
Moving into 2008 and Beyond

The New Joint Commission Standards
Some Practical Advice and Strategies to
Make Your Organization Resilient



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Simulation Education Services
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(Introduction by Joe Cappiello)

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Introduction (by Joe Cappiello)

In the ten years I spent as Vice President for Field Operations at The Joint Commission, I was privileged to have led many Joint Commission initiatives but none as important as emergency preparedness. I say that because every day somewhere across this nation there is a community struggling against the forces of nature or the folly of man. Hurricanes, floods, chemical plant explosions, forest fires, bridge collapses, extremes in weather just to mention a recent few. We witness it virtually every day. And what happens when disaster strikes a community? Where do the injured, the frightened, the worried, the affected, the hungry, the tired, and the families looking for their loved ones go? It's not to the firehouse or the police station. They flock to the hospital. They come because hospitals may be the most fortified structure in the community. They have emergency generators to mitigate the impact of weather and supply power, they have food to feed patients and staff, they have medicines when pharmacies are shut down, and they often have the only medical delivery system when the healthcare infrastructure of a community is shattered by an event. Hospitals are critical to the survival and sustainability of the community during times of disaster.

Beginning in January of 2008, the Joint Commission put into effect a significant change to its requirements for emergency preparedness. These changes came about as a result of the lessons learned from a variety of disasters that impacted health care organizations over the past five or six years. Joint Commission staff identified these lessons through direct debriefings with health care organizations impacted by these disasters, engaging emergency management experts, serving on national emergency management expert panels, and reviewing current literature on emergency management. These new standards were released for field review early last year and have been widely published in all the various media outlets of the Joint Commission. Yet here we are in 2008 and for many these standards seem to have snuck up on them. There is a flurry of activity that has begun but for many, they may have gotten off on the wrong foot. Let's step back for a moment and put the new standards into perspective and try to understand what the Joint Commission is really asking you to do.

First of all, it is apparent in nearly every disaster that escalating, multiple events occur rather than a single event. For example, the Katrina hurricane escalated from a wind and rain event into a flood event because the levees failed. The resultant flooding then escalated into civil unrest throughout the community and we went on to witness the collapse of a major American city. The lesson learned is that it is not enough to plan for a single event but to ingrain in your preparedness and response plans the ability to be flexible enough to respond to combinations of escalating events. In debriefing after debriefing, it became apparent that six critical factors need to be managed by health care organizations if they wish to maintain viability and continue to render service. Those areas are: communication, managing resources and assets, safety and security, staffing, utilities management, and the continuation of clinical activities. Each of these six critical areas has found their way into the new mandates and each has been elevated to their own individual standard. Planning with attention to these standards constitutes an "all hazards" strategy that will result in a more flexible and effective response as well as compliance with accreditation requirements. These requirements are not new but the reorganization of the standards in this format allows for an emphasis on "scalability" and the impact an escalating emergency would have on an organization and the reliance it has on its community.

96-Hour Rule

Perhaps the most misunderstood change in the standards is the so called "96-hour rule" that has been put into the revision of EC.4.12. The Element of Performance (EP 6) in question to that standard does not require hospitals to be able to sustain themselves without community support for 96 hours. It does not require hospitals to increase their fuel storage capacity, medical supply stores, food and provisions capacity or any other activity that is out of their routine to meet this requirement. It does, however, require hospital leaders and planners to understand and recognize the limitations of their resources, assets, utility systems and supply chain to stand alone for 96 hours. It is not a rule but a principal that requires significant thought and leadership involvement to determine strategies for the organization to sustain itself for 96 hours and if it cannot, what are the decision steps that lead to evacuation.

Strategies to Managing the 96-Hour Principle

There are steps that can be taken to evaluate how an organization will respond to a disaster and meet the "96-hour principle". These steps should be considered in the development of the disaster response plan and should be exercised, as required by the Joint Commission, on a regular basis to train staff, highlight planning gaps, identify improvement activities and stress the system in as realistic a manner as possible. Organization should consider the following decision steps as they work through a disaster scenario and look to keep their organization viable for 96 hours.

1. **Conservation of resources**
 - a. Reduce power consumption
 - b. Consolidate personnel and patients
 - c. Eliminate all non-emergency related activities

2. **Curtailment of services**
 - a. Eliminate all elective procedures
 - b. Shut down all non-emergency related equipment
 - c. Consolidate patients in general wards
 - d. Minimize the use of power-draining diagnostic equipment

3. **Supplementing resources from outside the local community**
 - a. Activate prearranged, out-of-area supply contracts and memoranda of understanding (MOU)
 - b. Prepare to augment personnel and supplies from non-governmental organizations(NGOs) into operations

4. **Staged or limited evacuation**
 - a. Identify patients most at risk if support systems fail
 - b. Prioritize the movement of patient and identify staff to accompany them
 - c. Arrange for an accepting organization and transportation to get them there

5. **Full evacuation**
 - a. Patient and staff safety is the prime consideration to reach this decision
 - b. Determine how to evacuate and how that decision will be made
 - c. Execute pre-determined and pre-exercised plans to safely move patient and staff

The 96-Hour Principle

Strategy	Operational Checklist
Conservation of resources	Curtail services and conserve resources: Step 1 – Build inventories Step 2 – Develop a conservation strategy Step 3 – Communicate the Conservation Plan Step 4 – Track Changes
Curtailment of services	
Supplementing resources from outside the local community	Supplementing resources from outside the local community: Step 1 – Establish contracts and MOUs Step 2 – Assess resource needs Step 3 – Manage resources
Staged or limited evacuation	Evacuation: Step 1 – Build a master evacuation list Step 2 – Assess resource needs Step 3 – Track movement of persons and resources between facilities Step 4 – Coordination and communication with transportation services
Full evacuation	

Operational Checklist

There are a number of different approaches to successful implementation of your organization's 96-hour strategy ranging from paper-based policies and procedures to IT system integrations. The overview presented here will outline the various tactics and itemize the necessary steps for successful implementation. The main focus of all the outlined operational steps is the "in-depth, robust preparation" approach to emergency management. The more effort put into consolidating information on people, resources and critical infrastructure pre-incident, the better able your organization will be to respond to any incident; regardless of its cause.

>>1. Curtail services and conserve resources

The first step in curtailing and conserving is an inventory of existing services and resources. What units are currently staffed? What beds are occupied? By whom? What resources are assigned to each? With an inventory of the current operational level in hand, it is then possible to take the next steps towards closing down services and de-activating resources. The goal here is to reduce power consumption and resource utilization to a minimum; ideally to the bare minimum required to support operations for the current crisis.

Step 1 – Build inventories

The ability to assess the current operational status is critical to managing service and resource reductions. The main sources for this status include patient census, bed occupancy, staffing schedules, and resource inventories. With the current inventory of services, people, equipment and supplies in hand, planning for reductions can begin.

Step 2 – Develop a conservation strategy

Clearly outlining the conditions for reduction in services and the procedure to achieve these reductions ahead of time is critical. Service reductions should be clearly outlined in your facility emergency operation plan (EOP) and can include references to the relevant policies and procedure to achieve these. With a conservation strategy plan, it is possible to move on the next phase of communication the plan across the organization.

Step 3 – Communicate the Conservation Plan

Service closures, patient transfers, staffing allocations and resource assignments must be clearly communicated to both staff and patients in order for successful implementation of the conservation plan. The ability to publish this plan to an information portal (intranet or website) can go a long way in sharing the strategy within the organization but notification services (PA, pager, mass notification systems) are generally required to point people to the location of this information.

Step 4 – Track Changes

Keeping tabs on the status of the resources during implementation of the conservation plan can assist greatly in maintaining a clear operational picture. Patient and staff locations, resource availability, and equipment status should be tracked dynamically and in real time.

>>2. Supplementing resources from outside the local community

While there are operational considerations to supplementing resources, the majority of the effort needs to occur pre-incident by laying the groundwork with response partners, vendors and suppliers and establishing relationships, means of communication and most importantly contracts and MOUs. With this groundwork in place, the act of requesting and receiving additional resources is greatly simplified.

Step 1 – Establish contracts and MOUs

These need to be in place pre-incident and the terms, conditions, and cost of resources should be clearly outlined. To simplify retrieval of these contracts and MOUs during a crisis a document repository that allows easy categorization, searching and sharing of documents is recommended. While it is still possible to share these documents by fax, communication is faster and more flexible with digital exchange of information.

>>2. Supplementing resources from outside the local community (cont'd)

Step 2 – Assess resource needs

Based on the current event, and the tasks required to manage the response, a resource needs list can be compiled. This list of required resources can then be compared to existing inventories to determine where there are gaps; both immediately and in the near future (12h, 24h, ..., 96h). Sources to fill these gaps must then be located using your existing contract and MOUs.

Step 3 – Manage resources

To properly manage resource requests, fulfillment and utilization, a large amount of information must be readily accessible including: current inventory, utilization and status, current deployment, resource gaps, and status of requests. While it is possible to handle this data with paper, making use of IT systems to manage requests, fulfillment and tracking of resources allows for considerable efficiency.

>>3. Evacuation

The decision to evacuate a facility, whether a partial evacuation or a full one, is one that is not undertaken lightly. Not only is there an increased risk to patients and staff, but the amount of information that must be tracked - within the evacuating facility, at the receiving facility, and between the two – is staggering. And the likelihood of making errors is greatly amplified. There are steps that can be taken to help maintain order during an evacuation, and much like the other 96-hour strategies, much of the benefit is established pre-incident.

Step 1 – Build a master evacuation list

The ability to accurately assess who is at the facility at the time of evacuation is critical. While accessing this information is a response activity, the ability to do so efficiently is based primarily on preparation activities. First, the sources to build the master evacuation list must be determined. What systems at your facility store information about people? Can you pull a real-time patient census from ADT or do you have to poll units to get an accurate list? Can you build a list of staff onsite from a scheduling application? From a time clock? What about visitors? Are there any security records or sign-in forms that can be accessed to build a list of visitors to the hospital? Ideally, these data sources should be established pre-incident and the procedure to generate a master evacuation list included in your EOP or referenced by it.

Step 2 – Assess resource needs

Assessing resource needs for an evacuation involves three main concerns: What is currently used/required at the evacuating facility, what can be sent with patients and staff, and what is available at the receiving facility. The ability to accurately compile resource requirements, assign these to patients and staff, and assess resource gaps at the receiving facility is a daunting task that requires considerable communication and information sharing between facilities. This is possible with a paper system but digital exchange of information across facilities (i.e. a non-intranet IT system) makes these tasks far simpler to manage.

Step 3 – Track movement of persons and resources between facilities

In addition to managing who needs to move and what is required to support this population, the location of these people and resources also needs to be monitored. Tracking includes assigning mobile resources to a patient or staff member (including check-in and check-out transactions), hand-off of patient records,

Step 3 – Track movement of persons and resources between facilities (cont'd)

confirmation of transfers (for patients, staff and resources) and communicating relevant information to the patients' families. Again, managing all of this information is simplified with IT systems like resource management, integrated ADT for patient transfers, and a secure means of communicating patient information to families (including policies to define rules for information sharing).

Step 4 – Coordination and communication with transportation services

One final consideration is the inclusion of transportation services in the movement of persons and resources. Transportation by ambulance, air, or other means must be factored into the planning component; not only to coordinate the act of transportation, but also to include these stakeholders in the information sharing process. Ideally, tracking the movement of persons and resources should include the ability to audit each stage of the transfer cycle, from the evacuating facility, to transportation, and finally to the receiving facility.

A Note on Simulation Exercises

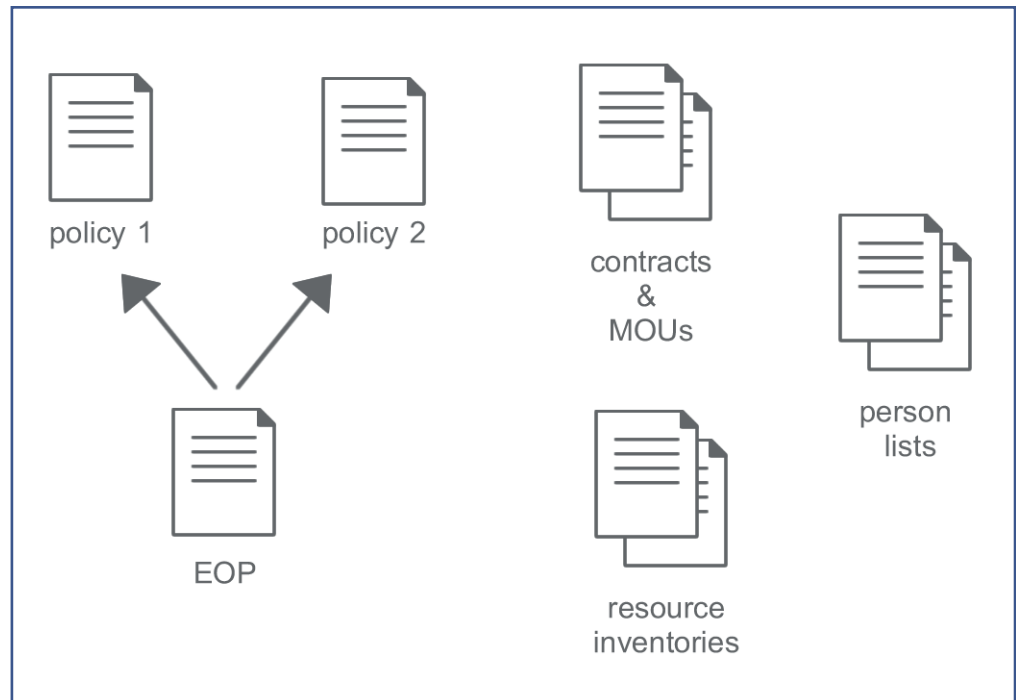
A number of reports have recently been published that have recognized the inadequate emphasis placed on systematical simulation of emergency operation plans. An interim report by The Blue Ribbon Commission on Mega-Catastrophes of the Financial Services Roundtable (November 2006) clearly articulated the failing of the federal government to systematically track the extent to which private and public organizations are simulating their plans to ensure feasibility. A commentary in Forbes (Prepare For the Next Disaster, January 17, 2008), calls on chief executives to focus on business continuity programs and to do so through written plans, mission critical systems redundancy, physical security, reliable communications and regular test and exercises. The rationale for simulation exercises is as simple as the continuous improvement cycle – plan, do, check, act. Simulation provides the ability to test the functionality of the organizational emergency operations plan; to communicate and coordinate with the community it must rely on for support; and do so in a non-disruptive and financial sound environment. An untested plan is a binder on a shelf gathering dust.

Sample Implementations

The key to properly manage the first 96-hours of a response is to have well-formed strategies in place ahead of time. Successful implementation of these strategies relies as much on this preparation as on the inclusion of IT systems or complex integrations. With that in mind, the following sample implementations assume that this pre-incident preparation activity has already occurred. With similar levels of preparation, there are considerable advantages to using well designed, integrated, and interoperable IT systems as part of your response strategy.

The grading of Good, Better, Best is a subjective one. It is up to each individual organization to determine the proper approach for these strategies given the operational parameters within their unique environment.

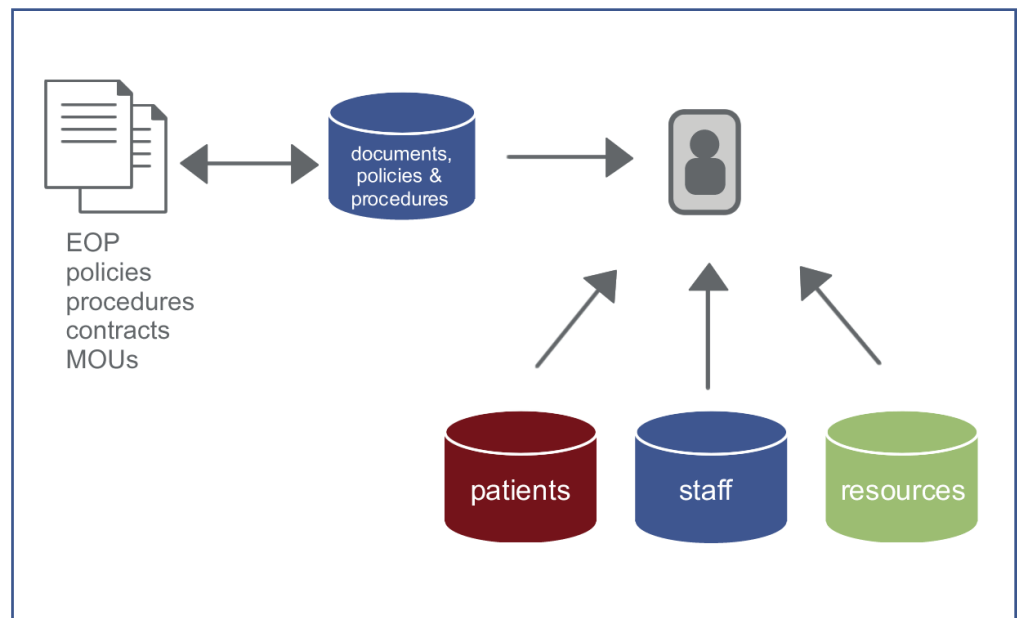
Good Implementation - paper



One of the key components of a paper based system is a complete EOP with references to annexes and policies as needed. The EOP needs to be structured to make access to information simple and allow responders to quickly locate the annexes or policies they require. The EOP should also include procedures to build response critical information lists as needed, including resource inventories and person lists.

In addition to the EOP, contracts and MOUs should be established pre-incident and stored in a manner that makes access to this information during a response simple and efficient.

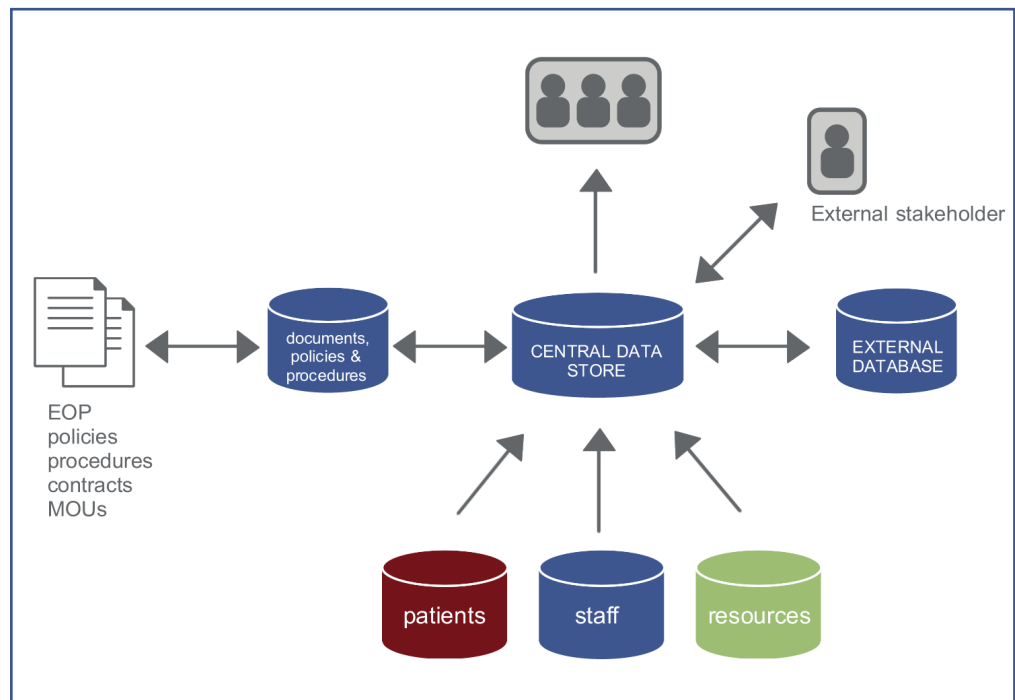
Better Implementation – Internal IT Systems



Better Implementation – Internal IT Systems (cont'd)

A more efficient implementation is achieved by the inclusion of IT systems to simplify information access during a response. The same level of preparation for the EOP is required but accessing the associated content is simplified by online storage (intranet) with categorization and search capabilities. One further efficiency is the ability to reference content like annexes and relevant policies with direct links. The procedures for compiling response specific data lists can now point to system tasks (e.g. generate a report from ADT to assemble a master patient list for evacuation), requiring fewer people and enhancing resource efficiency.

Best Implementation – Integrated IT Systems



Far greater efficiencies can be achieved when IT systems are integrated to work together – typically by sharing information over a common platform. This implementation provides all of the advantages of an internal IT configuration with the benefits of sharing information between facilities. This inter-facility information sharing greatly simplifies tasks such as resource tracking, patient transfers, and communications with external stakeholders such as transportation or patient families. This implementation allows for the greatest agility in response and the most efficient use of your internal resources.

Glossary

ADT - Admission, Discharge,
Transfer system

EOP - Emergency Operation Plan

IT - Information Technology

MOU - Memoranda of Understanding

NGO - Non-Governmental Organization

Conclusion

These new standards are but an evolutionary step in the plans the Joint Commission has for emergency management. It is anticipated that in 2009, emergency management will have its own chapter in the accreditation manual where all emergency management related standards will be consolidated for clarity and ease of identification. As the standards for emergency management evolve, so too must the role of your responders. The goal of an in-depth, robust preparation should be ingrained in your organization's vision for emergency management – encouraging scalability and flexibility in all responses no matter the source of the incident. The inclusion of IT systems for information exchange is another step towards achieving this enhanced scalability and flexibility. While robust preparation should become the new baseline, and a paper based system can be used to manage a response with proper preparation, IT systems provide far greater efficiencies and free up your most critical response resources, your people, to perform their most important task - caring for patients. Yet the only way to test and evaluate how your staff and the systems they work with function in a real situation is through simulation exercises designed to stress the response framework, identify shortcomings, and allow staff to be comfortable with the emergency response plan. Writing a plan and putting policies into place is but a first step in the preparedness continuum. All organizations seek the same outcomes in times of disaster; ensure safe patient care, protect patients and staff, keep the facility open and functioning, and recover as quickly as possible. The synergy created between robust systems and the ability to simulate response in realistic settings is the formula for creating staff confidence and competency.

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