The Joint Commission

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Emergency Management Leader™

A JOINT COMMISSION NEWSLETTER

Inaugural Issue

Letter to Readers

Welcome to *Emergency Management Leader*

***Emergency Management Leader*'s mission is to provide insights into The Joint Commission's Emergency Management (EM) standards; share tools, best practices, and lessons learned for all types of health care organizations; and keep you abreast of relevant EM news**

Welcome to the inaugural issue of *Emergency Management Leader™: A Joint Commission Newsletter*. Joint Commission Resources' new digital newsletter, which publishes bimonthly in 2024, is the result of customer requests and the increasing need for timely, comprehensive coverage of health care emergency management. It also reflects The Joint Commission's renewed focus on emergency management as an enterprise priority.

In recent years, natural disasters such as extreme weather and wildfires have become more intense and frequent, while the world experienced the most significant public health emergency in more than 100 years—the COVID-19 pandemic. On top of this, there has been a rise in violence and unrest in the United States and around the world. Mass attacks and shootings have surged in number, violence against health care workers has risen dramatically, and cyberattacks have skyrocketed. Moreover, many health care facilities have aging infrastructure and are at greater risk of internal emergencies such as flooding from burst pipes (*see* the article on page 7). In this environment of heightened risk, health care organizations (HCOs) need to be prepared for the worst and take a robust, all-hazards approach to emergency management.

The Joint Commission helps HCOs prepare for, manage, and recover from such crises through its Emergency Management (EM) standards, which have recently gone through revision and renewal. JCR, in turn, helps customers understand and comply with these standards by offering on-point publications and education. Intended for emergency managers and coordinators, multidisciplinary EM team members, and accreditation compliance professionals, *Emergency Management Leader* provides expert insights, sharing best practices, lessons learned, and tools in each issue.

This first issue of *Emergency Management Leader* is offered free to customers. Subsequent issues will require a paid subscription. If you are a subscriber to *Environment of Care® News*, you will receive a discount code to save on your subscription to *Emergency Management Leader*. If you are a subscriber to JCR's Digital Learning Center, *Emergency Management Leader* will be included, as are JCR's other newsletters.

Please tell us what you think of our inaugural newsletter. Your feedback is invaluable as we strive to make *Emergency Management Leader* an indispensable resource. Send your comments to EML@jcrinc.com. EML

Joint Commission News

New EM Chapter for Ambulatory Care Effective July 1, 2024

Ambulatory care organizations and office-based surgery practices will have new and revised standards, while the number of elements of performance has been reduced

Accredited ambulatory care (AHC) and office-based surgery practice (OBS) organizations will need to meet new Emergency Management (EM) standards effective July 1, 2024. The new EM chapter format is similar to that for hospitals and critical access hospitals (debuting July 1, 2022) and home care organizations (debuting July 1, 2023). For example, the chapter is organized sequentially from EM program development (EM.09.01.01) to program evaluation (EM.17.01.01).

The revised EM chapter is completely restructured, more closely aligned with current industry standards, and no longer redundant. The revision reduced the number of elements of performance (EPs) by more than 40%, says Angela Murray, MSN, RN, Project Director for Healthcare Standards Development in The Joint Commission's Department of Standards and Survey Methods.

Approved by the Centers for Medicare & Medicaid Services (CMS), the new EM standards better reflect the CMS Emergency Preparedness Final Rule. The Prepublication Standards are posted on The Joint Commission's website. The new standards will publish online in the spring 2024 E-dition® update to the *Comprehensive Accreditation Manual for Ambulatory Care* (CAMAC) and the *Comprehensive Accreditation Manual for Office-Based Surgery Practices* (CAMOBS). Program-specific *R*^{3} *Reports* for office-based surgery and ambulatory care provide the rationale for the new and revised EM requirements as well as references to the research and reports used to develop them.

Key changes

Although the numbering of the standards and EPs is completely different in the new chapter, much of the content will be familiar. Here are some of the significant content changes.

- **NEW:** Per **EM.09.01.01, EP 1**, the organization must have a written comprehensive EM program that uses an all-hazards approach. That is not new; however, to meet the CMS Emergency Preparedness Final Rule, the EM program now must address at least the following:
  - Leadership structure and program accountability
  - A hazard vulnerability analysis (HVA)
  - Mitigation and preparedness activities
  - Emergency operations plan (EOP) and policies and procedures

- Education and training
- Exercises and testing
- A continuity of operations plan (COOP)
- A disaster recovery plan
- Program evaluation

- **EXISTING:** Moved to the EM chapter from the "Leadership" (LD) chapter is the requirement for an organization's leaders to provide oversight and support for EM activities. **NEW:** However, per **EM.10.01.01, EP 2**, the organization's leadership now must identify one or more individuals who will develop and maintain the EOP, coordinate EM education and training, and conduct exercises to test the EOP and response procedures. This is a new requirement. The EM program lead(s) should be selected based on education, training, and experience in EM. If the organization is part of a health system with a unified and integrated EM program, the system's designated EM program lead may also serve as the EM lead for the organization, as long as there is adequate collaboration.
- **NEW:** Added to meet the CMS Final Rule, **EM.11.01.01, EP 2**, requires an organization's HVA to include a risk assessment for emerging infectious diseases (such as the Ebola, Zika, or SARS-CoV-2 viruses), as well as for the following hazards (per **EXISTING** requirements):
  - Natural hazards (such as flooding, wildfires)
  - Human-caused hazards (such as bomb threats or cybersecurity crimes)
  - Technological hazards (such as utility or information technology outages)
  - Hazardous materials (such as radiological, nuclear, or chemical)
- **NEW:** Per **EM.12.02.01, EP 2**—a new requirement based on customer feedback to The Joint Commission during the pandemic—the organization's written emergency communications plan must describe how it will deliver coordinated messages and information during an emergency or disaster to staff, patients, and other key stakeholders.
- **NEW:** Based on feedback during and after the pandemic and other disasters, **EM.12.02.03, EP 6**, is a new requirement for the organization's staffing plan

New EM Chapter Implementation Schedule

The Joint Commission's new "Emergency Management" (EM) chapter will eventually be implemented in all accreditation programs. Hospitals, critical access hospitals, and home care already have the new chapter. Here is the rollout schedule for the remaining accreditation programs:

- Laboratories—January 1, 2025
- Nursing care centers and assisted living communities—July 1, 2025
- Behavioral health care and human services organizations—January 1, 2026

to describe employee assistance and support during a disaster. The plan must address the following:

- Staff support (for example, housing or transportation)
- Family support for staff (for example, childcare or elder care)
- Mental health and wellness

- **NEW:** Added to meet the CMS Final Rule, **EM.15.01.01, EP 1**, requires ambulatory surgical centers (ASCs) that use their accreditation for deemed status purposes to have a written EM education and training program based on prioritized risks in the HVA, the EOP, the emergency communications plan, and the organization's policies and procedures. If the ASC is part of a health system with a unified and integrated EM program, the system program may include information specific to that ASC, eliminating the need for the ASC to have its own program.
- ASCs that use their accreditation for deemed status purposes must also have a written plan for annually testing their EOP. **NEW:** Per **EM.16.01.01, EP 1**, added to meet the CMS Final Rule, the organization must base emergency exercises on the following:
  - Likely emergencies or disasters
  - The organization's EOP and related policies and procedures
  - Prior after-action reports and improvement plans
  - The six critical areas of EM (communications, staffing, patient care activities, safety and security, resources and assets, and utilities)

Informed by experiences, the exercises should stress the limits of the organization's emergency response procedures to assess preparedness for a real event or disaster.

- **EXISTING:** Moved to the EM chapter from the LD chapter is a requirement for leaders to review evaluations of EM exercises and responses to real events to determine next steps. **NEW:** Per **EM.17.01.01, EP 2**, organization leaders must review all after-action reports, any identified opportunities for improvement, and any recommended actions to improve EM.

Again, this list is just a sampling of the new requirements. Be sure to review the Prepublication Standards and the spring 2024 update to E-dition. EML

Save This Date

The Joint Commission Resources 2024 Emergency Management Conference will be held June 18–20 in Orlando, Florida

Joint Commission Resources' next annual Emergency Management Conference will be held June 18–20, 2024, in Orlando, Florida. On June 18 JCR will conduct the 2024 Emergency Management Standards Base Camp Pre-Conference, which will focus on compliance with The Joint Commission's new "Emergency Management" (EM) chapter.

During the Emergency Management Conference on July 19–20, health care EM professionals from around the country and beyond will share their lessons learned from real emergencies and provide insights and best practices on topics such as the following:

- Establishing and evaluating a comprehensive and cohesive EM program
- Conducting an evidence-based hazard vulnerability analysis (HVA)
- Developing a thorough written emergency operations plan (EOP) based on the HVA
- Addressing the six critical areas of EM:
  - Communications
  - Staffing
  - Patient care and support
  - Safety and security
  - Resources and assets
  - Utilities
- Creating an effective EM education and training program
- Evaluating emergency response capabilities with well-designed EM exercises

This year, the Emergency Management Conference will include an exhibit hall. For information on exhibiting, e-mail jcrsponsorships@jcrinc.com.

To learn more about the 2024 Emergency Management Conference and the Emergency Management Standards Base Camp Pre-Conference, *see* page 25. Both events will take place at the DoubleTree by Hilton Hotel at the Entrance to Universal Orlando. EML

Case Study

Surmounting Successive Emergencies

Strong partnerships, robust plans, and innovative problem-solving helped Grady Health System successfully manage a massive flood and other crises in 2019–2022

Having just enjoyed a pedicure, Lori M. Wood, DHA, MBA, MSEM, EMHP, looked forward to what remained of her Saturday of shopping and self-care a couple of weeks before the winter holidays. Then she received a text from an emergency physician colleague: "Flooding in multiple areas of the hospital. Water in the waiting room stairwell and in room 13." Even so, the vice president of system emergency management for Atlanta-based Grady Health System wasn't too worried at first. Grady Memorial Hospital, built in the 1950s, had experienced flooding in the past and had protocols and procedures for managing it.

But soon after, Wood got an urgent call from her boss: "We have a problem." As it turned out, on that fateful day—December 7, 2019—a 24-inch pressurized water line had ruptured in the mechanical space between the hospital's 6th and 7th floors. "The chain that held up this water main broke; and when the chain broke, the pipe fell and broke the welds," Wood explains.

Because it was a Saturday, there weren't a lot of facilities staff on site to address the problem. Approximately 100,000 gallons of water escaped before the water was shut off. However, shutting off the water did not completely halt its flow. "They were able to bring the flow down to that of a one-inch water main, but water continued to run through the broken pipe for the next 18 hours," says Wood.

Georgia's largest hospital—a Level 1 trauma center with 953 licensed beds, more than 697,000 patient visits a year, and 153,000-plus patients treated annually in the emergency department (ED)—experienced devastating damage but, fortunately, no patients were harmed.

Thanks to strong external partnerships, dedicated and experienced staff, robust plans, and lessons gleaned from prior exercises and real events, Grady coped successfully with not only this disaster but also a series of other overlapping emergencies during the next three years. While still recovering from the flood, the safety-net hospital in the middle of downtown Atlanta faced COVID-19 patient surges and civil unrest after the death of George Floyd and soon after that, the death of Rayshard Brooks, an African American man killed by Atlanta police at a downtown fast-food restaurant. The closure of the only other Level 1 adult trauma center in the city in November 2022 completed the string of crises.

Flood damage and emergency response

The "Great Flood of 2019," as Wood refers to it, destroyed the first six floors of the hospital, forcing the relocation of 185 patients within the facility. "Staff moved

Georgia's largest hospital, Grady Memorial Hospital is the only Level 1 adult trauma center in Atlanta and a crucial safety-net hospital for the city. PHOTO COURTESY OF GRADY HEALTH SYSTEM. USED WITH PERMISSION.

patients to nontraditional areas such as hallways, the rehab gym, and waiting rooms," says Wood. Because of previous flooding at Grady, this process had become standardized, and the information technology (IT) and electrical infrastructure was already in place to convert those spaces quickly to inpatient care. Flooding also had consistently been among the top 10 risks prioritized in Grady's hazard vulnerability analysis, Wood adds.

But Grady had additional problems to grapple with. Most concerning, a bus duct got wet, triggering a prolonged power outage in the hospital. "We wound up on emergency power from December 7 until January 11 in one of our towers," Wood remembers. "We went on total diversion from the time of the event until December 13."

Due to both flood damage and being on emergency backup power, Grady lost use of the following:

- 220 patient rooms
- 14 elevators
- The heating, ventilation, and air-conditioning system
- Operating rooms
- The neonatal intensive care unit (NICU)
- Six inpatient units (mostly medical/surgical nursing units and postnatal care units)
- Several clinics
- Administrative offices
- The historic hospital's museum lobby

- Computed tomography (CT) machines
- Lighting in some spaces
- Ice machines

Because the red (emergency backup power) outlets are designated for critical equipment, which does not include television sets, patients could not watch TV. "A lot of our patients were quite upset about no TV," Wood recalls, noting that the hospital has many behavioral health patients. "Our public affairs team and patient experience team went out and bought games, playing cards, and coloring books—anything to keep everybody occupied."

The timing of the massive internal flood was also terrible. Grady is less than a mile from Mercedes-Benz Stadium, which was hosting the Southeastern Conference (SEC) college football championship that day, an event drawing some 75,000 attendees. "We're at the table for planning every big event in the city," notes Wood. At crowded, emotionally charged sporting events, there may be fans who need care in the nearest hospital ED. Having to be on diversion meant that Grady could not fulfill this vital civic role.

Indeed, because of Grady's importance to Atlanta, Georgia Governor Brian Kemp declared a state of emergency. This enabled the Georgia Emergency Management and Homeland Security Agency to obtain emergency response assets for Grady from North Carolina. Several Carolinas MED-1 Mobile Emergency Department trailers were deployed to Grady and parked in the ambulance bay. These mobile treatment facilities proved key to the hospital's continuity of operations during recovery.

The devastating flooding required the gutting and rebuilding of Grady Memorial Hospital from the sixth floor down. PHOTOS COURTESY OF GRADY HEALTH SYSTEM. USED WITH PERMISSION.

Parked in the ambulance bay, the Carolinas MED-1 mobile treatment facilities served as Grady's emergency department during the hospital's flood recovery period. PHOTO COURTESY OF GRADY HEALTH SYSTEM. USED WITH PERMISSION.

During the week of total medical diversion, Grady established a Regional Coordinating Center at the hospital to help local emergency medical services (EMS) know where to take patients in the area. "We created it in about five days so that we wouldn't overburden any one hospital," says Wood. "We used our paramedic nurse extenders who were working in the ED as our call takers, coordinated with the office of EMS, got their blessing, and got all the other hospitals' blessing. We wanted to make sure that we had full transparency with the other hospitals in Atlanta."

Rebuilding and recovery

When it began receiving new patients again in mid-December, Grady had converted part of its ED into an inpatient unit, while shifting emergency care to the mobile treatment facilities in the ambulance bay. Grady also had moved 30 long-stay patients to Emory Hillandale Hospital. "We essentially rented one of their wings that had 30 beds," Wood explains. "We sent our staff—one of our unit directors was over there—and the wing was known as 'Grady at Emory.' The patients stayed there about six months."

Reconstructing the damaged portion of Grady required gutting and rebuilding six floors. An extra generator was brought in to power the construction equipment. Given the loss of 14 elevators, the construction crew needed a fast way to dispose of all the debris. "They took a couple windows out on one side of the building," says Wood, "and turned those into debris chutes and then just dumped the debris out the window into roll-up containers on the street."

What were the lessons learned from this flood? For one thing, "the stress on staff was incredible," Wood emphasizes. "People were concerned about their jobs because we had just lost 220 beds. That's a lot of staff. But nobody lost their job. Of course, everybody was absolutely exhausted."

Wood also realized that the health system's executives and managers would have benefited from additional National Incident Management System (NIMS)/Hospital Incident Command System (HICS) training. This training, she says, is much more important than most people think and ideally should be completed before the emergency. Grady Health System now requires managers and executives to complete the Federal Emergency Management Agency's IS-100, IS-200, IS-700, and IS-800 training classes. In addition, Grady provides HICS training that is more specific to the health system.

Wood also notes that Grady could have been better prepared for the long recovery, which lasted six months. A typical EM exercise tests response to an emergency and ends with the after-action report, but recovery should be considered as well, she suggests.

Arrival of COVID-19

Grady saw its first COVID-19 patient in March 2020. "We went into the pandemic down 220 beds," Wood says. "We already had an incident command—we had had it since December—but we had to shift our focus."

At its peak, Grady had 234 COVID-positive patients, approximately 40% of its population. "Ventilator usage stayed at 90%," recalls Wood, "We were lucky we didn't have to go to the state to get 'emergency vents.' There were several facilities around us that did."

During the pandemic, Governor Kemp asked Grady to turn the Regional Coordinating Center, set up right after the flood, into the Georgia Coordinating Center. This call center and transfer portal assisted Georgia's overwhelmed critical access hospitals in finding facilities that could take their most seriously ill COVID-19 patients. The Georgia Coordinating Center also oversaw the transfer of patients to the alternate care site at the Georgia World Congress Center in Atlanta. However, the Georgia World Congress Center wasn't used as much as expected because families were reluctant to send their COVID-infected loved ones hours away for care.

Two waves of civil unrest

A few days after the death of George Floyd on May 25, 2020, protests began in Atlanta in several locations, all less than a mile from Grady: Centennial Olympic Park, the Governor's Mansion, the Mercedes-Benz Center, the Capitol, and City Hall. "Between May 29 and June 5, there were several hundred arrests in response to civil unrest," says Wood.

Then everything calmed down—until June 12, when Rayshard Brooks was shot and killed by Atlanta police following a complaint that he had fallen asleep in a restaurant drive-through lane. "The protests started again, and ultimately that restaurant was burned down by protesters," says Wood. "The protesters set up an encampment there."

These protests had a notable impact on Grady. "We had increased trauma volume from the protests and increased COVID volume because all these people were congregating and not many were wearing masks," says Wood. "But even more

Related Joint Commission Requirements

The Joint Commission's revised "Emergency Management" (EM) chapter had not yet been developed at the time of Grady's December 2019 flood. Nevertheless, Grady's implementation of the following foundational EM concepts outlined in the chapter helped the hospital manage the flood and other emergencies:

- The hospital has a comprehensive emergency management program that utilizes an all-hazards approach (EM.09.01.01).
- Hospital leadership provides oversight and support of the emergency management program (EM.10.01.01).
- The hospital conducts a hazard vulnerability analysis utilizing an all-hazards approach (EM.11.01.01).
- The hospital plans and conducts exercises to test its emergency operations plan and response procedures (EM.16.01.01).

  Note: *The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.*

significant was the emotional impact on our staff, the majority of whom are persons of color." Grady's leadership held listening sessions and hired a chief equity officer for the health system. Hospital leaders and staff also participated in a White Coats for Black Lives event with more than 1,000 Grady team members in attendance.

Hospital closures

In 2022 two Atlanta hospitals closed within less than six months of each other, resulting in a loss of 700 beds. One was the only other Level 1 adult trauma center in the city. In fact, there are only six Level 1 trauma centers in the entire state of Georgia. After the second hospital closure, "we made a commitment to never go on trauma diversion," Wood emphasizes.

Since then, Grady has seen a 35%–40% increase in trauma volume, a 40% increase in obstetrics-gynecology and NICU patients, and a 27% increase in arrivals by helicopter. Because the hospital's rooftop helipad can fit only two helicopters at a time, a second helipad is being built.

The Georgia Coordinating Center is busier than ever, fielding approximately 18,000 calls a month and identifying where to best send patients—"protect resources" being its guiding principle. Patients with minor, non-life-threatening trauma (such as a wrist fracture) can now be treated in non-trauma hospitals, with staff receiving additional training and telehealth support as needed.

Hospitals have started to recognize and notify the coordinating center when they are overwhelmed. "There is a lot of education about understanding your capabilities and calling for help when you need it," says Wood.

After the second hospital closed, the state gave Grady $130 million in American Rescue Plan Act (ARPA) funding to add 166 new inpatient beds. Construction will be completed in 2024. In addition, Grady opened a 650,000-square-foot

outpatient facility in March 2023 and will open four new outpatient clinics in a medically underserved area of Atlanta.

Four-year "flood-iversary"

It has now been more than four years since Grady's disastrous flood. Wood calls December 7 the hospital's "flood-iversary."

"There is no one drill, tabletop exercise, or plan that got us through that flood, which was catastrophic," Wood reflects. "It was the culmination of every single drill we've ever done, every tabletop exercise, every discussion, every real-world event—and that training on incident command and emergency management—that helped us be successful during that absolute catastrophe. And that's true of those other emergencies as well." EML

Tips and Insights

Top 5 Prep Strategies for Your Survey's EM Session

Have all needed documents organized and accessible, identify and prepare staff who will participate (and their backups), and be able to concisely describe your EM exercises and any real emergencies since your last survey

The Joint Commission requires organizations surveyed by *Life Safety Code*®* surveyors to participate in an emergency management (EM) session during the on-site survey. At present, this includes hospitals, critical access hospitals, ambulatory surgery centers, and freestanding emergency departments affiliated with hospitals. (Note that in certain circumstances, a clinical surveyor may conduct the EM session.)

The EM portion of your survey may seem intimidating—after all, emergencies, by definition, are unpredictable—and demonstrating preparedness may seem like a need to predict the future. But there's no need to feel overwhelmed. The EM standards make this process simple and focus on the most important aspects of preparedness. Also, the EM portion of the survey itself is divided into four parts to ensure that all areas are appropriately covered. (Keep in mind that some states such as Florida and California have additional requirements.)

To help your team prepare for survey, here are five strategies for success:

1. Familiarize your staff with what has changed since your last survey.

The Joint Commission's standards and elements of performance (EPs) are continuously evolving. The "Emergency Management" (EM) chapter has recently been overhauled for hospitals, critical access hospitals, and home care. Ambulatory care and office-based surgery practices are coming next, with other accreditation programs due to get their revised EM chapters soon. Ensure that key leaders in emergency management have the most current version of the EM standards for your organization so that they can begin preparations for the EM session during the survey.

2. List and prepare all documents needed for the EM session.

During the survey, the surveyor(s) may ask to review specific documents related to the emergency operations plan (EOP), policies, and procedures. The Joint Commission updates its *Survey Activity Guide* each year, which includes a list of required documents and outlines how the EM session will be conducted. The EM documents listed below must be updated and reviewed at least every two years (see also EM.17.01.01, EP 3):

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- EM program
- Hazard vulnerability analysis
- Emergency operations plan and policies and procedures
- Communications plan
- Continuity of operations plan
- Recovery plan
- Education and training program
- Exercise/testing program
- Program evaluation (after-action reports/improvement plans)
- Unified and integrated EM program (if applicable)
- Transplant programs (if applicable)

Prior to the survey, make certain that the documents have current dates and are still relevant to your organization's needs.

The organization should also provide its written education and training program, which describes the training provided to staff initially and on an ongoing basis (for hospitals and critical access hospitals only). In addition, the surveyors will need to see documentation of the annual exercises that were conducted and the future exercises that the organization plans to conduct. Along with the key documents listed in Figure 1, the organization should have all after-action reports and improvement plans available.

Key leaders involved in emergency management should have access to the EM documents, which should be saved to a dedicated space that is easy to find on survey day. Survey day can be stressful enough; make it easy for your staff to find what they need to share with the surveyor(s). Consider having both electronic copies and printed copies of these documents. And remember that electronic copies should be accessible by multiple individuals in case the primary owner is unavailable on survey day.

It can also be helpful to indicate which Joint Commission standards and EPs correspond to each document. When standards are updated, this will help you to check the document and revise it, if necessary.

3. Review the most frequently scored EPs and ensure that you comply.

By accessing your *Survey Analysis for Evaluating Risk*® (*SAFER*®) dashboard, you can view the most frequently scored EM EPs across organizations for a specific time frame. (Contact your Joint Commission account executive if you need help finding this information.)

Obviously, you must comply with all the EM standards and EPs, and you should review all relevant requirements before your survey. Many organizations fail to conduct the required number of EM exercises annually and have not updated

key components of their EOP. The hazard vulnerability analysis (HVA) should be comprehensively assessed and not just "rubber-stamped"; the identified risks (potential or unknown) should be thoroughly evaluated, with pertinent EM exercises conducted and staff educated, as appropriate. Also, pay attention to those challenging EPs that are frequently scored for noncompliance. These are often the focus of many surveyor questions.

4. Identify and prepare your staff for the EM session.

As listed in the *Survey Activity Guide*, participants in the EM session should include multidisciplinary team members from several departments (as listed below) and those who routinely participate in the EM committee, as applicable, as well as local EM officials or Department of Health representatives:

- EM program lead
- Senior leadership
- Nursing leadership
- Medical staff
- Pharmacy
- Infection prevention and control
- Facilities engineering
- Safety and security
- Ancillary staff
- Information technology

This breadth of representation is not required, however, because it could be challenging to assemble all of these people with unannounced surveys. Individuals attending the EM session should be keenly involved in all aspects of emergency preparedness and be able to add to the discussion about planning, logistics, mitigation, and so on.

Along with other survey preparation documents, keep a list of appropriate individuals to participate in the survey, including their current contact information. Review and update your staff list frequently to account for staff turnover, transfers and promotions, and changes to contact information. Also, make sure that each participant has a backup in case the primary participant is unavailable on survey day.

All participants should have access to The Joint Commission's educational materials to prepare for the survey, and they should be included in any staff meetings about the survey. Empower these individuals to suggest changes to your organization's policies and procedures to better align with Joint Commission standards. After all, they know your organization's EM capabilities the best.

5. Familiarize staff with the four parts of the EM session.

The EM session is divided into four parts:

In **Part 1, Actual Events**, your staff needs to be prepared to discuss any emergencies your organization has experienced since your last survey, the impact they had on your organization (such as operations, ability to provide services, length of the incident, and so on), how these events were risk-stratified on your HVA, and mitigation and preparedness measures you had in place at the time of the event. The surveyor(s) may further discuss how the event affected the six critical areas of emergency management: communications, staff management, patient care and support activities, safety and security, resources and assets, and utilities. Having the after-action reports available would be helpful to guide this discussion.

For **Part 2, EM Exercises**, your staff needs to be prepared to discuss the annual emergency exercise(s) the organization conducted. Based on your accreditation program type, at least one of these exercises must be operations based (a full-scale community-based or a functional exercise), and the other annual (or biennial) exercise may be another operations-based exercise or a discussion-based exercise (tabletop, seminar, and so on). Staff should be prepared to discuss why these exercises were selected (such as a past experience, known risks or hazards, and/or recent changes to the organization's EOP, policies, or procedures). Your exercises should include testing and evaluating of one or more of the six critical EM areas, identifying opportunities for improvement. All exercises and responses to actual emergencies must be documented, with the documents available to the surveyor(s) upon request.

In **Part 3, Education and Training**, your staff needs to be prepared to discuss the EM education and training that has been provided to your staff, including volunteers, in the past 12 to 36 months. EM.15.01.01, EP 1 (for hospitals and critical access hospitals only), requires a written education and training plan; this documentation should be available to the surveyor(s) upon request.

In **Part 4, Program Evaluation**, your staff needs to be prepared to discuss your evaluation process, lessons learned, and actions taken to improve your EM program. This would include any recommendations or actionable items provided to senior leaders and the outcomes of those decisions.

Poised for success

By following these five strategies, your organization will improve its ability to discuss any challenges your organization faced and how you overcame them. Just as you carefully and thoroughly prepare for emergencies, prepare for your EM survey session. EML

Toolkit

Prepare for Cybersecurity Threats

Cybersecurity breaches are on the rise in health care, with ransomware attacks becoming common. The provided Cyberattack Tabletop Exercise will help organizations prevent and respond to a cyberattack

Cybersecurity incidents are on the rise in health care, according to the US Department of Health and Human Services Office for Civil Rights (OCR). From 2018 to 2022, the number of large breaches reported to the OCR increased by 93%, from 369 to 712. In that period, breaches involving ransomware in particular climbed 278%.

Cyberattacks can compromise patient safety and privacy, leading to disruptions in care and the theft of personal data. Such breaches can also be financially devastating for health care organizations (HCOs). Accordingly, The Joint Commission recently issued a new *Sentinel Event Alert*, "Preserving Patient Safety After a Cyberattack," which focuses on maintaining patient care after a cybersecurity breach and emphasizes the importance of staff training.

Emergency management exercises are a key component of training and help HCOs understand their vulnerabilities and shortcomings in their emergency operations planning. Tabletop exercises, which are discussion-based, are an excellent way to test and improve your organization's ability to prevent, respond to, and recover from a cyberattack.

On the following pages, JCR's "Cyberattack Tabletop Exercise" tool is provided to help your organization with cybersecurity emergency preparedness. The tool contains two parts: a playbook that describes the purpose and scope of the exercise, the suggested participants, after-action activities, and relevant Joint Commission Emergency Management (EM) standards; and a slide deck cyberattack scenario with discussion questions for staff.

This tool is one of more than 70 resources in JCR's forthcoming new book *The Joint Commission Emergency Management Toolkit*. You can download a customizable version of both the playbook and the scenario. EML

Part 1: Playbook

Cyberattack Tabletop Exercise

Disclaimer: This exercise is provided as an example only and must be modified as appropriate for your organization. The information is a basic structure for a similar tabletop exercise for your organization. Your organization will need to revise it accordingly to suit your staffing, resources, needs, and health care setting.

Purpose and Scope of the Tabletop Exercise

- The organization has prioritized the threat of a cyberattack due to its recent prevalence and likelihood as well as its potential impact on operations and patient safety and care quality. After planning and preparing for such a threat, the organization is conducting a tabletop exercise to identify gaps in and test its emergency management plans.
- This exercise will satisfy The Joint Commission's requirement for an exercise of choice (Standard EM.16.01.01).
- This tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario(s) and a set of prepared questions designed to challenge the emergency plan.
- The participants include the following:
  - Appropriate organization staff who would be responding in the event of an actual cyberattack
  - Evaluators who will be assessing organization staff response to the emergency scenario
  - Observers who will be learning or providing any necessary information upon request
  - Appropriate community partners, such as law enforcement and vendors of software and hardware used by the organization, that would be involved in responding to a cyberattack
- The exercise concludes with an After-Action Report that documents the organization's response to the exercise and identifies areas for improvement. This report draws upon participant feedback and evaluator observations and assessments.

Objectives of the Exercise

1. To evaluate and test the organization's policies and procedures, in particular, its decision-making process and actions in the event of a cyberattack
2. To understand the extent of the potential impact of a cyberattack on clinical operations, including patient safety and quality of care
3. To identify opportunities to improve cybersecurity in the organization, bolster continuity of operations as they pertain to information technology, and thereby safeguard patient safety and quality of care

Suggested Participants in the Exercise

- **Organization participants**
  - Managers or designated representatives from the following departments:
  - Information management (IM)/Information technology (IT)
  - Security
  - Clinical staff
  - Facilities management
  - Administration
  - Legal
  - Public relations/communications
- **Community partners (if possible)**
  - Law enforcement
  - Vendors for software/hardware products used by the organization

Roles and Responsibilities of Participants During the Exercise

1. A **facilitator** from the organization's Emergency Management Committee does the following:
   - ☐ Coordinates/sets up the exercise
   - ☐ Conducts any pre-exercise briefings, particularly for evaluators who may have questions about the scenario and the assessment questions. The facilitator should ensure that the evaluators have the expected/proper responses to the assessment questions so that they can judge responses adequately. (Responders should not have access to the proper responses to the assessment questions before or during the exercise, as they are the ones being tested.)
   - ☐ Provides participants with any relevant information and documents (for example, the organization's policy and procedure regarding potential cyberattacks)
   - ☐ On the day of the exercise, briefs all participants on the exercise's scope, objectives, participants, and limitations
   - ☐ Directs/narrates the action of the cyberattack scenario, using the slideshow presentation
   - ☐ Facilitates discussion of the scenario, asking the responders the probe questions about their decisions and actions during the cyberattack
   - ☐ Ensures that the exercise stays on course with the scenario and re-directs the group as necessary
   - ☐ Collects completed evaluations and participant feedback surveys
   - ☐ Participates in the After-Action Report development for the tabletop exercise
2. **Evaluators** should include a member of the IT/IM staff with knowledge of the organization's cybersecurity policies and procedures; a leader from clinical care services (such as a nurse manager); a leader from the administrative support staff; and, if available, a cybersecurity expert from state law enforcement or the Federal Bureau of Investigation (FBI). Evaluators do the following:
   - ☐ Observe the exercise and listen to the discussion.
   - ☐ Take notes on the discussion.
   - ☐ Record observations related to the stated objectives.
   - ☐ Guide the post-exercise debriefing.
   - ☐ Provide the facilitator with their written observations and evaluations of the exercise, including strengths and opportunities for improvement.
3. **Observers** (optional) do the following:
   - ☐ Observe the exercise and listen to the discussion.
   - ☐ Provide information on relevant topics, if asked by discussion participants.
   - ☐ Otherwise refrain from interacting with other participants.
4. **Responders—both organization staff and community partners**—do the following:
   - ☐ Participate in discussion about their intended response to the scenario, as applicable to their job duties and responsibilities.
   - ☐ Answer the probe questions from the facilitator during the scenario.
   - ☐ Provide written feedback on the exercise.

Emergency Management Processes and Procedures to be Tested During the Exercise This specifically, includes those actions and decisions generally required of organization staff in response to a cyberattack.

1. **Information management (IM) and information technology (IT) staff:**
   - ☐ Respond to reports of a potential cyberattack, determine validity, and gather information.
   - ☐ Secure information systems against further incursion or damage.
   - ☐ Evaluate extent/scope of incursion or damage, and determine potential cause(s) and effects.
   - ☐ Collaborate with vendors and law enforcement as appropriate to address the problem.
   - ☐ Verify data integrity.
   - ☐ Restore information systems to secure status.
2. **Clinical staff:**
   - ☐ Report information systems problems and irregularities promptly to the IM/IT department.
   - ☐ Implement alternative processes for data collection and management to avoid further incursion or damage.

(continued)

Emergency Management Processes and Procedures to be Tested During the Exercise (continued)

- ☐ Instruct affected patients on management of affected medical equipment or devices, as applicable.
- ☐ Return to normal operation when security is restored.

3. **Public relations (PR) staff:**
   - ☐ Manage communications about the cyberattack from patients, the public, and the media, as appropriate.
   - ☐ With leadership and information management (IM) guidance, identify and communicate key points to share with various audiences.
   - ☐ Present a consistent, accurate message about the cyberattack and the organization's response.
4. **Legal staff:**
   - ☐ Contact law enforcement and interface with them about the cyberattack as appropriate.
   - ☐ Manage any legal implications of the cyberattack and the organization's response.
5. **All organization staff:**
   - ☐ Demonstrate knowledge of organization-specific cybersecurity education and actions to take in response to cyberattacks.

Emergency Management Education and Orientation to be Tested During the Exercise (specifically related to cybersecurity)

- **All organization staff** receives training on cybersecurity, prevention of cyberattacks, recognition of cyberattacks, and cyberattack response procedures as part of their initial orientation and annual emergency preparedness education and competency.
- **All organization staff** receives training on the use of information technology equipment, including hardware and software, and medical equipment, as relevant and applicable to their job duties and responsibilities.
- **Information management and information technology staff** receives training from vendors on potential cybersecurity risks related to their products, including preventive actions and response procedures. This includes installation, use, updates and upgrades, patches, and decommissioning/transitioning to new systems, as applicable to their job duties and responsibilities.

Note: *Facilitator Begins the Exercise Scenario. See Cyberattack Tabletop Exercise.*

After the Exercise

1. **Debriefing**
   - ☐ Immediately after the exercise, all participants will go through a debriefing about the experience. Evaluators will have an opportunity to ask questions based on their notes and observations and determine whether the exercise addressed one or more of the six critical areas of emergency management:
     - Communications
     - Staffing
     - Patient care and support
     - Safety and security
     - Resources and assets
     - Utilities
   - ☐ Evaluators will give feedback to the responders on their performance, including both strengths and opportunities for improvement.
   - ☐ Responders and observers also provide their thoughts and feedback on the exercise during the debriefing.
2. **Written feedback and evaluations**
   - ☐ All participants complete a feedback survey and return it to the facilitator or Emergency Management Committee representative within 48 hours of the exercise.
   - ☐ Evaluators also provide their written observations, assessments, and suggestions for corrective actions by the designated deadline to the facilitator or Emergency Management Committee representative.

(continued)

After the Exercise (continued)

3. After-Action Report

- ☐ The facilitator or other designated Emergency Management Committee representative collects all these documents, analyzes them, and uses the information to generate an after-action report (AAR) using the organization's established template. The AAR is provided to the EM Committee for use in its performance improvement activities.
- ☐ The AAR is among the EM documents that must be provided to the organization's senior leadership.

References*

Joint Commission Emergency Management (EM) Standard EM.16.01.01, Element of Performance (EP) 1: The [organization] describes in writing a plan for when and how it will conduct annual testing of its emergency operations plan. The planned exercises are based on the following:

- Likely emergencies or disaster scenarios
- Emergency operations plan and policies and procedures
- After-action reports (AAR) and improvement plans
- The six critical areas (communications, staffing, patient clinical and support services, safety and security, resources and assets, and utilities)

Joint Commission Standard EM.16.01.01, EP 2: The [organization] is required to conduct two exercises per year† to test the emergency operations plan.

- One of the annual exercises‡ must consist of an operations-based exercise as follows:
  - — Full-scale, community-based exercise; or
  - — Functional, facility-based exercise when a community-based exercise is not possible
- The other annual exercise must consist of either an operations-based or discussion-based exercise as follows:
  - — Full-scale, community-based exercise; or
  - — Functional, facility-based exercise; or
  - — Mock disaster drill; or
  - — Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

Exercises and actual emergency or disaster incidents are documented (after-action reports).

* At the time of this publication, the new "Emergency Management" (EM) chapter was in place for hospitals, critical access hospitals, home care organizations, and (effective July 1, 2024, ambulatory care organizations and office-based surgery practices). All other accreditation programs still have the former EM standards structure and numbering system.

† The following types of accredited organizations are required to conduct emergency management exercises at least annually rather than at least twice a year: ambulatory care organizations, behavioral health care and human services organizations, home health agencies, laboratories, office-based surgery practices, and rural health clinics.

‡ For those accredited organizations required to conduct at least one EM exercise per year, a full-scale community-based exercise or (or if that opportunity is not available) a functional facility-based exercise must be conducted at least every other year.

Part 2: Exercise Scenario

Tabletop Exercise Scenario: Cyberattack

Joint Commission Resources

Phase 1

It's early Tuesday morning after a three-day holiday weekend. Some of the organization's administrative support staff are returning to work after time off. The atmosphere is cheerful. People are sharing stories and catching up with coworkers.

An administrative assistant in the scheduling department opens their computer and is confronted with dozens of emails that have piled up over the weekend. The administrative assistant notices one e-mail with the subject line, "URGENT: Update password." The source appears to be the organization's IT department, so the assistant opens the email and clicks the link and is directed to a website that looks like the organization's intranet log-in page. The assistant follows directions to enter the existing password, then a new password. The system returns the assistant to their desktop, and the workday seems to continue normally for a time.

However, this administrative assistant has unknowingly opened a phishing email and has introduced malware to the organization's information systems, the effects of which will soon become apparent throughout the organization.

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Phase 1: Probe/Assessment/Discussion Questions for Responders

1. What education is provided to organization staff to assist them with identifying and responding to at-risk emails? Rather than clicking on the suspicious email, what should the administrative assistant have done?
2. How frequently is cybersecurity education provided to staff? Is it part of orientation? And does IT test or assess staff's knowledge of cybersecurity? How so? And how often? Where and how are this education and orientation documented?
3. Is this erroneous action of opening the at-risk email something that can be quickly identified and mitigated by IT security?
4. If the administrative assistant did identify it as a risky email and reported it to IT, what would IT security do to address the situation? Explain the procedure.

Joint Commission Resources

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Phase 2

It is now Wednesday morning, a day after the risky email was opened, and the organization is not yet aware of the cyberattack.

Meanwhile, two dozen patients have contacted the main number for the organization, asking about email messages from the organization offering copies of their medical records for a fee of $199. Most suspect a scam and want to know if the email is actually from the organization. Unfortunately, some believed the email was legitimate and called to complain about the price. And still others provided their credit card information, only to have their credit card companies alert them to unauthorized charges in the thousands of dollars.

By the end of the day, the number of people calling the organization about the suspicious email has grown to 329.

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Phase 2: Probe/Assessment/Discussion Questions

1. At what point is this situation escalated to leadership? What would next steps be for leadership to handle this fraudulent email?
2. Have you involved your incident management team?
3. Have IT, Risk Management, Privacy/Compliance, and the Public Relations office been notified? What should each department be doing at this point in response to this situation?
4. If IT identifies the cause as a cybersecurity attack, what are your next steps? What is everyone's role and responsibility to handle this situation? Please explain the response in detail, including timing and accountabilities.

Joint Commission Resources

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Phase 3

It is now Wednesday afternoon, and the problem seems to have spread beyond the initial fraudulent email to patients outside the organization. Now, patient care nurses and others across the organization are encountering problems with the electronic health record (EHR) system. Records are loading very slowly, closing unexpectedly, needing to be reopened, and/or not opening at all. This is slowing down provision of care and frustrating staff and patients.

In one case, an emergency department patient experienced an adverse medication event because their EHR could not be accessed prior to providing acute care. The patient's family is furious. They make a scene in the emergency department and threaten to sue the organization and post their displeasure on social media.

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Phase 3: Probe/Assessment/Discussion Questions

1. What actions do you take at this point? What are the responsibilities of each affected and/or responsible department in response to this situation?
2. Are there any proactive measures you need to take?
3. How is your incident management team structured?
4. If your network is compromised, how will you communicate internally?
5. What external agencies will you notify? When do you involve law enforcement and/or hardware/software vendors?
6. How do you resolve this problem and bring the organization back to normal operations?

Joint Commission Resources

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Other Learning Opportunities from The Joint Commission and Joint Commission Resources

In-Person Education

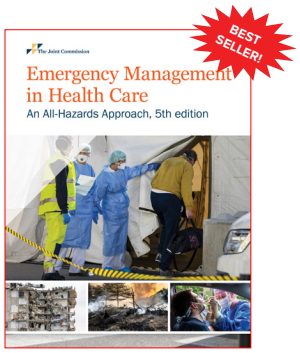
- Emergency Management Standards Base Camp Pre-Conference (in-person only), Orlando, Florida, June 18, 2024

  Offered the day prior to The Joint Commission's Emergency Management Conference, this program will provide in-depth discussion of the functional components of The Joint Commission's "Emergency Management" (EM) chapter, including the six critical areas of emergency management: communications, staffing, patient clinical and support activities, safety and security, resources and assets, and utilities. Understanding The Joint Commission's EM chapter and helping your organization maintain compliance with these standards are essential for emergency preparedness.

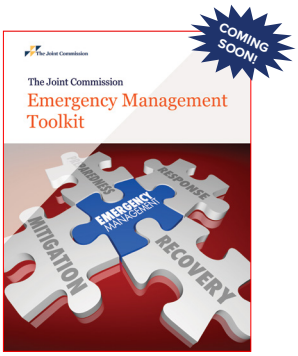
- Emergency Management Conference (in-person only), Orlando, Florida, June 19–20, 2024

  At Joint Commission Resources' 2024 Emergency Management Conference, health care EM professionals from around the country will share lessons learned from real emergencies and offer insights and best practices for developing and evaluating EM plans, emergency exercises, and EM education and training curricula. This conference is also a great networking opportunity for those in health care emergency management. In addition, this year's conference will feature an exhibit hall. For information on exhibiting, e-mail jcrsponsorships@jcrinc.com.

JCR Publications



Emergency Management in Health Care: An All-Hazards Approach, Fifth Edition



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