

EC News

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Special Pathogens Preparedness and Response



Nicholas V. Cagliuso Sr.,
PhD, MPH

ACTIVATE YOUR INCIDENT COMMAND SYSTEM AS SOON AS YOU FORESEE AN IMPENDING OUTBREAK, AND PROVIDE ONGOING TRAINING AND FEEDBACK IN ALL HEALTH CARE SETTINGS, URGES NICHOLAS V. CAGLIUSO SR., PHD, MPH, WHO OVERSEES EMERGENCY MANAGEMENT FOR NEW YORK CITY HEALTH + HOSPITALS

In late March, Nicholas V. Cagliuso Sr., PhD, MPH, took 15 minutes out of his frenetic schedule as the senior assistant vice president for emergency management at New York City Health + Hospitals (NYC H+H) to share some of his insights on the COVID-19 pandemic and pathogen preparedness in general. The largest municipal health care delivery organization in the United States, NYC H+H includes 11 acute care hospitals, 5 skilled nursing facilities, 6 neighborhood health centers, and more than 70 community-based clinics.

Cagliuso has extensive experience in preparing for and responding to high-consequence infectious disease (HCID) and emerging infectious disease outbreaks, from measles to Zika virus disease to Ebola virus disease. He is a founding core faculty member of the National Emerging Special Pathogens Training and Education Center (NETEC), formerly the National Ebola Training and Education Center, and leads this organization's exercise resources team.

The following Q&A interview with Cagliuso has been edited for length and clarity.

How has your experience with Ebola and other special pathogens informed your response to COVID-19?

New York City Health + Hospitals saw this coming, like a lot of health care organizations, in late December and early January. Given that we operate the country's largest municipal health care delivery system, we activated our Incident Command System on January 21—well in advance of the peak here domestically.

With everything we do—whether it's preparing for naturally occurring events like extreme weather, disease outbreaks such as COVID or Ebola, intentional events such as terrorism, or technological events such as power outages and the like—we follow across our system an emergency management-centric approach that is very modular and scalable based on the incident. If we have a single incident that impacts just one of our 11 hospitals, we'll react in the same way but on a smaller scale. Of course, when it comes to COVID, we've activated our Incident Command System on a much, much larger scale.

Since January 21, our incident commander has been our chief medical officer, Mabelle Allen, MD, and she oversees the daily [COVID-19 response] operations.

We convene once a day with all senior staff, clinical staff, operational staff, and financial staff to review what has been taking place at our facilities over the past 24 hours and what our next operational period looks like. Admittedly, with the rapid changes, those operational periods have largely become 12 hours in nature because of the increase in patient volumes and the like that we're seeing. Addressing anything past that really becomes very, very difficult.

At New York City Health + Hospitals, we have a mantra that we live by, which is "Ready or not, patients will present." In other words, whether or not a health care facility is prepared, patients will present for care. We provide ambulatory care, inpatient care, and post-acute care, as well as community-based care and a number of other services, and we work very diligently to make sure that every one of those service lines is prepared.

Across those lines, not surprisingly, the demand for services is increasing. The good news is that as a result of our Ebola experience from 2015 to 2016, we've developed a systemwide Special Pathogens Program. We have a director and an assistant director who oversee those efforts, which address everything from managing our systematic response to seasonal influenza to responding to a measles outbreak that we had here. When we have an emerging infectious disease, that team coordinates everything we do.

Specific to COVID, the special pathogens team planned and implemented just-in-time training for our health care providers on the necessary personal protective equipment (PPE) and how to don and doff it. We've really increased the comfort level of frontline providers with this equipment.

After activating our Incident Command System, we also augmented the number of what we call mystery patient drills, during which we would send a fictitious patient [a trained "actor" who may be NYC H+H staff] to our sites to identify what is working and what is not. Immediately after those drills, our team would stop and sit with the frontline providers to give constructive feedback. These preparatory drills addressed travel screening, patient history taking, the donning and doffing of personal protective equipment, and the like. This again is thanks to our ongoing work in special pathogens resulting from our Ebola experience. But as the number of confirmed and suspected COVID cases ramped up, we shifted our resources more and more from training to response.

What have you been doing to motivate your staff and frontline clinicians during this extremely stressful time?

I say to my [emergency preparedness and response] team every day that the only reason we come to work is to make sure that our clinicians and those who support them can care for patients safely and effectively. This reflects New York City Health + Hospitals' mission, which is that regardless of your ability to pay, regardless of your immigration status, you will receive consistent, safe, and effective care at our facilities. That's why we come to work every day. We're the stagehands, if you will, providing clinicians with what they need during emergencies. That includes training. But it's also supplies. It's financial resources. It's videoconference

lines. We are the ones who make sure that we match up those resources to the providers.

Most important, we play a key role in making sure our clinicians on the front lines feel safe. They need to be confident in their equipment. They need to be confident in themselves and their teammates. In fact, every single time I interact with providers, the ones actually delivering care, I ask, “Do you feel safe?” Because if they do not inherently feel safe, nothing else matters.

That’s something we emphasize in our work with the National Emerging Special Pathogens Training and Education Center (NETEC), cofounded by Emory University Hospital, University of Nebraska Medical Center, and New York City Health + Hospitals. We go around the country to share our experiences and to learn from others; we’ve probably been to every one of the 50 states, and we’ve also done countless videoconferences.

During these events, I stress what we’ve put into practice [at NYC H+H]. With all the exercises that we do—whether it’s a tabletop exercise where we go over policies and procedures, whether it’s a full-scale exercise where we use fictitious patients or medical mannequins and practice donning and doffing equipment—we emphasize the safety of our clinical staff. And we give special attention to equipment doffing. Staff need to realize that taking off that equipment can be very risky; many people have been contaminated from improper doffing. So it’s something we really, really emphasize. During training exercises, we ask staff to imagine that an observer with a checklist is watching what they’re doing whenever they remove their personal protective equipment. It’s critically important for staff to slow down and follow the steps in sequence exactly as they were trained.

What other safety protocols are part of your approach to special pathogens preparedness and response?


We have timeouts [during the COVID-19 response as well as during less-intense periods] wherein if somebody sees something being done unsafely, he or she will actually stop the process. Once you’re ill or injured, you can’t provide care anyway, so it is counterproductive to rush through protocols trying to care for more patients; you might as well do critical tasks a little more slowly and a little more methodically.

In addition, we developed a frontline planning guide for special pathogens that was distributed nationally. We’ve essentially adopted the recommendations of the Centers for Disease Control and Prevention in taking an approach called the Three I’s: Identify, Isolate, and Inform.

So, whether a patient presents to an ambulatory care setting or an acute care setting or even if a patient presents to one of our nursing homes, the staff are trained in the exact same thing: Identify what you’re dealing with. Isolate the patient safely. And then inform. By that, we mean inform your infection prevention and control officer or unit, inform the local health department, and inform our central office Special Pathogens Program and senior staff in emergency management. We then will work to get the next steps underway.

Would you like to add any concluding remarks?

We have to focus on the fundamentals—that is the key. Again, COVID is with us. I don't think anybody has a forecast as to when this will truly end. We need to manage what is presenting to us now.

I think we are doing extraordinarily well under the circumstances. But to my counterparts in health care emergency management, I advise this: Stick with the fundamentals. Stick with ensuring that you and your families and, of course, your teams, are safe and well. And just make sure that everything you do follows a solid Incident Command process. It works very, very well. The reason it has been in place for decades in the United States is that it has gotten us through all sorts of incidents. It has helped us to manage our very scarce resources. But it has also helped us to fulfill our mission of taking care of patients. 

Responding to COVID-19

HAVING SEPARATE EMERGENCY DEPARTMENT ENTRANCES TO ISOLATE SUSPECTED CORONAVIRUS PATIENTS FROM OTHERS IS ONE RECOMMENDED BEST PRACTICE

Editor's Note: During the COVID-19 pandemic, we're trying to provide helpful information in an ever-changing environment. To keep health care organizations up to date, The Joint Commission and Joint Commission Resources have compiled comprehensive and authoritative resources on the coronavirus pandemic that can be accessed from The Joint Commission's home page at <https://www.jointcommission.org>. (See also the list of websites in the "Stay Current on COVID-19" box at the end of this article.)

To cope with the surge of COVID-19 patients, it is essential to separate suspected infectious patients from others. Isolating a potentially infectious patient requires creating physical barriers between the patient and other people. That isolation should begin immediately upon the patient's arrival at your facility, as soon as it is determined that the patient may be a risk.

"You need to ensure that no suspected COVID-19 patients are allowed to enter the facility and sit with other patients and families," says Eric R. Alberts, CEM, FPEM, FPEM-HC, CHPP, CHEP, SEM, the corporate director of emergency preparedness for Orlando Health, Orlando, Florida, and a member of the *EC News* Customer Advisory Board. "They should be taken directly to a negative airflow room or a private room with the door closed."

The Centers for Disease Control and Prevention (CDC) recommends that any separate waiting area for potentially infected patients allows at least 6 feet of separation between patients. Respiratory hygiene supplies such as alcohol-based hand sanitizer that is 60% to 95% alcohol, tissues, touchless trash receptacles, and (if available) face masks should be within easy access.*

In hospital emergency departments (EDs), establishing separate entrances for potentially infectious and noninfectious patients can be effective, suggests James Kendig, MS, CHSP, CHCM, CHEM, LHRM, field director—surveyor management and development for The Joint Commission's Division of Accreditation and Certification Operations (ACO). "Consider separating the emergency department into two areas—for example, one area for broken bones and chest pain versus another area for flulike symptoms," he says.

Kendig favors a long-term solution: establishing a permanent protocol of separating contagious from noncontagious patients through the construction of separate ED entrances and interior spaces during upcoming construction or renovation projects. But during the pandemic, spaces can be and are being reconfigured and repurposed. For example, many hospitals have set up triage tents outside their EDs in response to COVID-19. Rush University Medical Center in Chicago and Vanderbilt University Medical Center in Nashville, Tennessee, are among those hospitals that have converted parking lot and garage space into coronavirus assessment areas.

*All CDC information in this article comes from this [site](#).

The CDC recommends that during any surge of infectious patients, hospitals use such engineering controls as partitions to guide patients through triage areas, curtains between patients in shared areas, closed suctioning systems for the airway suctioning of intubated patients, and air-handling systems that are properly installed and maintained.

Separate patient isolation rooms

The CDC advises placing an admitted patient with known or suspected infection in a single-person room with a dedicated bathroom, with the room door closed. In certain situations, an infected patient should be housed in a single-patient airborne infection isolation room (AIIR) under negative pressure, with a minimum of six air changes per hour.

“Organizations need to ensure that their airborne infection isolation rooms are properly functioning, as this is where they will house their patients who have tested positive for the novel coronavirus and need aerosol-generating procedures,” says Herman A. McKenzie, MBA, CHSP, The Joint Commission’s director of engineering.

Hospitals could bring in temporary air handlers to convert standard rooms into isolation rooms, but that may be insufficient and impractical during the worsening outbreak. And for the makeshift hospitals in converted hotels, college dormitories, and similar spaces, airborne isolation may not be feasible.

Health care facilities facing outsized demand for isolation care can sometimes find extra space by thinking outside the box, notes Timothy Markijohn, MBA/MHA, CHF, CHE, field director–surveyor management and support for The Joint Commission’s ACO division. “It would be extremely costly and time-consuming to

Photo by Nacian Largoza. Used with permission




The Ernest N. Morial Convention Center in New Orleans is one of several convention centers that have been converted into field hospitals.

convert single-patient rooms to AIIRs,” he says. “Rather, many organizations have converted sections of their building as an ‘isolation suite’ in case they get a large number of confirmed patients that need to be isolated. At one hospital I worked at during H1N1, we converted a portion of the ED into a suite we could make negative, and we could then ‘cohort’ many infectious patients there instead of trying to convert single rooms.”

Yale New Haven Hospital in New Haven, Connecticut, learned valuable lessons during the 2017–2018 influenza season. During that patient surge, the hospital solved its temporary capacity problems by converting a conference room into a low-acuity inpatient medical unit in less than four days. The room was modified to create 16 bays for patient care using steel cable and curtains; the carpeted floor was covered in shrink-wrap; and the heating, ventilation, and air-conditioning system was adjusted to perform 10 air changes per hour, among many other alterations. Similar conversions can help hospitals expand their capacity for low-acuity patients during the current pandemic.

To increase inpatient capacity on a much larger scale, several major convention centers—including the Jacob K. Javits Convention Center in New York City, McCormick Place Convention Center in Chicago, and the Ernest N. Morial Convention Center in New Orleans—have been converted into field hospitals to treat either non-COVID-19 patients or patients with less severe COVID-19 symptoms. (An article on how field hospitals are addressing environment of care challenges will be published in the next issue of *EC News*.)

COVID-19 is stretching health care facilities to the breaking point. Assessing lessons learned from this continuing pandemic will help health care organizations be better prepared for the next infectious disease outbreak. Meanwhile, by using ingenuity, working collaboratively, keeping up to date on the latest developments, and taking advantage of available physical and informational resources, organizations can provide the best possible care for all their patients during the coronavirus crisis. 

Stay Current on COVID-19

Up-to-date information on COVID-19 and best practice recommendations for health care organizations are available from these organizations’ webpages:

Centers for Disease Control and Prevention

<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>

World Health Organization

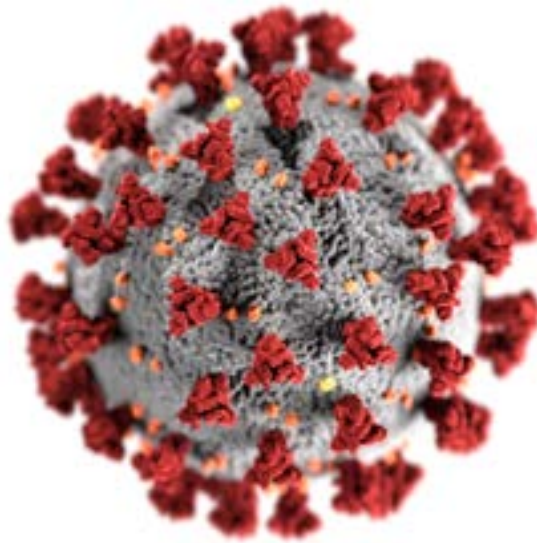
<https://www.who.int/emergencies/diseases/novel-coronavirus-2019>

The Joint Commission

<https://www.jointcommission.org/en/resources/patient-safety-topics/infection-prevention-and-control/>

Environmental Protection Agency

<https://www.epa.gov/coronavirus>



TOOLBOX

Is Your Organization Prepared?

ASSESS YOUR VULNERABILITIES AND LEARN FROM GOOD PRACTICES AT OTHER ORGANIZATIONS WITH THE HIGH-CONSEQUENCE INFECTIOUS DISEASE PREPAREDNESS CHECKLIST

As COVID-19 ravages health care systems across the country, organizations should leverage lessons learned from the pandemic to revise their Emergency Operation Plans (or Emergency Management Plans). Excerpted from the newly updated JCR book *EC Made Easy: Your Key to Understanding EC, EM, and LS, 3rd edition*, the High-Consequence Infectious Disease Preparedness Checklist can help organizations assess risks and vulnerabilities so they are as well prepared as possible for the next severe outbreak and patient surge.

A customizable, downloadable Word version of the checklist is available [here](#) and published on the next page in full.

Published in *EC Made Easy: Your Key to Understanding EC, EM, and LS*, 3rd edition. Joint Commission Resources, 2020.

APPLICABLE PROGRAM(S)			
<input checked="" type="checkbox"/> AHC	<input checked="" type="checkbox"/> BHC	<input checked="" type="checkbox"/> CAH	<input checked="" type="checkbox"/> HAP
<input type="checkbox"/> LAB	<input checked="" type="checkbox"/> NCC	<input type="checkbox"/> OBS	<input checked="" type="checkbox"/> OME

High-Consequence Infectious Disease Preparedness Checklist

From measles and Middle East respiratory syndrome (MERS) to Ebola virus disease and the extremely contagious COVID-19, high-consequence infectious diseases (HCIDs) can wreak sudden and deadly havoc on health care facilities. Health care organizations should regularly consult the “Division of High-Consequence Pathogens and Pathology” section of the Centers for Disease Control and Prevention’s website (<https://www.cdc.gov/ncezid/dhcpp/index.html>) for the latest evidence-based guidelines and protocols on what to do in cases of suspected or confirmed HCIDs. Keep in mind that the precautions and procedures that need to be followed are often specific to the size, type, and configuration of a health care facility. How a health care facility responds to HCID outbreaks must be covered in the organization’s Emergency Operations Plan (called the Emergency Management Plan for ambulatory care and behavioral health care organizations), as required by The Joint Commission’s Emergency Management (EM) standard and element of performance EM.02.01.01, EP 5, as well as in the organization’s Infection Prevention and Control Plan (required by The Joint Commission’s Infection Prevention and Control [IC] standard IC.01.05.01).¹

Unless otherwise noted, most of the checklist items are recommendations or best practices rather than Joint Commission requirements.

Answers to all questions should ideally be **Y** for **Yes** (unless marked **NA** for **Not Applicable**). Use the **Comments** section to indicate any required follow-up action(s) identified by an **N** for **No** response.

Organization: _____ Department/Unit: _____

Date of Review: _____ Reviewer(s): _____

QUESTIONS	Y	N	NA	COMMENTS
Does the health care organization include high-consequence infectious diseases (HCIDs) of various types in its hazard vulnerability analysis? (This is new to the preface of the “Emergency Management” chapter in The Joint Commission’s <i>Comprehensive Accreditation Manuals</i> .)				
Does the health care organization address HCIDs of various types in its Infection Prevention and Control Plan? TJC requirement				
Does the health care organization address HCID outbreaks in its written Emergency Operations Plan (or Emergency Management Plan)? TJC requirement				
Is the organization leveraging lessons learned from the COVID-19 pandemic (as well as Ebola, H1N1, and so on) to create a special pathogens preparedness and response plan within its Emergency Operations Plan (or Emergency Management Plan)?				
Does the organization’s Emergency Operations Plan (or Emergency Management Plan) address the need for enough personal protective equipment (PPE) such as N95 respirators and medical equipment such as ventilators to respond to various types of HCID outbreaks?				
Does the organization have a plan for monitoring its supply chains for the PPE and medical equipment likely to be needed in an HCID outbreak?				

High-Consequence Infectious Disease Preparedness Checklist *continued*

QUESTIONS	Y	N	NA	COMMENTS
Has the organization determined whether the health care region's stockpile includes sufficient and appropriate PPE for a large-scale HCID outbreak?				
In its Emergency Operations Plan (or Emergency Management Plan), does the health care organization address the need for ongoing communication and collaboration—with other health care organizations in the area, with local or state public health departments, and with the state hospital association—to ensure that supplies and equipment can be distributed where needed most during patient surges in an HCID outbreak, an epidemic, or a pandemic?				
Does the organization regularly consult the CDC's website (https://www.cdc.gov/ncezid/dhcpp/index.html) for the latest recommendations on how to best respond to various HCIDs and update the Infection Prevention and Control Plan and Emergency Operations Plan (or Emergency Management Plan) accordingly?				
Does the organization initiate its Incident Command System as soon as an HCID outbreak is foreseen?				
Does the organization follow the CDC's "Identify, Isolate, and Inform" methodology when someone is suspected of having a particularly lethal HCID such as Ebola virus disease or an extremely contagious and previously unknown disease such as COVID-19?				
If the health care organization is planning new construction or renovation of its hospital emergency department(s) or freestanding emergency medical facilities, has it considered having separate entrances and waiting areas to isolate suspected infectious patients from other patients (those with broken bones, cardiovascular conditions, and so on)?				
Does the health care organization conduct training exercises for HCIDs across all sites and departments? Joint Commission standard EM.03.01.03, EP 3, requires that hospitals, critical access hospitals, inpatient hospices, and rural health clinics/federal qualified health centers conduct emergency response exercises at least twice a year. Ambulatory surgical centers must do so at least annually. TJC requirement				
Do the training exercises for HCIDs emphasize the proper use of PPE and require staff to practice donning and doffing PPE?				
To assist with the identification of patients with HCIDs, has the organization's electronic health record (EHR) system been programmed to alert users to ask all patients for their recent travel history?				
Does the EHR system have mechanisms in place for alerting staff when a patient's travel history and presenting symptoms indicate the possibility of an HCID?				

High-Consequence Infectious Disease Preparedness Checklist *continued*

QUESTIONS	Y	N	NA	COMMENTS
Does the organization have protocols in place for alerting staff during patient handoffs that a patient's travel history and presenting systems indicate the possibility of an HCID?				
For hospitals, is there always an infectious disease specialist, intensivist, or emergency physician on-site or on call who has expertise in HCIDs, infection control, and current outbreaks of concern? One good practice is to have that expert carry a dedicated pager.				
Does the organization have a highly trained multidisciplinary biothreats readiness team in place to assume a leadership role during an HCID outbreak? This volunteer team should include clinicians from intensive care (adult and pediatric), infectious diseases, respiratory therapy, and other areas.				
Does the health care facility follow the good practice of having ongoing "no notice" 15-minute training exercises in clinical settings that focus on priority responsibilities in the initial moments of an HCID event?*				
Does the organization conduct full-scale exercises that evaluate interdepartmental coordination, including the movement of patients and resources throughout the building?†				
Does the organization conduct "tabletop exercises" that walk through appropriate responses to an HCID event?‡				
After an HCID event is underway, does the organization conduct on-site "mystery patient drills," in which an actor pretending to be a patient presents with HCID symptoms? The facility or department can be evaluated on whether it follows the organization's protocols for taking a patient's travel history, using PPE, and so on.				
Does the organization have a process for submitting 1135 waiver requests directly or through local or state officials or the state hospital association? TJC requirement				
Does the organization have a succession plan to support the command center and the Incident Command System? TJC requirement				

* Such exercises help critical stakeholders develop reflexive actions to facilitate interdepartmental response to an HCID outbreak.

† The benefits of full-scale exercises include the ability to test protocols in a real-world environment and help staff develop muscle memory by testing the plan in a familiar setting.

‡ The benefits of such exercises include more detailed discussions that provide context such as theory and history, as well as the ability to involve more staff members in the training. Effective March 15, 2020, one tabletop exercise can be used to meet the Joint Commission requirement of conducting two emergency response exercises a year.

Reference

1. Joint Commission Resources. Combating HCIDs. *Environment of Care® News*. 2019 Jun;22(6):8–14.

Revised Joint Commission Standards Reflect CMS Burden Reduction Rule

SEVERAL EMERGENCY MANAGEMENT REQUIREMENTS HAVE CHANGED

BACKGROUND: The Centers for Medicare & Medicaid Services (CMS) issued its Omnibus Burden Reduction (Conditions of Participation) Final Rule CMS-3346-F on September 26, 2019. As part of this ruling, The Joint Commission revised its Emergency Management (EM) requirements for health care organizations that use Joint Commission accreditation for CMS deemed status purposes and for federally qualified health centers.

The resulting modifications to the EM standards, approved by CMS, took effect on March 15, 2020.

Last September, the Centers for Medicare & Medicaid Services (CMS) released its Omnibus Burden Reduction (Conditions of Participation) Final Rule, which minimizes regulatory burdens across a variety of health care settings. The goal was to lighten or remove certain requirements and make it easier for facilities to fulfill necessary duties such as reporting.¹ Per CMS, these changes are expected to save providers 4.4 million hours formerly spent on paperwork yearly and to trigger approximately \$8 billion in savings over the next decade.²

Accordingly, The Joint Commission has updated many of its standards to align with revised regulations for accreditation programs with deemed status and for federally qualified health centers. Finalized requirements are now in effect for hospitals, critical access hospitals, ambulatory surgery centers, and home health and hospice organizations.³

“The 2019 CMS burden reduction final rule impacts many different health care organizations,” explains Angela Murray, MSN, RN, TNS, clinical project director for the Department of Standards & Survey Methods in The Joint Commission’s Division of Healthcare Quality Evaluation. “CMS identified specific regulatory language that had become burdensome to these organizations. Consequently, CMS eliminated or reformed regulatory language to help improve effectiveness and/or reduce unnecessary reporting requirements.”

James Kendig, MS, CHSP, CHCM, CHEM, LHRM, field director—surveyor management and development for The Joint Commission’s Division of Accreditation and Certification Operations, notes that many CMS changes—and subsequent revisions to related Joint Commission standards—involve Emergency Management (EM) issues, which this article emphasizes.

“The Joint Commission has spent a lot of time thoroughly reviewing its EM standards and making updates that reflect CMS burden reduction changes. I think our accredited organizations will appreciate that we’ve eased some of the associated regulations and clarified others,” says Kendig, who co-chairs The Joint Commission’s Emergency Management Committee.

Among the most important revisions affecting EM standards “are those that address the frequency of EM exercise and testing requirements and the expansion of the types of testing allowed to meet those requirements,” says Murray, also a co-chair of the EM Committee.

More flexibility with EOP testing exercises

EM.03.01.03 now has an all-new EP 3 (EP 20 for rural health clinics and federally qualified health centers in *the Comprehensive Accreditation Manual for Ambulatory Care [CAMAC]* and its E-dition® counterpart), which replaces previous EPs 1 through 4. EP 3 and EP 20 still require hospitals, critical access hospitals, hospices, and rural health clinics/federally qualified health centers to conduct exercises to test their emergency plans twice per year at minimum (ambulatory surgical centers must do so at least annually).

“However, these new changes allow for more flexibility in the types of exercises allowed—which now include tabletop sessions—that can be conducted to assess the impact on the organization’s Emergency Operations Plan (EOP),” says Murray. (Ambulatory care and behavioral health care organizations use an Emergency Management Plan instead of an EOP.)

The new language states that the first annual exercise should be a full-scale community-based one; if that’s not possible, a facility-based functional exercise is allowed (either is required every other year for ambulatory surgical centers). The second yearly exercise (opposite years for ambulatory surgical centers) may be—but isn’t limited to—one of the following options:

- A full-scale community-based exercise
- A facility-based functional exercise
- A mock disaster drill
- A tabletop exercise or a workshop led by a facilitator that includes group discussion of the following:
 - A clinically relevant, narrated emergency scenario and a set of problem statements, directed messages, or prepared questions aimed at challenging an organization’s emergency plan

“For example, a hospital that uses Joint Commission accreditation for deemed status purposes will still be required to test its EOP twice a year,” says Murray. “The first of these exercises should be a full-scale community-based exercise, if available, or a facility-based functional exercise,” says Murray. “The second exercise can repeat this same directive or be a tabletop exercise or a workshop—whatever the organization chooses.”

This revised EP further stipulates that if the health care organization experiences a real-life natural or man-made emergency that necessitates emergency plan activation, that organization is exempt from having to conduct its next required full-scale community-based exercise or facility-based functional exercise. (With the current COVID pandemic, this will likely exempt many accredited health care organizations from having to conduct their next full-scale community-based exercise or

facility-based functional exercise, as most, if not all, health care organizations have activated their emergency plans.)

Clarification of Note Omission

Effective March 15, 2020, The Joint Commission revised Standard EM.03.01.03, Element of Performance (EP) 3 for hospitals and critical access hospitals. Following the publication of this update, it came to the attention of the Department of Standards & Survey Methods (DSSM) that the original note regarding conducting annual exercises for freestanding buildings was inadvertently omitted. The Joint Commission would like to clarify that although the note was omitted, the annual exercise is still required for freestanding buildings of hospitals and critical access hospitals.

The note was originally located in EM.03.01.03, EP 1. The note is now located in EM.03.01.03, EP 3, as a result of consolidations that occurred in this standard in the March revisions.

The language of the notes in EP 3 is as follows, with the omitted Note 3 underscored and in red:

Note 1: *If the hospital experiences an actual emergency (natural or man-made) that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full-scale, community-based exercise or facility-based, functional exercise following the onset of the emergency event.*

Note 2: *See the Glossary for the definitions of community-based exercise, full-scale exercise, and functional exercise.*

Note 3: *Staff in freestanding buildings classified as a business occupancy (as defined by the Life Safety Code) that do not offer emergency services nor are community designated as disaster-receiving stations need to conduct only one emergency management exercise annually.*

This correction will appear in the next E-dition update and in the 2021 hard-copy versions of the *Comprehensive Accreditation Manual for Hospitals* and the *Comprehensive Accreditation Manual for Critical Access Hospitals*.

More time to evaluate risks and threats

“The second biggest change to our EM standards,” notes Murray, “reflects the frequency of auditing EM policies and assessing the organization’s hazards and risks. Organizations now have more time to do so.”

Here, several revised EPs apply, particularly EPs 1, 2, and 4 of EM.03.01.01. New changes specify that hospitals and critical access hospitals are obligated to conduct reviews of their risks, hazards, and potential emergencies (as defined in their hazard vulnerability analysis) and of the scope and objectives of their EOPs and document all findings—at least every two years. Previously, this was an annual duty, as was the requirement to forward emergency planning reviews to the organization’s senior leadership for review (which is now mandated at least every two years).

“Organizations can conduct these reviews more frequently if they wish, but many have expressed that making this a once-every-other-year requirement is a welcome change,” adds Kendig.

Other shifts from annual to biennial

Additional EPs that extend a yearly requirement to every two years at minimum include the following:


- EM.01.01.01, EP 4, instructs hospitals and critical access hospitals to communicate their needs and vulnerabilities—whenever these change or during the biennial review of their EOP—to community emergency response agencies and to identify the community’s capability to meet their needs.
- EM.02.01.01, EP 10 (EP 20 of CAMAC covers rural health clinics and federally qualified health centers), mandates that ambulatory surgical centers, home health agencies, hospices, rural health clinics, and federally qualified health centers must review and update their Emergency Management Plan, including the communication plan.
- EM.02.01.01, EP 16, requires that the emergency management policy and procedure documents of hospitals and critical access hospitals be reviewed and updated in a format they choose.
- EM.02.01.01, EP 17 (of the *Comprehensive Accreditation Manual for Home Care* or its E-dition counterpart), requires that inpatient hospice staff and volunteers review their emergency preparedness plan procedures necessary to protect patients and others.
- EM.02.02.07, EP 13 (EP 20 of CAMAC covers rural health clinics and federally qualified health centers), obligates hospitals, critical access hospitals, ambulatory surgical centers, home health agencies, hospices, rural health clinics, and federally qualified health centers to provide and document emergency preparedness training to staff, volunteers, and individuals offering on-site services (under arrangement) during initial training, when roles or responsibilities change, when policies and procedures are significantly updated, or at least every two years.
- EM.02.02.07, EP 21, is a brand-new EP instructing hospitals, critical access hospitals, ambulatory surgical centers, home health agencies, and hospices to have an emergency preparedness training program in place that’s based on its EOP; this training program must be reviewed and updated at minimum every two years.
- EM.04.01.01, EP 1 (EP 5 of CAMAC covers rural health clinics and federally qualified health centers), calls for hospitals, critical access hospitals, ambulatory surgical centers, rural health clinics, and federally qualified health centers to document their participation in the review of their health system’s integrated emergency preparedness program.

Amended language on community collaboration

A final EM standard change of note concerns EM.02.02.01, EP 22 (EP 34 of CAMAC covers rural health clinics and federally qualified health centers), which eases the previous burden of documentation required regarding cooperative emergency management efforts with local officials.

Now, hospitals, critical access hospitals, ambulatory surgical centers, home health agencies, hospices, rural health clinics, and federally qualified health centers must have a process in place for cooperation and collaboration with local, state, tribal, regional, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency.

In summary, Murray says it's important to be aware of these and other alterations and additions made to language found in your most current *Comprehensive Accreditation Manual* and its E-dition counterpart.

"Organizations should follow our new EM standards closely to be compliant. As of March 15, 2020, our surveyors began holding organizations accountable for these changes, as we are required to follow CMS regulatory language," she says. "Remember, too, that maintaining compliance for accreditation is the key to a successful survey." 

*A special thanks to the Emergency Management Committee:
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—Angela Murray and Jim Kendig, committee co-chairs*

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Developing a K-9 Security Program

AMONG THE FIRST IN OHIO, THE K-9 PROGRAM AT MOUNT CARMEL HEALTH SYSTEM HELPS REDUCE SECURITY RISKS WHILE OFFERING PEACE OF MIND AND PET THERAPY BENEFITS

From de-escalating potentially violent situations to providing stress relief for staff and patients alike, K-9 security programs can offer a novel approach to security that complements existing programs. Outcomes such as these first spurred Mount Carmel Health System to investigate creating and implementing a K-9 security program across its seven-facility health system in and around Columbus, Ohio, several years ago.

“As a security team, we had taken note of the increased incidents of workplace violence throughout the country,” says Michael Angeline, BS, CHSP, CHRM, HEM, regional director—environmental health & safety and emergency preparedness for Mount Carmel Health System, Columbus, and a member of the *EC News* Customer Advisory Board.. “The Joint Commission even sent out an alert related to this uptick. As a result, we began to look at ways to address issues that would occasionally arise where hospital visitors would become combative or aggressive.” (See The Joint Commission’s [Workplace Violence Prevention](#) portal for links to resources on this topic.)

Although Joint Commission standards don’t specifically address K-9 security programs, such a program can be part of an approach that meets Environment of Care (EC) Standard EC.02.01.01: The [organization] manages safety and security risks. A K-9 security program can also be incorporated into a health care organization’s Emergency Operations Plan (or Emergency Management Plan), helping the organization to comply with Emergency Management (EM) Standard EM.02.02.05: As part of its Emergency Operations Plan, the [organization] prepares for how it will manage security and safety during an emergency.

Angeline and his team learned that Mount Carmel’s sister hospital, St. Joseph Mercy Ann Arbor (Michigan), had already implemented a K-9 security program with success and thus began their research with a field trip north. “You don’t need to re-create the wheel when you have organizations with successful programs in place that are willing to share their experiences,” he says. “I encourage anyone looking to start a K-9 security program to take the time to investigate the pros, cons, risks, and benefits of existing programs.”

Angeline and team used insights from their field trip and other research to craft a proposal for Mount Carmel’s senior leadership team, outlining the benefits of such a program as well as projected costs. Those included the cost of the dogs themselves, which for Mount Carmel ran in the range of \$5,000 to \$6,000 per animal. Specialized training is another significant cost, which for Mount Carmel was approximately \$4,000 per dog.

“Our foundation paid for the [initial] dog, its training, and relevant startup equipment,” Angeline says. “We then operationalized additional expenses into our department budget for such things as food, veterinary expenses, and other supplies.”

Mount Carmel launched its K-9 security program in 2013 with one dog, a German shepherd, and eventually grew the program to five dogs. At present, the hospital system maintains two dogs who, with their handlers, typically work an eight-hour shift patrolling hospital grounds, both inside and out.

Angeline notes that the dogs are sheltered only in nonclinical areas such as the security office. “They cannot enter negative pressure or isolation rooms,” he says. “We have a strict policy regarding the cleanliness of the K-9 security dogs, much like what our therapy dogs go through.”

In addition to security training, each dog has a specific specialty. One of the dogs can sniff out narcotics; the other can sniff out bombs. “From a risk management perspective, it can be quite beneficial to have a dog that can sniff out narcotics,” Angeline says. “We don’t want someone bringing our patients illegal substances, particularly when our medical staff is giving them prescribed medications.”

When a K-9 patrol dog and its handler respond to security situations in a patient’s room, the dog is trained to remain in the doorway. The dog will respond only upon a voice command from its handler.

“We would never use a patrol dog to control a patient,” Angeline says. He notes that even if someone is physically aggressive with the handler in clear view of the patrol dog, the dog will not respond unless its handler issues a voice command.

Angeline says this is important because many health care settings and scenarios can present gray areas. “Say there’s a lightheaded patient who passes out, and a security officer catches him or her; it may look to the dog like the handler is in danger,” Angeline explains. “Similarly, if a patient is having a seizure, we don’t want the dog turning on him or her.”

Angeline points out that the mere presence of a K-9 patrol dog in a health care setting can de-escalate the beginning of potentially aggressive situations. “That’s why we patrol,” he notes. “In actuality, 90% of what these dogs do is provide social interaction and pet therapy. People light up when they see the dogs. For staff, the dogs provide a sense of security, and patients routinely ask to approach and pet the dogs.”

Handler requirements

For those organizations looking to start a K-9 security program, Angeline emphasizes the importance of the handler role and creating a comprehensive policy for the program overall. Among the key areas of the policy should be expectations and allowances for the handlers.

“The dogs need to go home each night with their handlers and become part of their families,” Angeline explains. “In our experience, if the needs of the handler are taken care of, the needs of the dog are taken care of.”

To that end, Mount Carmel has created a specific K-9 handler job description and worked closely with its legal department to create a contract that includes a minimum five-year handler agreement with a noncompete clause for handlers caring for organization or foundation-gifted dogs. “If you don’t have a contractual agreement like this, you could end up losing a dog if the handler decides to leave the organization,” Angeline says. “If the handler still wants to continue working with the organization after the five years are up, he or she can sign on for another five years. Typically, these dogs have a service life of at least 10 years.”

Mount Carmel has also built in additional pay for those security officers who serve as K-9 handlers. “The handler is responsible for cleaning the dog, picking up food, etc.,” he notes. “So, we budgeted an extra 30 minutes a day of wages to account for those extra K-9 maintenance services handlers must perform.” Mount Carmel provides its K-9 handlers with debit cards to purchase food and pet hygiene supplies and closely monitors those expenses.

Another piece of the Mount Carmel handler job description is the understanding that the handler must also commit to three months of rigorous training with the dog—focused on socialization, patrol, bomb detection, contraband detection, and aggression management. “These dogs are specially trained to work in hospital environments,” Angeline notes. “Not all dogs, including law enforcement dogs, are accustomed to close spaces like hospitals. We work with a trainer who trains our dogs to work in close quarters and to work as both patrol dogs and pet therapy dogs.”

Transporting the dogs is another detail and expense to consider. “We got creative with that,” Angeline says of Mount Carmel’s approach. “We looked at vehicles

Courtesy of Mount Carmel Health System



Security officer Joe Brown (left) with Titan and security supervisor Jeremy Reisinger with Argo make up Mount Carmel Health System’s K9 security team.

retired by police departments that we could obtain, refurbish, and in which we could install a cage. This is important because the security officer will be taking the dog home after every shift and bringing the dog back again the next day.”

Promoting the program

The Mount Carmel K-9 security program has been embraced by leadership, staff, patients, and visitors since day one, Angeline maintains. Part of that early enthusiasm stemmed from close collaboration between his team and the hospital’s communications department to promote the program from its inception.

Together, the teams launched a K-9 naming campaign. The handler selected five names on which staff, patients, and visitors could vote. The marketing team created trading cards with a photo of each dog and its stats to be distributed to visitors. The dogs also routinely make appearances at hospital special events, often in their K-9 security vest and badge.

Angeline recommends using a hospital’s social media channels to promote the K-9 security program and to share photos and fun facts about each dog.


Tracking metrics

When creating a K-9 security program, Angeline recommends establishing appropriate metrics from the get-go. He advises tracking every time the dog or dogs respond to a call. Other metrics could include use of K-9s in contraband or bomb detection (suspicious packages) and special requests for pet therapy. These metrics can then be shared with hospital leadership. The Mount Carmel security team also routinely shares its success metrics with the hospital’s foundation, which continues to help fund the program.

While for Mount Carmel the benefits of a K-9 security program have outweighed any disadvantages, Angeline acknowledges that there can be bumps in the road. “A program like this is not for every health system,” he says. “You have to have supervision and management willing to stay on top of the program to make sure the needs of the handlers and the dogs are met.

“It’s important to communicate with all of your security officers the role of the K-9 handler and how it may differ from theirs. We’ve had instances where security officers didn’t understand why handlers might not have been able to take on a specific duty because they couldn’t leave their dog unattended.”

As stated earlier, no Joint Commission standard specifically addresses K-9 security programs, and for its part, Mount Carmel has never received any feedback from surveyors.

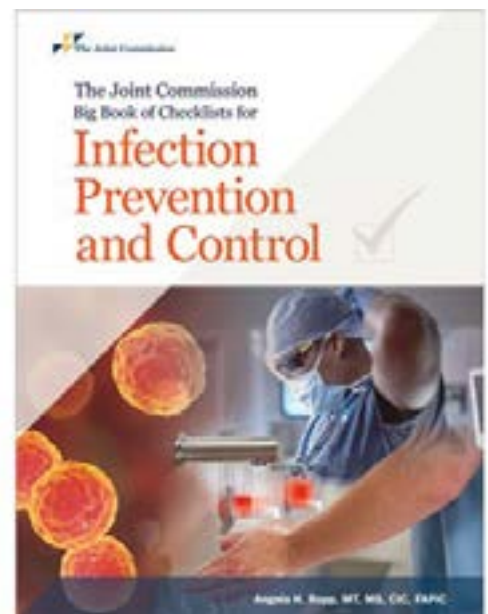
“We consider the K-9 program simply to be another tool in our arsenal for ensuring optimal patient, staff, and visitor safety,” Angeline says. 



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