Emergency Preparedness: Response & Recovery

Executive Summary

It is no longer sufficient to manage emergencies as they arise; rather, facilities must plan and prepare, in advance, to mitigate, respond to, and recover from natural and human-made emergencies and disasters.

Since the 2001 attacks on the World Trade Center, healthcare facility preparedness has improved as facilities in the United States have faced a wide variety of large-scale emergencies and disasters from natural, technological, and terrorist-related causes. Between 2007 and October 2018, the Federal Emergency Management Agency (FEMA) declared an emergency 1,477 times in the United States. (FEMA “Disaster Declarations”)

Out-of-court settlements for deaths and injuries at facilities during Hurricane Katrina in 2005 made clear that failure to properly prepare for and respond to an emergency can have not only a horrible human toll but also disastrous financial consequences. Media coverage of several recent natural disasters showcased providers who demonstrated little or no advance emergency planning and woefully inadequate responses, placing residents’ lives at risk and in some cases resulting in resident deaths. Media accounts of emergency planning failures during 2017 Hurricanes Harvey, Irma, and Maria demonstrate that much work remains before organizations will be sufficiently prepared for events from service disruptions to major disasters. The correct question to ask is not if, but when, will an emergency occur. Then ask, will the organization be ready?

High-visibility disasters have led the federal government to emphasize community-wide emergency planning. The Centers for Medicare and Medicaid Services (CMS) issued the emergency preparedness final rule (CMS “Final Rule” 42 CFR 483.1-483.180) in 2017, establishing “national emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers to plan adequately for both natural and man-made disasters, and coordinate with federal, state, tribal, regional, and local emergency preparedness systems.” The rule is enforced through conditions of participation (CoPs) for Medicare and Medicaid service providers. The regulation applies to 18 types of Medicare- and Medicaid-participating providers and suppliers, but it excludes fire and rescue units, ambulance services, and single- and multispecialty medical groups. In 2017 CMS released its State operations manual: interpretive guidance for surveyors. Providers can use this guidance to evaluate their organization’s emergency response and recovery program.

CMS regulations require organizations to take a “comprehensive, consistent, flexible, and dynamic regulatory approach to emergency preparedness and implement a response that incorporates the lessons learned from the past, combined with the proven best practices of the present into an emergency operations program” (CMS “Final Rule”). Once an emergency operations committee (EOC) is established, the EOC must develop a comprehensive emergency preparedness or emergency operations plan (EOP). Risk managers often play a direct role in the development of policies and procedures related to emergency management, such as those addressing disaster related standards of care, modification of the privileging and credentialing process, and negotiation of mutual-aid agreements with other facilities. A comprehensive understanding of emergency preparedness is necessary to be effective. This guidance article touches on EOC activities and the response and recovery elements of a comprehensive EOP. Links to useful resources are included to assist organizations in achieving compliance with CMS’s emergency preparedness final rule.

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Action Recommendations

- Activate the emergency operations plan (EOP), the healthcare coalition (HCC) plan, and the incident command system (ICS) protocols.
- Set up the incident command center.
- Activate the communications plan and institute alternative means for communicating with critical stakeholders, if necessary.
- Ensure clear criteria are used to evaluate whether to shelter in place or to evacuate.
- Activate enhanced safety and security measures during emergency or disaster events.
- Implement a triage protocol that supports identification and prioritization of residents after mass-casualty or multiple-casualty events.
- Activate crisis standards of care (CSC).
- Conduct ongoing monitoring of the facility's surge capacity and transfer or divert residents when surge capacity is exceeded.
- Meet staff needs during a prolonged event.
- Activate the disaster volunteers program for use of licensed and non-licensed independent practitioners.
- Implement the temporary credentialing and privileging process.
- Use emergency and standby power systems as needed.
- Conduct ongoing evaluation of access to supplies, staff, equipment, medication, food, potable water, and fuel needed during a prolonged emergency event.
- Monitor availability of supplies from alternative vendors during prolonged emergencies.
- Ensure that a facility-wide all-hazards vulnerability analysis (HVA) is completed after the event ends and evaluate findings.
- Correct gaps that would delay return to full operation.
- Initiate recovery activities to help the organization return to normal operations.
- Understand the different types of local, state, and federal emergency declarations and the effect they have on receiving assistance before, during, and after an event.

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