strategies.		
Evaluate/re-evaluate need for deploying a Liaison Officer to the local EOC.		
Evaluate/re-evaluate need for deploying a PIO to the local Joint Information Center.		
Ensure incident action planning for each operational period and a reporting of the Incident Action Plan at each shift change and briefing.		
Evaluate overall hospital operational status, and ensure critical issues are addressed.		
Review /revise the Incident Action Plan with the Planning Section Chief for each operational period.		
Ensure continued communications with local, regional, and state response coordination centers and other HCCs through the Liaison Officer and others.		
Ensure your physical readiness, and that of the Command Staff and Section Chiefs, through proper nutrition, water intake, rest periods and relief, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well-Being Unit Leader.		
Upon shift change, brief your replacement on the status of all ongoing operations, critical issues, relevant incident information and Incident Action Plan for the next operational period.		

Demobilization/System Recovery	Time	Initial
<p>Assess the plan developed by the Demobilization Unit Leader and approved by the Planning Section Chief for the gradual demobilization of the HCC and emergency operations according to the progression of the incident and facility/hospital status. Demobilize positions in the HCC and return personnel to their normal jobs as appropriate until the incident is resolved and there is a return to normal operations.</p> <ul style="list-style-type: none"> • Briefing staff, administration, and Board of Directors • Approve announcement of "ALL CLEAR" when incident is no longer a critical safety threat or can be managed using normal hospital operations • Ensure outside agencies are aware of status change • Declare hospital/facility safety 		
<p>Ensure demobilization of the HCC and restocking of supplies, as appropriate including:</p> <ul style="list-style-type: none"> • Return of borrowed equipment to appropriate location • Replacement of broken or lost items • Cleaning of HCC and facility • Restock of HCC supplies and equipment; • Environmental clean-up as warranted 		
<p>Ensure that after-action activities are coordinated and completed including:</p> <ul style="list-style-type: none"> • Collection of all HCC documentation by the Planning Section Chief • Coordination and submission of response and recovery costs, and reimbursement documentation by the Finance/Administration and Planning Section Chiefs • Conduct of staff debriefings to identify accomplishments, response and improvement issues • Identify needed revisions to the Emergency Management Plan, Emergency 		

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(continued)

Figure 3-1. Hospital Incident Command System Examples, *continued*

Job Action Sheet

Command
INCIDENT COMMANDER
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Demobilization/System Recovery	Time	Initial
<ul style="list-style-type: none"> • Operations Plan, Job Action Sheets, operational procedures, records, and/or other related items • Writing the facility/hospital After Action Report and Improvement Plan • Participation in external (community and governmental) meetings and other post-incident discussion and after-action activities • Post-incident media briefings and facility/hospital status updates • Post-incident public education and information • Stress management activities and services for staff 		
Documents/Tools		
<ul style="list-style-type: none"> • Incident Action Plan • HICS Form 201 – Incident Briefing Form • HICS Form 204 – Branch Assignment List • HICS Form 207 – Incident Management Team Chart • HICS Form 213 – Incident Message Form • HICS Form 214 – Operational Log • HICS Form 252 – Section Personnel Time Sheet • HICS Form 261 – Incident Action Plan Safety Analysis • Hospital emergency operations plan and other plans as cited in the JAS • Hospital organization chart • Hospital telephone directory • Radio/satellite phone 		

Source: Reprinted from HICS IV “Hospital Incident Command Guidebook” (“Appendix C Materials—Job Action Sheets”), Aug. 2006. California Emergency Medical Services Authority. Available online at http://www.emsa.cahwnet.gov/hics/job_action_sheets.asp.

BE PREPARED TIP

Making the Hospital Incident Command System Work

Implementing the Hospital Incident Command System does not necessarily ensure that a hospital will be able to effectively respond to a mass-casualty incident; that requires collaboration between hospital teams, leadership, and external agencies locally and nationally. Teams require flawless communication and coordination to maintain the awareness required to manage these complex events.

Sidebar 3-2.

Using the National Incident Management System and the Hospital Incident Command System to Navigate the Emergency Management Process

Emergency management is not something that can be done “on the fly.” To be effective at emergency response, organizations must use an approach that is planned and structured, yet flexible and scalable. Not only does this make common business sense, but federal, state, and local governments, as well as accrediting agencies, such as The Joint Commission, require it. Creating an emergency management program that encompasses an “all-hazards” approach can be daunting for some organizations. To help with this process, organizations might wish to seek compliance with an existing emergency management system. Two of the most common systems are the National Incident Management System (NIMS) and the Hospital Incident Command System (HICS).

What Is the NIMS?

In 2004, through a presidential declaration, the NIMS was created. The NIMS is intended to be an umbrella approach for unifying local, state, and federal responses to emergencies. The system is designed to promote collaboration, integration, and interoperability and ultimately lead to better responses to emergencies by communities throughout the United States.

The NIMS was not specifically designed for hospitals and health care systems; however, several such organizations have pursued NIMS implementation since 2004. In 2006 the NIMS Integration Center (NIC), in collaboration with the Department of Health and Human Services (HHS), released a document targeted to hospitals and health care systems, *NIMS Implementation Activities for Hospitals and Healthcare Systems*.¹

“Hospitals and health care systems are not required by the government to comply with NIMS. However, health care organizations seeking federal funding from the Health Resources and Services Administration (HRSA) must comply with NIMS,” says Jerry Gervais, C.H.S.P., C.H.F.M., associate director, Standards Interpretation Group, The Joint Commission. The HRSA required hospitals and other health care organizations seeking funding to complete NIMS implementation before August 31, 2007.

Organizations must implement 17 elements to be compliant with the NIMS. These elements address the following seven principal topic areas:

1. Organizational adoption
2. Command and management
3. Preparedness planning
4. Preparedness training
5. Preparedness exercises
6. Resource management
7. Communication and information management

The previously mentioned HHS implementation document gives background, implementation guidance, implementation examples, and references for each of these health care–focused elements.

Ultimately, the implementation of the 17 activities is designed to enhance the relationship between hospitals and their respective local government, public health, and other emergency response agencies. According to the NIC, “Hospitals and health care systems are strongly encouraged to coordinate with local public health agencies to work through these implementation activities.”¹ For more information on the NIMS, organizations can go to http://www.fema.gov/emergency/nims/nims_compliance.shtml.

What Is the HICS?

The HICS, revised in August 2006, is an incident management system that assists hospitals in improving their emergency management planning, response, and recovery capabilities for both unplanned and planned events. The principles embodied in the HICS are applicable to both emergent and nonemergent incidents. (The HICS was formerly called the Hospital Emergency Incident Command System [HEICS]; however, due to its applicability to both emergency and non-emergency events, the word *emergency* was dropped from the original name.)

The HICS is a methodology for using an incident command system (ICS) in a hospital/health care environment. It was redesigned in 2006 to parallel the NIMS program.

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Sidebar 3-2, continued**Using the National Incident Management System and the Hospital Incident Command System to Navigate the Emergency Management Process**

HICS materials include a variety of useful emergency management tools, including the following:

- A guidebook to the HICS
- Incident command practices
- HICS implementation and utilization considerations
- Incident planning guides
- Job action sheets (JAS) for each incident management team position
- Documentation forms
- Electronic slideshow education modules

“There are also incident response guides (IRGs) that serve as emergency management brain teasers for incident commanders and staff,” says Craig DeAtley, director of the Institute for Public Health Emergency Readiness at the Washington Hospital Center in Washington, D.C., and co-project manager for the HICS IV project, sponsored by the California Emergency Management Services Authority (EMSA). “The IRGs are based on 14 external and 13 internal emergency scenarios and can be used to help organizations train and drill for emergencies.” External drills focus on topics such as plague and anthrax, and internal drills include such topics as child abduction, fire, and utility loss. (See the box at right for an example of an external scenario.)

It is important to note that the HICS is not a template for a hospital emergency management plan, nor is it a hospital emergency operations plan. It is an emergency management system that focuses on the ICS. All HICS materials are posted on the California EMSA Web site (<http://www.emsa.ca.gov>) and are available for download at no cost. The national work group that created HICS Education and Training recently launched a Web site (<http://www.hicscenter.org>) as a repository for all HICS materials. “This Web site helps us share lessons learned from organizations using HICS and also provides access to the people who designed the HICS for individuals with questions,” says DeAtley. “We have also created an 8-hour introductory training to HICS and a 16-hour train-the-trainer course.”

External Drill Scenario: Anthrax Exposure

The following is an example of an external scenario provided by the HICS.

Urban City is a metropolis with a large commuter workforce with major hubs where large numbers of commuters congregate while waiting for connections. Recently, Urban City has been experiencing an early influenza season, with more than usual numbers of people becoming ill with colds and flu.

One weekday, the Universal Adversary terrorist group disbursts aerosol anthrax among the commuters using a concealed improvising spray device. The commuters do not notice the fine aerosol hanging in the air around them.

Twelve hours post-release, patients within and outside of Urban City present to emergency departments with influenza-illness-like complaints and symptoms. Many are seen and discharged, whereas a few are serious enough to require admission. Eighteen hours post-release, with large numbers of patients overwhelming emergency departments and clinics, and with multiple fatalities, a diagnosis of respiratory anthrax is made in several hospitals in the area. Local public health departments determine that the cases shared common commute locations and issue a case definition and alert to health care providers. Law enforcement and the Centers for Disease Control and Prevention are notified.

Source: California Emergency Medical Services Authority: *Hospital Incident Command System—External Scenarios*. http://www.emsa.ca.gov/hics/external_scenarios.asp (accessed Feb. 10, 2008).

How Are the HICS and the NIMS Related?

“Although HICS is not required for federal funding, it is a helpful tool for organizations seeking NIMS compliance or compliance with Joint Commission standards,” says DeAtley. Although HICS is consistent and compatible with NIMS

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Sidebar 3-2, continued

Using the National Incident Management System and the Hospital Incident Command System to Navigate the Emergency Management Process

principles, by itself it will not result in a hospital being totally compliant with all NIMS activities. For example, the NIMS has specific training requirements for individuals assuming an incident command management position and for other individuals involved in incident command. “While HICS does not require specific education, the program does provide education modules that explain all the information found in the HICS package,” says DeAtley. In addition, the previously mentioned HICS introductory training and train-the-trainer courses are designed to cover most of the specific course listings found in the NIMS guidance document. “HICS is not intended to address all 17 NIMS activity areas,” says DeAtley. “But it does support NIMS practices and is a designed program that provides health care organizations with a comprehensive, adaptable, scalable, and flexible approach to incident command. Plus, many organizations are already using the HEICS system and have a head start on complying with HICS.” Key difference from the HEICS include the incident management team chart with updated and expanded JAS, NIMS/HICS-compliant forms for docu-

mentation, hazard-specific planning and operational guidance, and information for addressing the NIMS.²

The HICS, The NIMS, and Joint Commission Standards

Both the HICS and the NIMS can help organizations comply with the Joint Commission’s emergency management standards. “The Joint Commission standards relating to emergency management require organizations to take an ‘all-hazards’ approach to managing emergencies, including establishing an ‘all-hazards’ command structure. Both the HICS and NIMS help organizations establish such a structure,” says Gervais. Although the HICS and the NIMS can be used to comply with many of the Joint Commission requirements, compliance with the HICS or the NIMS does not automatically mean compliance with Joint Commission requirements found in the Emergency Operations Plan standard. The Joint Commission standards offer a framework for effective emergency management, and each organization must tailor an effective program for emergency management within that framework.

References

1. Federal Emergency Management Agency: NIMS implementation activities for hospitals and healthcare systems. *NIMS Alert*, Sep. 12, 2006.
2. California Emergency Management Services Authority: *California EMSA Releases HICS Guide*. Oct. 19, 2006.

Source: Reprinted from Joint Commission Resources: Managing an emergency. *Environment of Care News* 10:5, May 2007.

BE PREPARED TIP

Readying the Command Post

At a minimum, the command post should have emergency power and be stocked with cellular phones, flashlights, battery-powered lamps, portable radios, telephones, computer network hookups, and detailed building plans. It is not necessary for all this equipment to be physically located in the command post, but it should be easy to find and transport there when needed. There should also be a list in the command post of critical telephone, pager, and fax numbers.

The EOP should state that the organization operates under an ICS that is coordinated with the community, along with a few details about the process and a cross-reference to the policy and/or procedure for doing so. The EOP also should identify to whom staff report in the organization's incident command structure. Early steps in coping with most emergencies and putting an EOP into place are notifying key staff and setting up the command post. The plan must clearly spell out the following:

- Who is the responsible individual to be contacted
- All areas of responsibility
- The circumstances under which the plan is to be activated and by whom
- Who is initially in charge

During business hours, for example, the administrative offices of Medicare-/Medicaid-based long term care organizations or the emergency departments of hospitals most often get calls. At other times, in a rapidly developing incident, the first person notified is the in-house nursing supervisor, the emergency department supervisor, or the administrator on call. In more slowly evolving incidents, the CEO or his or her designee is the first to be contacted by the administrative offices. If the CEO is not the initial activator of the plan, then the plan should describe what actions the activator should take and how to ultimately transfer to the CEO or designee at the command post. It is important to specify the chain of notification in the plan, including what key staff must be notified at the onset of an emergency, and to review the contact numbers periodically. Because outgoing communications might become jammed by a flood of incoming phone calls, even when the phone system is not directly affected by the emergency, there should be a contingency plan for other ways to reach people. (Establishing emergency communications strategies is discussed in detail in Chapter 4.)

The individual in charge of the organization's central command site must be in regular communication with first response teams at the site of the emergency. This gives the organization a greater understanding of the magnitude of the emergency and helps the command site know if, when, and how many patients are leaving the emergency site for treatment at the facility, as well as the severity of any injuries.

The command post needs to be in a predesignated area of the health care organization, and it is also a good idea to identify an alternative site in case the emergency affects the command post itself or prevents access to it. The plan should state who is responsible for delivering equipment to the command post

and setting it up. Some suggested numbers to have on hand are listed in Table 3-3 (page 40).

Staff essential to the health care organization's operation should be assigned to the command post. Together, members of this group will oversee carrying out the EOP. Depending on the size of the organization and the number of available resources, this group usually includes the CEO or director, chief operating officer, chief financial officers, chief of the medical staff, chief nursing officer, director of nursing, director of plant operations, media/marketing director, and security chief. Secretarial assistance also might be useful in the command post. Sidebar 3-3 (page 40) provides information about how to develop and maintain an EOP and an ICS.

Initiating and Terminating Response and Recovery Phases

The EOP should be specific in describing the processes for initiating and terminating the response and recovery phases of emergency management, including who has the authority to activate the phases and how the phases are to be activated. The Joint Commission emphasizes these two aspects of emergency management in the EOP standard. Being specific in how the response phase begins and ends is critical because the *response* refers to the actual emergency management of treating victims, reducing impact to the organization, and controlling the negative effects of the emergency situation(s). The *recovery* phase is likewise important because it means that the organization is moving back to normal operations. Again, in detailing initiation and termination of response and recovery phases, the EOP should address the six critical areas of emergency management (communication, resources and assets, safety and security, staff responsibilities, utilities management, and patient clinical and support activities).

Going It Alone for 96 Hours

One of the new emergency management requirements relates to the need to plan for what an organization will do when the community cannot assist or support it. Large-scale disasters such as the terrorist attacks of 2001 and Hurricane Katrina on the Gulf Coast demonstrated how an event can cripple a region and leave health care organizations on their own. Creating a detailed EOP in the face of uncertain resource support is a daunting challenge.

The EOP standard requires that the EOP identify the organization's capabilities and establish response efforts when the organization cannot be supported by the local community for at least

Table 3-3. Telephone Numbers to Have in the Command Post

- | | |
|--|---|
| <ul style="list-style-type: none"> • Contact numbers for all departments <ul style="list-style-type: none"> – Telephone – Fax • Contact numbers for key staff <ul style="list-style-type: none"> – Home phone – Pager – Fax – Next-of-kin notification • Pay phones in the facility and their locations • Elevator telephones • Neighboring health care organizations • Regional contacts <ul style="list-style-type: none"> – Police – Fire department – Public/state health department | <ul style="list-style-type: none"> – National Guard – Civil defense – Red Cross – Television stations, radio stations, and print media – State and county emergency operations centers – Essential vendors (linen, food, fuel, etc.) – Utility companies – Blood banks – Ambulance services – Coroner's office – Nursing registry – County medical society – Funeral homes – Pharmacies |
|--|---|

Source: Joint Commission Resources: *Guide to Emergency Management Planning in Health Care*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2002.

Sidebar 3-3.

Developing and Maintaining an Emergency Operations Plan and an Incident Command System

Whereas the standard requiring the management of the consequences of emergencies discusses the planning aspect of emergency management, the EOP standard addresses an organization's response. The standard requires organizations to develop and maintain an Emergency Operations Plan (EOP). This is a document to help guide an organization in its emergency response and recovery efforts and should include a description of the organization's incident command system (ICS).

"An ICS at a fundamental level helps organizations identify who is in charge during an emergency and which individuals will carry out the decisions of the individual in charge," says James Augustine, M.D., an emergency medicine physician at Emory University in Atlanta. Augustine serves as the American College of Emergency Physicians liaison to the Joint Commission's Hospital Professional and Technical Advisory Committee and thus had input into the development of the revised emergency management standards. "An ICS does not need to be rigid, but everyone in an organization should understand the basic principles of the ICS and how it applies on a day-to-day basis. If this basic understanding exists, then staff can scale up response efforts when necessary."

Peter Brewster, director of education and training for the Emergency Management Strategic Healthcare Group, a part of the U.S. Department of Veterans Affairs, points out that one important aspect of emergency response addressed in the new standards is the focus on health care organization sustainability. "Organizations must understand how they will continue operations even when the community cannot support them," he says. Specifically, within the EOP, an organization must understand how it would respond to an emergency in which community support is unavailable for 96 hours.

"It is important to realize that an appropriate response may involve closing or evacuating the health care organization after a certain period," explains John Fishbeck, R.A., associate director, Division of Standards and Survey Methods, The Joint Commission. "For example, if an organization determines it has enough fuel and supplies to last for 48 hours, then it knows it can effectively continue operations for that time period. However, the organization also must realize that after 48 hours without community support, it must either evacuate or discharge patients. This is something that should be considered and planned for."

Source: Reprinted from Joint Commission Resources: Revised emergency management standards for 2008. *Environment of Care News* 10:8, Aug. 2007.

Ten Weaknesses in Emergency Operations Plans

1. Lack of critical information
2. Not flexible enough
3. Do not address communication issues broadly or in enough detail
4. Do not contain enough multidisciplinary input
5. Do not contain adaptable forms for managing information
6. Do not consider enough scenarios (or enough hazard vulnerabilities)
7. Poorly document incidents
8. Do not include troubleshooting tools
9. Lack alarm points signaling that critical supplies are running low
10. Have not undergone a detailed review with local agencies and do not consider community linkages or processes

Source: Bruce C.: Troubleshooting your top ten weaknesses in emergency preparedness plans. *Environment of Care News* 3(2):11, 2000.

96 hours. Acceptable response efforts include conserving resources or supplementing them from beyond the affected area, curtailing some services, or evacuating the facility. In other words, hospitals and long term care organizations must consider how they will address communication, resources and assets, safety and security, staff responsibilities, utilities management, and patient clinical and support activities (see the standards discussion in Chapters 4 through 9) over a four-day period if an emergency leaves them without any outside assistance.

If an organization chooses to stay, it must have plans to be self-sufficient for 96 hours. If this is not possible, then the organization should have plans in place to evacuate after a predetermined period. For example, an organization might determine that it can be self-sufficient during an emergency for 48 hours, after which point it will initiate evacuation procedures. However, the organization should also make plans so that its evacuation can be supported 48 hours after the start of an emergency. If the organization begins evacuating at 48 hours and the rest of the community has evacuated after 12 hours, the health care organization might run into significant problems.³

Identifying Alternative Care Sites

The last requirement for the standard under discussion in this chapter is one that has long existed in emergency standards: identifying alternative sites for care that meet the needs of patients during emergencies. When a health care organization's facility cannot support adequate patient care, or if it becomes unusable, then the organization must initiate processes for establishing an alternative care site(s) that has the capabilities to meet patient needs.

Some issues to consider when choosing an alternative care site include the following:

- How patients, staff, and equipment will be moved
- How medical records and medications will be moved
- How patients will be tracked to, within, and from the site
- How interfacility communication will occur

It might be useful to maintain a list of neighboring health care organizations that includes their staffing and equipment capabilities. The list should start with the closest facility and end with the one that is farthest away. These relationships should be defined and spelled out, in detail, in the EOP prior to a disaster.

Hospitals and long term care organizations should consider establishing prearranged mutual aid agreements with other local or area institutes to serve as alternative care sites. State hospital or nursing home associations, local emergency planning committees, or other similar groups might be able to assist in coordinating such agreements. The memorandum of understanding, though, is only a starting point, as it requires additional planning and practice to be functional during an emergency.

Cooperative planning among health care organizations also should include the following:

- Essential elements of the command structures and control centers for emergency response
- Names, roles, and telephone numbers of individuals in the command structures
- Resources and assets that could potentially be shared or pooled in an emergency response (see the discussion in Chapter 5)

CASE EXAMPLE:

LOUISIANA HOSPITAL FACES A WEEK ALONE AFTER HURRICANE KATRINA

East Jefferson General Hospital (EJGH) in Metairie, Louisiana, had a solid disaster plan in place. However, it was not sufficient for a disaster on the scale of Hurricane Katrina. The plan, which was designed for a disaster lasting two to three days, became irrelevant just as the crisis was getting started. However, this is not to say that the plan was not valuable.

“Some might say that our disaster plan didn’t work,” says Donald Chenoweth, EJGH’s chief information officer. “But in a lot of ways, it still did. Because we had put a lot of work into developing the plan, there was a level of discipline that the emergency team had. Even though we weren’t able to use some of the specific details of the plan, we knew what to bring in, we knew what to worry about, we knew what we had to get fixed first. That adaptability and the ability to work well under significant pressure came from our plan.”

With water lapping at the back door, the generator that powered the air-conditioning having gone out, and no phone or Internet access, EJGH was effectively isolated from the rest of the city for about a week. “The biggest concern was that we didn’t know how long it was going to be like that,” Chenoweth says. “Fortunately, we have a very smart and flexible staff.”

To regain Internet access, EJGH staff located a single dial-up line that was still working because it went through Baton Rouge instead of New Orleans. They connected PCs to it and set up some free, Web-based e-mail accounts. They also realized that although local cell phone service was down, a few phones that had exchanges outside the local area codes were occasionally working—and although voice service was sporadic, text messaging was usually operating normally.

With these simple communication methods, staff were able to communicate with friends, family, and coworkers; make contact with federal, state, and local disaster efforts; and order food, water, and medical supplies for the more than 3,000 patients, staff, and evacuees in the facility.

Through a great deal of effort and ingenuity (and some good fortune, Chenoweth says), EJGH was able to receive patients again just one week after the storm began. Many of these new patients included Hurricane Katrina survivors and emergency workers.

Since then, EJGH has revised its disaster plan significantly. “Our old disaster plan was built around being able to recover equipment and get systems back up and running so that we can continue to treat patients, but our equipment was fine,” Chenoweth says. “What happened was that we became isolated and didn’t have power, and nobody thought that would take place.”

Because the biggest problem EJGH saw during the hurricane was the failure of its communication methods, that was the focus of revisions to the plan, Chenoweth says. “We had a lot of lines, but they all went down. We had backup cell phones, but the only ones that were working were the ones with phone numbers from out-of-state locations, and we found that out by accident.

“The new plan calls for high-speed Internet access and phones to be connected through a satellite. If we’d had that during Katrina, we would have had plenty of ability to communicate,” says Chenoweth. “Not being able to contact anyone outside the hospital was nerve-wracking, but now we’re modifying our plan to take care of that.”

Source: Joint Commission Resources: *Safer Emergency Care: Strategies and Solutions*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2007, p. 87.

BE PREPARED TIP

Agency for Healthcare Research and Quality Tool for Alternative Care Sites

The Agency for Healthcare Research and Quality (AHRQ) has released a tool to quickly locate alternative care sites in the event that hospitals are overwhelmed by patients due to a bioterrorist attack or other public health emergency. The tool, produced by AHRQ partner Denver Health Medical Center, allows regional emergency planners to locate and rank potential alternative sites, such as stadiums, schools, recreation centers, motels, and other venues, based on whether they have such resources as adequate ventilation, plumbing, toilet facilities, communication lines, and food service areas. The tool lists about 30 attributes in all. The spreadsheet, which also addresses necessary equipment, supplies, staffing considerations, and coordination with local agencies to ensure that potential sites have not been designated for another use, is available at AHRQ's Web site at <http://www.ahrq.gov>.

Non-health care organization sites also should be considered as potential alternative care sites. These could include schools, college dormitories, libraries, recreation centers, sports stadiums, military armories, closed hospitals, places of worship, and hotels. Even large corporate buildings might have spaces that could serve as areas to deliver care or as discharge centers. Health care organizations should coordinate with other local agencies, however, to ensure that potential sites have not been designated for another use.

There are many factors to consider when selecting an alternative care site. Some might be less or more important, depending on the type of emergency at hand and the time of year that the emergency occurs. For example, ventilation might be less of an issue if victims do not have to be isolated or decontaminated. Heating is not as important if the event occurs in the summer or in a warm part of the country. Table 3-4 (page 44) provides a list of possible alternative care sites that organizations might wish to consider. Among the factors to consider when selecting an alternative care site are the following⁴:

- Ability to lock down the facility
- Adequate building security personnel
- Adequate lighting
- Air-conditioning/ventilation
- Area for equipment storage
- Biohazard and other waste disposal
- Communications capability
- Door size adequate for gurneys
- Electrical power with backup
- Family areas
- Flood supply/preparation area
- Floor and walls adequate
- Heating
- Laboratory/specimen handling areas
- Laundry area

- Loading dock
- Oxygen delivery ability, compressed medical air, and suction availability
- Parking for staff/visitors
- Patient decontamination areas
- Pharmacy areas
- Proximity to hospital/long term care facility
- Toilet facilities/showers/waste
- Two-way radio capability
- Water supply
- Wired for information technology/Internet access

Medications, medical records, and any medical equipment required by patients must be transferred, along with the patients themselves, during the transition to the alternative care site. To accomplish this, organizations might wish to consider developing a checklist to ensure that the patient has all of his or her vital information. It could include a medication list, a diagnosis or problem list, a medical history with the names and phone numbers of physicians, and a list of allergies and sensitivities. Organizations might also choose to develop an abbreviated medical record for use in a large-scale emergency that can be kept with the patients as they move through the system.

In addition, patients have to be tracked to, within, and from the alternative site. One of the best ways to ensure the accurate tracking of patients is to start with an accurate list of all patients and their locations within the organization. Some hospital associations are assisting members with this task by developing patient tracking systems. As part of the HICS, the Disaster Victim/Patient Tracking Form (*see* Figure 3-2, page 45) is an example of a tool that can be used to account for the location of patients receiving medical attention throughout a facility. The document has space to list the names, sex, dates of birth, triage area, disposition, and other essential information for up to 21

BE PREPARED TIP

Choosing an Alternative Care Site

Develop a spreadsheet, placing factors from the list of items to consider when selecting an alternative care site on one axis and the list of potential alternative care sites on the other. Use a 0 to 5 rating scale (bad, poor, fair, good, excellent) for each factor to determine the best alternative site(s).

Table 3-4. Possible Alternative Care Sites

- | | |
|---|--|
| <ul style="list-style-type: none"> • Aircraft hangars • Closed hospitals or nursing homes • College dormitories • Community/recreation centers • Fairgrounds • Government buildings • Hotels/motels • Libraries • Meeting halls • Military facilities | <ul style="list-style-type: none"> • National Guard armories • Places of worship • Schools • Sports stadiums/facilities • Tents • Trailers • Warehouses • Unleased/empty open-space buildings (such as grocery stores) |
|---|--|

Source: Joint Commission Resources: *Are You Prepared? Hospital Emergency Management Guidebook*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2006.

patients or victims of an identified event. It is designed to be completed hourly and at the end of each operational period, upon arrival of the first patient and until the disposition of the last.

Finally, patients and staff will require transport to the alternative care site. Ground transportation options include the following:

- Ambulances
- Ambulette services, which are equipped with wheelchair lifts

- Facility-owned buses or vans
- Family members' and volunteers' automobiles
- Prearranged use of local school bus company or school district buses

Inclement weather or poor terrain can make driving difficult; therefore, air transfer, such as helicopters, might have to be considered.

Coordinating with the Media

An emergency operations plan (EOP) should include policies and procedures for coordinating with the media, recognizing that emergency responses are improved when the media has been given accurate and current information. A 2007 study shows, though, that journalists and public health information officers (PIOs) often don't see eye to eye during disasters, with perspectives and organizational processes cited as limiting effective communication. Solutions to the challenge of sharing accurate and appropriate information include journalist participation in disaster exercises and drills, sharing of informational resources, and raising awareness at trade meetings.¹

To the extent possible, the organization representative coordinating with the media should respond promptly and informatively to the media. The information must be accurate while also protecting patient confidentiality.

When speaking with the media, consider the following tips²:

- Speed is crucial in working with the media. Promptly call back reporters, as they frequently need the information to meet a deadline.
- Remain calm. If a reporter gets aggressive, stay focused on the question at hand and try to answer to the best of your ability.
- Never say, "No comment." It is okay to say, "I don't know."
- Look for opportunities in the interview to share key messages.
- Talk from the audience's or reader's point of view and avoid organization-specific jargon.
- Remember that anything you say during the course of the conversation could appear in print. There is no such thing as "off the record."
- If a reporter uses negative language, do not repeat it and do not repeat the question.
- Never argue with a news reporter about a story.
- Never flatly refuse to give information. Explain why the information is not available.
- Do not let a reporter put words in your mouth. Clarify comments when necessary.
- Repeating key messages is acceptable. Sometimes a reporter needs to hear a message several times and in several ways before he or she understands it.
- Answer questions directly, without giving more information than necessary.

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1. Lowrey W., et al.: Effective media communication of disasters: Pressing problems and recommendations. *BMC Public Health* 7:1–8, Jun. 2007.
2. Joint Commission Resources: *Guide to Emergency Management Planning in Health Care*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2002.

CASE EXAMPLE:**PANDEMIC PREPAREDNESS**

Nobody has to tell you that health care organizations come in all sizes and offer all types care for all different kinds of patients. Let's look at how two vastly different organizations—a health care system and a small community hospital—are handling the planning process to prepare for a likely pandemic.

The Veterans Health Administration: The Nation's Largest Integrated Health Care System

Imagine providing medical, surgical, and rehabilitative care to 5.3 million patients at 154 medical centers and 1,300 sites of care, including 875 ambulatory care and community-based outpatient clinics, 136 nursing homes, 43 residential rehabilitation treatment programs, and 206 Veterans Centers.

That's the challenge faced by the Veterans Health Administration (VHA), the largest integrated health care system in the United States. In 2005 the Bush administration asked the VHA to come up with a strategy for dealing with pandemic flu. Although no one is certain about the exact biological characteristics of the next pandemic, it's likely to be caused by the H5N1 strain, known as avian flu. However, the VHA's plans and preparations must anticipate both likely and observed threats, such as H5N1, and threats from new, unrecognized strains of influenza virus.

"The number of people who are potentially eligible for our health care services is about a quarter of the nation's population, including veterans, their family members, and survivors of veterans," says Victoria J. Davey, R.N., M.P.H., deputy chief officer, Office of Public Health and Environmental Hazards, VHA.

Responding to the White House directive, the VHA named a 70-person team of staffers from all Department of Veterans Affairs (VA) divisions, including clinicians, hospital administrators, and infection control policy and leadership experts. These team members were divided up into work groups, and five months later, they delivered to the Homeland Security Council a 150-page detailed report on how to plan for and respond to a pandemic flu.

The plan is aimed at the VHA's stakeholders, including 25 million veterans, 235,000 VA employees, 93,000 volunteers, and 83,000 annual trainees. "We're also part of any federal report," says Davey, "so if an emergency is declared, we'd be working with civilian health care units and with health care units in other agencies, such as the Department of Defense. We're there for everyone who needs us."

A Model Plan

The Homeland Security Council rates the VHA's effort a "model plan," and other federal agencies have asked the VHA to share it with them. The plan explains how to prepare employees for a pandemic and how to handle space planning, infection control, supplies, heightened surveillance, staff illness, precautions for health care facility staff, mental health support for patients and staff, security, supplies, and many other subjects.

Another section includes instructions on responding to an actual pandemic, including information on refocusing patient care priorities, hand and respiratory hygiene, support for all ill staff members, antiviral drugs, vaccines, diagnostics, flexible work standards, recredentialing of the organization's retirees, changing demands and surge, advice line/telemedicine, fatality management, and security for health care sites. The final section of the plan deals with returning to normal operations and services following a pandemic.

(continued)

Case Example: Pandemic Preparedness, *continued*

“Health care organizations of any size will find the plan’s 50-page toolkit section particularly interesting and useful,” says Davey. “It features checklists for preparing for and responding to a pandemic. VA hospitals will use this framework to develop their own pandemic flu preparedness plans. They’ll also appreciate the planning templates for use by local hospital management.” The VHA plan is furnished in an editable format so hospitals can adapt different pieces of the plan to their own situations. “It will probably save them a great deal of time,” says Davey.

So far, the VHA has distributed its plan only within the VA. However, after the mostly minor suggestions from the Homeland Security Council have been incorporated, the VHA pandemic flu plan will be available for download from the VHA Web site, at <http://www.publichealth.va.gov/flu/pandemicflu.htm>.

“Most of the questions we’ve gotten so far are about whether hospitals have to do their planning just the way we suggest,” says Davey. “The answer is that we’ve tried to make this document very light on policy and instead offer suggestions that local health care organizations can adapt to their needs. Rather than, ‘You must do this!’ our tone has been, ‘Consider including this.’”

Portrait of Northwest Community Hospital

Beds: 488 for inpatient and outpatient services

Inpatients per year: 28,500

Outpatient visits per year: 350,000

Physicians with offices throughout service area: nearly 1,000

Employees, including nurses, allied health professionals, and administrative and support personnel: 3,700

Northwest Community Healthcare: A Community-Sized System

Northwest Community Healthcare (NCH), which serves the suburbs northwest of Chicago, has been working on its pandemic flu plan since February 2005. The hospital solicited input from a broad multidisciplinary team within the hospital, including representatives from various clinical units, as well as from respiratory therapy, trauma, emergency medical services (EMS), the emergency department, radiation, oncology, infection control, and intensive care. NCH also held planning meetings with the regional Hospital Incident Command System.

The result of NCH’s work is a four-page, tiered plan modeled on a plan issued by the Department of Health and Human Services. The plan explains what to do in case of varying levels of emergency, including a pandemic alert, seasonal influenza, a pandemic outside the United States, a pandemic inside the United States, and a local pandemic afflicting residents in the surrounding three-state area.

At each level, the plan deals with specific subjects, including hospital surveillance, hospital communication, staff education and training, triage, clinical evaluation and admission procedures, facility access, occupational health, use and administration of vaccines and antivirals, surge capacity, security, and mortuary issues.

“We’ve addressed as well as we can the unknown biological characteristics of a pandemic flu,” says Mary Casey-Lockyer, R.N., C.C.R.N., the hospital’s emergency response coordinator. “A plan like this can’t be done overnight. Instead, we see

(continued)

Case Example: Pandemic Preparedness, *continued*

it as a living document on which we'll continue working for a long time. And we're partnering on it with regional, state, and federal authorities."

NCH is also planning regionally for alternative care sites for the minimally ill in case of a pandemic. "We're looking at which buildings could be used in case of a pandemic," says Casey-Lockyer. "We'll need clear criteria for hospital admission in case of a pandemic, and we're hoping that those criteria will be issued by our public health authorities at the county and regional level. We may have to ask our EMS providers to keep people at home and make sure they have fluids."

Respirators and Masks

One item that has proven controversial is the use of masks and respirators for staff members. Says Casey-Lockyer, "We are taking a risk-benefit approach by fit-testing a large percentage of our staff members, and we've alerted our N-95 vendors that we may ask them to fit-test some of our employees as well." NCH has stockpiled N-95 respirators and masks, and it's possible that the Illinois Department of Public Health would permit reuse of N-95s. "We have more than one per person, but no one can be sure how quickly these respirators would be used up."

NCH is considering a train-the-trainer approach in which it would train a corps of employees to fit-test other employees on a just-in-time basis. Casey-Lockyer anticipates that NCH might have some leeway on this in terms of time. "A pandemic in Asia would probably move fit-testing onto the front burner for us, especially since the World Health Organization is being so vigilant about tracking avian flu in various sites around the world as well as among our own animal and human population."

Communicating the Plan

The NCH home health care department presents guidelines on pandemic flu and emergency readiness at staff meetings, general meetings, and monthly emergency management committee meetings, and all this information is relayed to employees. In case of an emergency such as a flu pandemic, NCH would activate a pager alert system to its leaders, containing a dedicated emergency extension, which they would call to get instructions about whom to call back.

Partnering with Others

NCH is working with the EMS in the municipalities it serves. It also meets each month with the Northern Illinois Emergency Management Consortium, which has been coming together since the September 11 attacks to share concerns, plans, and information. During those meetings, NCH updates the participants on the medical and health aspects of various hazards.

"We've become partners," says Casey-Lockyer. "Hospitals are increasingly reaching out to the community and vice versa to plan for hazards such as a pandemic. That way, if I encounter trouble, I'll know that someone from a nearby community will lend a hand. Knowing everyone face to face reassures us that we all have each other's backs."

Source: Reprinted from Joint Commission Resources: Pandemic preparedness. *Environment of Care News* 10:5, May 2007.

CASE EXAMPLE:

LONG TERM CARE ORGANIZATIONS AND EMERGENCY RESPONSE

The World Trade Center and Pentagon attacks of September 11, 2001, showed the major role that long term care organizations could be asked to play during an emergency. Following the attacks, the Department of Health and Human Services (HHS) waived the three-day hospital stay requirement for Medicare coverage of nursing home care in the affected areas for the duration of the disaster. This allowed hospitals to discharge less than severely ill patients to long term care facilities. All long term care facilities in the area were required to report their bed availability to the HHS.

New York's Jewish Home and Hospital took a number of patients out of Lenox Hospital and Mount Sinai to free up the hospitals for the forecasted, but never materializing, deluge of patients. The long term care facility's own physicians and ambulances transported the transferring patients to the Jewish Home and Hospital so as not to call on the hospitals' ambulances and staff. The Jewish Home and Hospital also took a number of the more frail residents of Hallmark at Battery Park City, an independent and assisted living facility that had to evacuate all 75 residents and 40 staff members immediately following the attack. The evacuation went smoothly and nobody was hurt.

In addition, the New York Association of Homes and Services for the Aging, Jewish Home and Hospital, and other long term care organizations coordinated blood donation and other volunteer operations to assist the rescue effort. Long term care physicians and nurses volunteered their services in the triage areas set up at Chelsea Pier.

For Additional Assistance

- Hospital Incident Command System (HICS; through the California EMS Authority): <http://www.emsa.ca.gov>
- Center for HICS Education and Training: <http://www.hicscenter.org>
- U.S. Department of Health and Human Services, Centers for Disease Control and Prevention: *Long Term Care and Other Residential Facilities Pandemic Influenza Planning Checklist*: <http://www.pandemicflu.gov/plan/LongTermCareChecklist.html>
- The Joint Commission: *Standing Together: An Emergency Planning Guide for America's Communities*: <http://www.jointcommission.org/PublicPolicy/>
- American Health Care Association: *Disaster Planning Guide: A Resource Manual for Developing a Comprehensive Preparedness Plan*: <http://www.ahca.org/news/nr060424b.htm>
- Agency for Healthcare Research and Quality (AHRQ): *Emergency Preparedness Atlas: U.S. Nursing Home and Hospital Facilities*: <http://www.ahrq.gov/prep/nursinghomes/atlas.htm>
- AHRQ: *AHRQ Disaster Response Tools and Resources*: <http://www.ahrq.gov/path/katrina.htm>
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