Emergency Preparedness: Planning & Mitigation

Executive Summary

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

Healthcare facilities in the United States have faced a wide variety of large-scale emergencies and disasters resulting from natural, technological, and terrorist-related and other human-made causes. Between 2007 and September 2018, the Federal Emergency Management Agency (FEMA) declared an emergency in the United States 1,451 times. (FEMA “Disaster Declarations”)

Out-of-court settlements for deaths and injuries at hospitals and other healthcare facilities during Hurricane Katrina in 2005 made clear that failure to properly prepare for and respond to an emergency can result not only in a horrible human toll but also in disastrous financial consequences for a healthcare organization. Media coverage of several recent natural disasters highlighted providers who demonstrated little to no advanced emergency planning and woefully inadequate responses, placing resident 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 for hospitals and other providers to complete in order to 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 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.” (CMS “Final Rule”)

The rule is enforced through conditions of participation (CoPs) for Medicare and Medicaid service providers. The scope of the regulation was expanded to apply to 18 types of Medicare and Medicaid providers and suppliers, but it excludes fire and rescue units, ambulances, and single- or multispecialty medical groups. The effective date of the regulation was November 15, 2016, with an implementation date of November 15, 2017. In June 2017, CMS released an advance copy of its State operations manual: interpretive guidance for surveyors. Providers can use this guidance to evaluate the organization’s emergency preparedness program.

The 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”).

CMS contends these new regulations strike a balance between being specific and general that permits providers and suppliers to develop an effective 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 hospitals or other healthcare facilities. A comprehensive understanding of emergency preparedness is necessary to be effective. This guidance article touches on operations of the emergency operations committee (EOC) and on the planning and mitigation elements of a comprehensive EOP and includes links to resources that can assist organizations in complying with CMS's emergency preparedness final rule.

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Action Recommendations

- Ensure that the risk manager participates with the EOC.
- Confirm that the EOP is reviewed and updated, if necessary, at least annually.
- Ensure that the EOP addresses key components of preparedness, mitigation, response, and recovery.
- Evaluate how the facility’s EOP fits within the local, regional, and state emergency management programs.
- Encourage the organization to join a healthcare coalition (HCC).
- Prepare for use of volunteer healthcare providers and nonclinical personnel.
- Ensure that a process is in place for granting temporary privileges to medical staff.
- Work with the ethics committee to establish crisis standards of care (CSC) and protocols for triage during disasters, and incorporate these standards and protocols into the EOP.
- Ensure that both a facility-based and a community-based hazard vulnerability assessment (HVA) are conducted at least annually.
- Evaluate the findings of both the facility-based and community-based HVAs.
- Confirm that the EOP is consistent with the findings of both HVAs.
- Review EOP policies and procedures to ensure consistency with the all-hazards focus of the HVA at least annually.
- Ensure the communications plan includes alternative means for communicating with critical stakeholders.
- Test alternative communication methods.
- Ensure that the incident command system (ICS) is flexible enough to address both large- and small-scale emergencies.
- Work with the EOC and training coordinator to confirm that staff are trained and tested regarding the EOP, their role, and their responsibilities.
- Ensure that the training and testing plan is reviewed and revised, if needed, on an annual basis.
- Conduct an annual community-wide drill exercise that includes a surge of incoming patients or residents.
- Conduct an annual community-wide drill exercise that simulates an event that is so far reaching that the local community cannot support the facility.

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