History of Joint Commission’s Emergency Management Standards

Prior to 2001 – “Emergency Preparedness”
- Static plans (provided no flexibility)
- Created in a vacuum
- Emphasized initial response to major trauma events

In 2001 – “Emergency Management”
- Requires dynamic and flexible system
- Integrates with community to maximize resources
- Addresses on-going emergencies

Studies and feedback indicated:
- Not sufficient for organizations to plan for managing the immediate effects of one single event
- Organizations need to be flexible to respond to series of escalating events

Disasters Studied through Hospital/Community Debriefings:
- Tropical Storm Allison-June 2001
- Power Outage-Summer 2003
- Hurricane Isabel-Fall 2003
- SARS (Asia/Toronto)-Spring 2003
- Hurricane Katrina & Rita-2005
- Terrorist Attacks-September 2001
**Major Issues Began to Surface**

- Problems with communication
- Inadequate utility plans (esp. emergency generator backup)
- Faulty Incident Command Systems
- Lack of involvement with community’s Emergency Operations Center (EOC)
- The extent of a hospital's planning effort was dictated by the impact of its most recent or worst disaster

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**Health Care Model**

- **Emergency**
  - Infrastructure intact
  - Sustainable
  - No deaths
- **Disaster**
  - Infrastructure damaged
  - Sustainable
  - Few deaths
- **Catastrophe**
  - Infrastructure damaged
  - Not sustainable
  - Many deaths possible

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**The Common Characteristics**

- Sustained
- Affected multiple communities simultaneously
- Impacted public services
- Threatened entire healthcare delivery system
- Stressed federal response
What Happened to Community Health Care?
- Home Care closed
- Long-Term Care closed
- Physician Offices closed
- Outpatient Pharmacy closed
- Dialysis Center closed (no generators)
- Outpatient Cancer Centers closed
- Ventilator & other special needs
- Discharged patients (wouldn’t leave)

How Did These Pressures Affect Hospitals?
- Increased admissions
- Decreased discharges
- Citizens seeking non-healthcare services
- Increasing pressure on limited resources

Major Issues Facing Hospitals
Core of Debriefings
- What were the common problems to be solved?
- To “Shelter in Place” or to “Evacuate”?
Goal of Emergency Management Standards

The healthcare organization should be an important resource available to the community during an emergency, and not itself become a victim of the emergency.

Summary of 2009 Emergency Management Standards

- Management of six critical functions during emergencies to respond to all hazards
- "Scalable approach" to manage response to combination of escalating events
- Identify capabilities and responses when not supported by community for 96 hours
- Planning and testing response plans for emergencies during conditions when the local community cannot support the healthcare organization - "test and stress"

2007 Standards

- Are all rolled into the 2009 Standards
- Formerly one standard with 21 EP’s
- 2009 - 8 Standards with 66 EP’s
2008 COMPARED WITH 2009

- All standards and elements of performance are restructured into the 2009 Emergency Management Chapter
- New chapter contains some standards that were in human resources and medical staff chapter
- No new expectations were created
- Survey process is similar to 2008

Top 5 Scored Em Standards in first 6 months of 2009

- EM.02.02.13 #75
- EM.03.01.03 #76
- EM.01.01.01 #79
- EM.02.01.01 #88
- EM.02.02.15 #100

EM.02.02.13

During disasters, the hospital may grant disaster privileges to volunteer licensed independent practitioners.
EM.03.01.03
The Hospital evaluates the effectiveness of its Emergency Operations Plan.

EM.01.01.01
The Hospital engages in planning activities prior to developing its written Emergency Operations Plan.

EM.02.02.01
As part of its Emergency Operation Plan; the hospital prepares for how it will communicate during emergencies.
EM 02.02.15

During disasters, the hospital may assign disaster responsibilities to volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification, or registration.

What is the 96 hour “Rule”?

EM. 02.01.01, EP3

Question?

Are we supposed to stand alone for 96 hours?
- e.g., stockpile supplies on hand, etc?
- or can we just say we have enough to last 96 hours and then evacuate, etc?
- Why did the Joint Commission pick 96 vs. 72?

The EOP identifies the organization’s capabilities and establishes response procedures for when the organization cannot be supported by the local community for at least 96 hours in the six critical areas.

Note: An acceptable response effort would be to temporarily close or evacuate the facility, consistent with their designated role in their community response plan.
The main point is that the organization knows its capabilities. Respond according to this knowledge.

Regarding the 96 vs 72 hours
- The Joint Commission onsite evaluations indicated that 96 hours was a more realistic expectation.
- This was confirmed during Standards Review.

Striving for 96 Hours....

<table>
<thead>
<tr>
<th>Normal - Generator Fuel</th>
<th>Emergency - shut down some floors, cancel elective surgeries.</th>
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</thead>
<tbody>
<tr>
<td>Normal - Clinical Supplies</td>
<td>Emergency - curtail some services, discharge some patients.</td>
</tr>
<tr>
<td>Normal - Water (Sanitary)</td>
<td>Emergency - water conservation (sponge baths, waste disposal).</td>
</tr>
</tbody>
</table>

0 hrs 24 hrs 48 hrs 72 hrs 96 hrs

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