

CHAPTER LEADER'S GUIDE TO

Emergency Management

Second Edition



Thomas J. Huser, MS, CHSP, CHEP, MEMS

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Huser has published 17 articles in the *Journal of Healthcare Security* on the topics of disaster drill planning, emergency decontamination, incident command systems, and hazard communications programs. He is the author of *The Environment of Care Handbook*, *The Emergency Management Compliance Manual*, and *Life Safety Survey Companion*. He has given numerous presentations on the topic of hospital safety, including at the Ascension Health Safety Conferences in 2000, 2001, and 2002; the National Fire Protection Association World Fire Safety Conference in 2003; and the National Earthquake Conference in 2004.

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Huser holds an associate's degree in applied fire science, a BS in business administration, and an MS in health and safety management; he is a Certified Healthcare Safety Professional, Healthcare Emergency Planner, and Military Emergency Management Specialist. He was a volunteer firefighter/EMT/hazardous materials specialist for 37 years and is currently a volunteer with the Hamilton County, Indiana, Emergency Management Agency.

PART 1

State of Preparedness

There is not one hospital in the United States that is immune from disasters, whether caused by internal system failures or events externally directed at them and the communities they serve. Yet many of the nation's healthcare organizations make preparedness a low priority and fail to build the resiliency necessary to continue or quickly restore operations in the face of significant events.

We have seen cities along the Gulf and East Coasts devastated by hurricanes. We have seen the need to evacuate large urban centers in the face of impending storms, forcing healthcare organizations to make terrifying decisions with long-range implications. And we have seen cities such as New Orleans and Galveston fractured by storms, with near complete loss of their healthcare infrastructure.

We have seen hospitals in the Midwest directly affected by flooding; the East Coast from Washington, D.C. to New England has experienced major blizzards and ice storms, and western regions have had to deal with raging wildfires as well as drought conditions. Planning for climate change is now required of local and state emergency management agencies by the

Building resiliency within the organization and its staff requires an understanding of how disasters impact not only an organization, but also the community it serves. Disasters are usually joint ventures often impacting one constituent greater than the other and, in rare circumstances, devastating both with equal force. Analysis of past disasters gives a reasonable picture of what to expect when a disaster strikes your community or facility, and those historical records and experience should be used in construction of current plans. These impacts should be identified in the joint hazard vulnerability analysis (HVA), which must be reviewed and updated annually. When conducting the HVA, be sure to take into account the changing climate and how these changes may have adverse effects on your facility operations.

Understanding the Community

There are several keys to understanding the community's involvement during an emergency:

1. **Healthcare preparedness is a given.** In the minds of most community emergency planners, there is an expectation that hospital-based care will be available regardless of the situation. It is up to healthcare organizations to ensure that community planners have realistic expectations of the healthcare infrastructure (hospitals, clinics, dialysis centers, pharmacies, home care, long-term care facilities) and its survivability and sustainability during disasters. It is also imperative that community planners are made aware of what support is needed from the community to keep healthcare organizations open and functional.
2. **Competing priorities exist within government.** During a disaster and the recovery stage, local government will concentrate on restoring essential services. In most cases, that does not include healthcare. Rescue and safety of citizens will be the top priority, followed by restoration of power, water, and communication if they have been affected.

- Creativity and flexibility
- Emotional intelligence
- Influence and negotiation
- Conflict management
- Effective communication
- Role-modeling

During a crisis, leaders set the tone by their example and conduct. They must pay attention to what they say and do and be purposeful in their actions. Like it or not, leaders will have a significant impact on the very human, highly charged emotional climate that is prevalent during a crisis. And it is often not what they do, but rather how they react, how they sift through the options and choices, how carefully they listen to others, how they clearly articulate what needs to be done, how they demonstrate their sincere interest and genuine concern for others, and how they support the mission and values of the organization even during a crisis.

“No amount of personality, political skills, or cracker-barrel wit can disguise technical and managerial competence. And almost nothing can multiply employee anxieties and reduce confidence more during crisis than a leader who is perceived to be marginally competent.”

Crisis Leadership, by Gene Klann,
The Center for Creative Leadership (2003)

The daily grind of hospital management certainly provides adequate opportunity for leadership skills to be honed and new leaders to be identified and developed.

Common characteristics of significant disasters:

- The event was sustained, lasting multiple days, weeks, months, or even years
- Multiple communities, neighboring and distant, were affected
- Public services were significantly impacted or debilitated
- Local, state, and federal agencies were overwhelmed
- The entire healthcare infrastructure of the community was threatened

Impact on hospitals:

- Home care, freestanding dialysis centers, outpatient cancer centers, outpatient pharmacies, and physician offices, mental health, and drug rehab (methadone) clinics closed or not accessible
- Long-term care facilities consider evacuation
- Special needs patients unable to be supported at home
- Discharged patients unwilling to leave the hospital, resulting in increased admissions and decreased discharges

Leadership thoughts during a disaster:

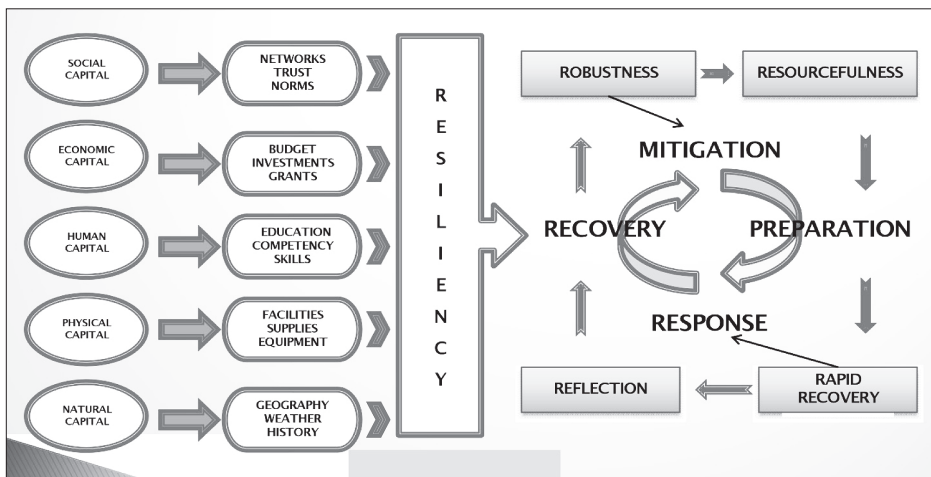
- **Rapidly set priorities for the staff to follow.** The reality of any disaster or significant event is that staff will have to exercise independent judgment with minimal or possibly without the input and oversight of leadership. Decisions will be made every minute by staff without leadership input. Help them out. Give everyone a simple set of guiding principles (vision and values) during exercises and be sure that every person in the facility knows what behaviors are expected during an actual event. Often, the simpler the instructions, the easier they are adopted by staff. For example, you may state that when forced to make independent decisions, staff should use the following priorities as they consider what actions to take:

The elements of resiliency

1. **Robustness:** The ability to continue to function during disruption. The EOP lays the foundation for this element. Through thoughtful planning with leadership and the community, provisions are made to carry on operations in the face of a significant insult.
2. **Resourcefulness:** Managing the response to a disruption. The HICS is specifically designed to allow trained and qualified individuals to manage the crisis as it unfolds and to direct resources and personnel to key elements of the system to keep it functional.
3. **Rapid recovery:** The ability to return things quickly back to normal. The combination of a thoughtfully constructed EOP and a well-executed HICS in response to a crisis is the surest means to a rapid restoration of services.
4. **Reflection:** The ability to absorb lessons learned from the disruption. The very reason The Joint Commission requires exercises and, more precisely, an objective observer to evaluate each exercise is to provide feedback to improve system and individual performance.

1.1

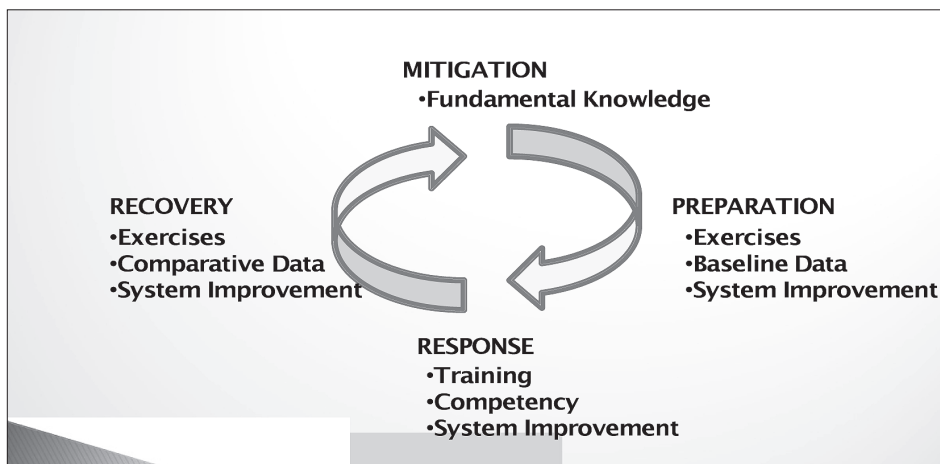
Resiliency Cycle Relationships



- **Protect staff.** Do not put staff in harm's way if it can be avoided. Staff are the most important resource for the delivery of patient care and the protection of patients. Injured staff diminishes the ability to provide care and adds to the burden of caring for the injured. Make sure staff understand that you are not looking for heroes.
- **Protect patients.** Tell staff to do everything in their power to act in the best interest of their patients. That means providing care that they have competency in, that is within the scope of their license, and that is ethical and prudent. Give them the authority to do the right thing knowing that you will support their actions. They should not have to wait for orders or directions if immediate action would protect patients and preserve lives.

1.2

The Resiliency Cycle



Look for the most updated but user-friendly systems and be sure that the system you select to use in emergencies is one that staff can and will use on an everyday basis. When all else fails, runners are an excellent solution to communicate with functional areas or groups.

Combining runners, iPad® devices (excellent for writing messages and keeping a message log), and digital cameras creates the opportunity to receive quick, visual status reports from any part of the hospital. Digital images and recorded reports can be delivered to the hospital's emergency operations center and displayed there.

- **A functioning kitchen and food for staff and patients is a critical element.** If the disaster extends beyond 24 hours and normal operations are significantly disrupted, the ability to house and feed patients, staff, volunteers, families, public safety employees, and those who have arrived simply seeking shelter will become a critical operational function.

Understanding Resiliency

When applied to organizations and communities, “resiliency” is essentially a metaphor. It has its roots in the sciences of physics and mathematics, as well as the clinical science of behavioral health. “Resiliency is often referred to as a construct connoting the maintenance of positive adaptation by individuals despite experiences of significant adversity or trauma. Or in the physical sciences, a resilient material, for example, bends and bounces back, rather than breaks, when stressed” (Bodin & Wiman, 2004).

“In physics, resilience is not a matter of how large the initial displacement is or even how severe the oscillations are, but is more precisely the speed with which homeostasis is achieved” (Norris, Stevens, et al., 2007). In other words, resiliency is a measure of how much disturbance a system can absorb before it breaks down so fundamentally that it can’t return to the way it once was.

In his book *The Age of the Unthinkable*, author Joshua Cooper Ramo writes, “Complex systems and problems are not incomprehensible or unsolvable. What is worrisome is those that cling to old ideas and are bent on preserving bad systems. Such systems might look good for awhile but when hit with the unexpected, they react in ways that doom them.” He is referring to systems without the ability to rebound and recover: systems that lack resiliency.

This section explores the concept of resiliency as it pertains to emergency management activities and demonstrates the elements necessary to build a resilient healthcare system. In the depiction described in Figure 1.1, a resilient system is broken down into its five

component parts demonstrating the impact of each on the level of resiliency that can be expected from the system. In other words, if the system has a high input of natural capital (located in a mild climate without a history of severe weather) and a low investment of human capital (training, response skills, competency achieved through exercises), should an unexpected natural event occur, the general resiliency of the system could be predicted.

The diagram in Figure 1.1 does not offer nor suggest that a mathematical formula could be constructed to measure the state of resiliency of an organization based on a manipulation of the five components. It does, however, offer insight into how a resilient system is built and what it takes to achieve and maintain resiliency. It's a bit like a wind sock: It cannot give precise readings of wind direction and speed but provides enough information to make it valuable, reliable, and indispensable.

1. **Social capital** refers to connections within and between social networks. It is a means to facilitate individual or collective action. These are the linkages between the hospital and the community, other hospitals or healthcare organizations, and staff. The resiliency value of the capital comes from the depth of the connections, the trust that exists between leadership and staff, and the agreements that are struck and sustained by the various entities.
2. **Economic capital** refers to the monetary investments that are made to strengthen and sustain the organization. Some of these may not have been initially identified as resiliency investments, but the nature of the expenditure allows them to be carried as resiliency investments. Budgets for emergency management activities and equipment, the seeking of state and federal grants for preparedness activities, and cost-sharing with other organizations to purchase or stockpile equipment are all considered economic capital investments.

3. **Human capital** refers to the competencies, knowledge, experience, and personal attributes all staff members (professional and nonprofessional) bring and invest in the organization. It also refers to the amount of investment the organization makes in expanding the competencies, knowledge, and experience of staff through education, training, exercises, mentoring, and leadership development.
4. **Physical capital** refers to the assets the organization has, such as buildings, equipment, supplies, vehicles, or land. The greater the structural integrity of the buildings, the higher the resiliency factor. The more modern and protected essential equipment such as generators, communication equipment, or the presence of an on-site water well, the greater the resiliency factor.
5. **Natural capital** refers to the physical location of the organization and the ecosystems that surround it. It is the one element of the equation that cannot be altered but must be respected in the geographic and historical perspective. An organization that understands its environment, assesses its ongoing risk, and prepares for the inevitable storm, flood, or earthquake that has historically presented itself makes an investment in resiliency.

The Deming Cycle or its antecedent, the Shewhart Cycle, has been a part of the quality improvement movement since the 1920s. Its simple concept of “Plan, Do, Study, Act” has provided a formula to improve processes and performance. In fact, the emergency management cycle or preparedness cycle that we are familiar with today has its roots in the work of Deming and Shewhart. See Figure 1.2 for more information.

Recovery (reflection) is the final phase of the cycle. It continues until all systems return to normal or near normal activity.

1. Be self-reliant
2. Take care of staff and their families
3. Provide a safe environment
4. Restore essential functions by priority
5. Keep meticulous financial records
6. Realize you have now become a community resource
7. Be prepared for donations, gifts, and drop-offs that you don't want, can't use, and don't know what to do with
8. Be prepared for this phase to have the potential to last for an extended period of time

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PART 2

The 96-Hour Principle

The roots for this strategy are found in the 2004 hurricane season in Florida, one of the deadliest and most costly Atlantic hurricane seasons on record using inflation-adjusted costs. It was the first time in recorded history that four hurricanes hit that state and the first time four hurricanes have hit any one state since Texas suffered that fate in 1886.

Hurricanes Charley, Frances, Ivan, and Jeanne struck Florida between August 13 and September 25, a period of less than six weeks. Hurricanes Frances and Jeanne hit the East Coast and followed a nearly identical path across the state, while Charley came ashore on the Gulf Coast and Ivan slammed the Florida Panhandle.

It was estimated that approximately one out of every five homes in Florida was damaged by the four hurricanes and some \$50 billion in insured and uninsured damage was caused by the storms. More importantly, it demonstrated that it was not possible for local, state, or federal agencies to respond to recurring large-area disasters in a rapid manner.

with a clear vision of your desired direction and destination and using your skills and determination to make that happen.

First we decide on what to test. Will it be communications, technology, existing resources, knowledge, skills, or adaptability? The more specific the goals, the easier it is to construct the scenario, conduct the exercise, and achieve the desired goal.

HSEEP is a capabilities- and performance-based exercise program that provides a standardized methodology and terminology for exercise design, development, conduct, evaluation, and improvement planning. It provides a national standard for all exercises and allows the hospital to speak the same language as planners in the community. HSEEP lists eight steps to exercise construction:

1. Assess needs
2. Define scope
3. Write statement of purpose
4. Write objectives
5. Compose narrative
6. Write and detail events
7. List expected actions
8. Prepare messages

Although the HSEEP guidelines and course materials are extremely helpful and well constructed, some modification and much consideration needs to take place to adapt exercises to a hospital environment.

It is critical to choose the right type of exercise to engage the medical and professional staff of the hospital. It must be something that challenges them and allows them to demonstrate their adaptability and tactical thinking. The quality of the exercise scenario and the degree to which it is executed will most often determine the level of staff engagement and, therefore, the value of the lessons learned.

Keep the scenario fresh and current by throwing in a few surprises. Keep participants engaged by not letting them gain control of the situation. Once the participants feel that they have resolved the crisis, learning stops.

Inserting surprises or unexpected developments tests the participants' knowledge of how to respond within the framework of the EOP. Running an exercise is an art form. The basic scenario must allow for feasible and realistic escalation to keep all parties engaged. Going too far astray from "reality" or making the exercise too imaginary will cause participants to be "turned off" and any potential for learning lost.

The inserts or exercise messages (the surprises) need to take specific groups out of their comfort zone. Nothing should be allowed to run smoothly for very long, especially communication. In every real disaster, the first casualty is usually the ability to communicate effectively. That may be among various departments within the hospital or between the hospital and its community.

PART 4

Effective Survey Preparation

The Joint Commission evaluates and accredits nearly 21,000 healthcare organizations and programs in the United States, according to the Joint Commission website. An independent, nonprofit organization, The Joint Commission has been developing standards and conducting accreditation surveys since its formation in 1951.

It currently accredits general, children's, long-term acute, psychiatric, rehabilitation, and surgical specialty hospitals, nearly 88% of all the nation's hospitals. A majority of state governments recognize Joint Commission accreditation as a condition of licensure and the receipt of Medicaid reimbursement.

The Centers for Medicare & Medicaid Services (CMS) has granted "deemed status" to The Joint Commission, meaning that accreditation by The Joint Commission is deemed to meet the Medicare *Conditions of Participation*, a requirement for hospitals seeking reimbursement for services. Joint Commission accreditation is generally regarded as the "gold standard," signifying an organization's commitment to delivery of high-quality, safe patient care.

Accreditation is viewed not only as a demonstration of an organization's commitment to quality, but as a very public verification of the organization's ability to meet ever-evolving standards of quality.

Loss of accreditation or anything less than full accreditation jeopardizes an organization's reputation and provides a significant competitive advantage to its competitors. Joint Commission accreditation is required to maintain graduate medical education residency programs, an important and prestigious status for those that support academic affiliations; it is usually required by insurance companies, bond raters, and financial institutions that provide monies for capital expenditures.

In other words, Joint Commission accreditation is a big deal and failure to be fully accredited can carry severe ramifications for the facility.

Many would say that The Joint Commission is the most important driver of safety in America's hospitals. Although there are other accrediting bodies "deemed" by CMS (e.g., the American Osteopathic Association and Det Norske Veritas), The Joint Commission is the most influential and most aspired to.

The standards and practices of The Joint Commission evolve with the times. They attempt to reflect the concerns of patients and practitioners alike and act as a central authority to drive improvement in healthcare delivery. Do they always get it right? Unfortunately, no. There have been numerous examples of well-meaning efforts to drive the safety and quality agenda forward that have lacked substantive evidence or failed to appreciate the negative consequences of those actions. Fortunately, The Joint Commission listens to its customers and has



Appendix A

Joint Commission Emergency Management Standard Checklist

	Yes/No	Action Needed
Standard EM.01.01.01—The organization engages in planning activities prior to developing its written emergency operations plan (EOP)		IF NO
Has the healthcare organization leadership been actively involved in planning activities leading to the development of the EOP?		<ol style="list-style-type: none">1. Develop CEO letter outlining support for emergency management as a major emphasis2. Involve CEO or COO chair of emergency management committee
Is there a committee identified that meets routinely to discuss and preside over emergency management and planning issues? Are all healthcare organization departments and activities represented on this committee?		Develop emergency management committee

Joint Commission Emergency Management Standard Checklist *(cont.)*

	Yes/No	Action Needed
Standard EM.01.01.01—The organization engages in planning activities prior to developing its written emergency operations plan (EOP)		IF NO
Has the emergency management coordinator developed a working relationship with the community emergency management agency (EMA)?		Establish a relationship between EMA and emergency management coordinator
Does the healthcare organization have representation on the local/state healthcare/public health working group?		Appoint emergency management coordinator to local, regional, or state healthcare EM working group
Does the healthcare organization possess and utilize an updated hazard vulnerability analysis (HVA) using an all-hazards approach?		Conduct healthcare HVA incorporating facility-specific as well as EMA planning scenarios
Has the healthcare organization leadership been directly involved in the development of the HVA?		CEO approves healthcare HVA
Have the top scenarios identified in the community HVA been incorporated into the development of the healthcare organization HVA?		Incorporate community planning scenarios into healthcare HVA and EOP
Have the emergency scenarios been prioritized, with the top several scenarios used as the basis for healthcare organization emergency planning?		Outline top three emergency planning scenarios into healthcare EOP
Has the healthcare organization developed a preparedness plan to address the top-rated hazard scenarios identified in the HVA?		Develop a complete EOP

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Chapter Leader's Guide to Emergency Management, Second Edition breaks down The Joint Commission's Emergency Management requirements into easy-to-understand solutions to meet the challenges of these complex standards. You get simplified explanations of the chapter's key components along with communication techniques to help foster a strong and successful partnership between survey coordinator, chapter leader and staff of all levels.

Plus, to make staff training easy, this guide includes a downloadable PowerPoint® presentation highlighting key compliance takeaways and other valuable tools.

What's inside:

- ▶ Keep your facility up to speed on the ever-increasing emergency management requirements
- ▶ Pinpoint compliance loopholes in your current emergency management program
- ▶ Understand what it means to be prepared for an emergency under Joint Commission and CMS standards
- ▶ Educate and prepare organizational leaders to take a key role in emergency preparedness
- ▶ Ensure the highest possible level of preparedness and cooperation within your community?

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