"Are We Ready?"

The BCPWHO* Survey on
Disaster Preparedness of US Healthcare Facilities

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*Business Continuity Planning Workgroup for Healthcare Organizations

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An Insider's Perspective

Why we did the survey

Baystate Medical Center (Baystate Health) – Springfield, MA

Children's Hospital & Regional Medical Center – Seattle, WA

Caritas Christi Healthcare System -- Boston, MA

Background Documents

AMA/APHA report (http://www.ama-assn.org/ama1/pub/upload/mm/415/final_summit_report.pdf)

HSPD-21 (http://www.whitehouse.gov/news/releases/2007/10/20071018-10.html)

Joint Commission 1/1/08 revised standards, EC.4.10 and EC.4.20

Regional Approaches to Hospital Preparedness (http://www.upmc-biosecurity.org/website/resources/publications/2007_orig-articles/2007-04-09-regionalapproacheshospitalprep.html)

Trust for America's Health (http://healthyamericans.org/reports/bioterror07/)

Report Findings

Recurring Issues

► Public health, EMS and medical preparedness at state and local levels are poorly integrated.

► "Under-preparedness" to deal with mass casualties, including lack of capability for coordinating resources.

► No all-hazards standards or guidelines for measuring health system preparedness.

► No shared platform for public health and healthcare organizations to build advocacy and legislative agenda to improve and sustain preparedness.

(Improving health system preparedness for terrorism and mass casualty events – Recommendations for Action (AMA & APHA, July 2007)

Priority Categories & Issues

- ► Collaboration, coordination and planning

- ► Communications and information exchange

- ► Disaster recovery and health systems

- ► Education and training

- ► Funding

- ► Health system surge capacity

- ► Legislation and regulation

- ► Research

The Survey

Participants

- ► Academic Medical Centers
- ► Trauma Centers
- ► Community Hospitals
- ► Health Clinics
- ► Children's Hospitals
- ► Psychiatric Hospitals
- ► Long Term Care Facilities
- ► Health Systems
- ► Others

Survey Organization

► Response Profile

► Emergency Management Infrastructure

► Disaster Preparedness

► Business Continuity Planning/Disaster Recover Planning

► Hazard & Vulnerability Assessment/Business Impact Analysis
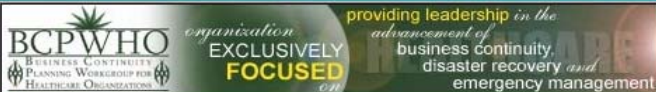
► Communications

► General Comments

Survey Distribution

Listservs & Forum
- ► BCPWHO
- ► Yahoo groups EM
- ► IAEM
- ► Region 1 ESF8
- ► MA DPH Hospital
- ► American Nurses Association
- ► Emergency Nurses Association

Other
- ► AMA TIIDE Partners
- ► State Hospital Preparedness/Bioterrorism Coordinators
- ► Personal contacts
- ► Forwarded to colleagues by primary recipients

US Hospital Facility/Healthcare System Emergency Management Survey

8%

US Healthcare Facility/Healthcare System Emergency Management Survey

Sponsored by the Business Continuity Planning Workgroup for Healthcare Organizations (www.bcpwho.org)

The American Medical Association and the American Public Health Association convened a series of meetings in 2005, 2006 and 2007, by 18 national medical, dental, nursing, public health, hospital and EMS organizations to deliberate the deficiencies in the medical and public health disaster response system and the lack of necessary integration and interoperability between key components of this system. The report produced by this Leadership Summit, titled "Improving Health System Preparedness for Terrorism and Mass Casualty Events – Recommendations for Action," published in July 2007, serves as a national call for action. The Leadership Summit developed 53 recommendations to strengthen health system preparedness, response and resilience to terrorism and other catastrophic events. The AMA/APHA Leadership Summit is now working on ways to "give legs" to their recommendations. Their report defines "where we should be."

Also, The Joint Commission's new Revisions to Emergency Management Standards for Critical
Access Hospitals, Hospitals, and Long Term Care (Environment of Care standards EC.4.10 and EC.4.20) will become effective January 1, 2008. The revised standards emphasize a "scalable" approach that can help manage the variety, intensity, and duration of the disasters that can affect a single organization, multiple organizations, or an entire community. The revisions also stress the importance of planning and testing response plans for emergencies during conditions when the local community cannot support the health care organization. These standards define "where we are expected to be."

This survey you are asked to complete will help establish "where we are now." While not intended to be all inclusive of the priority areas of the report or responsive to all the revised Joint Commission standards, the survey is designed as a first attempt to establish a baseline for important areas of disaster preparedness and emergency management for hospitals and other healthcare facilities and organizations.

Conferences such as the upcoming Joint Commission "Preparing for the Unknown: 'Are You Ready?' Emergency Preparedness Conference" in October 2007 will help identify "what we need to do to get there." The developers of this survey plan to present the survey results at this conference.

We ask that you complete this survey and provide the information requested in as much detail as possible. Your input, as the emergency management/disaster preparedness expert for your facility/organization is essential in helping "us", individually and collectively, to be better prepared "for the next one."

Contact Ric Skinner (ric.skinner-gis@bhs.org) or Jennifer Davey (jd9913@gmail.com) with questions and/or comments.
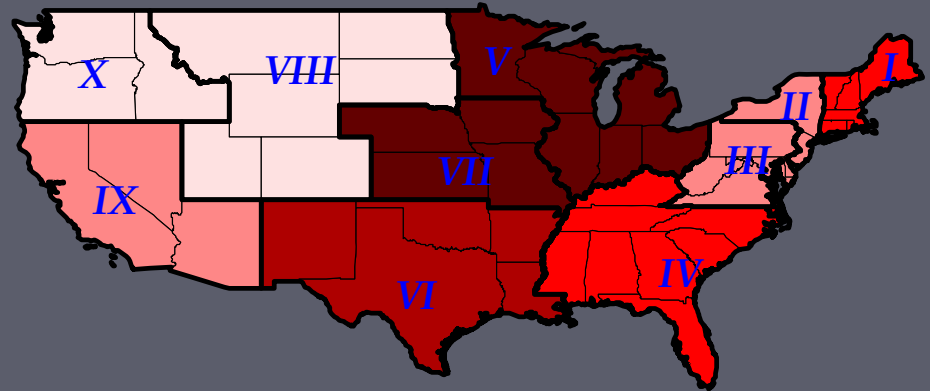
Analysis

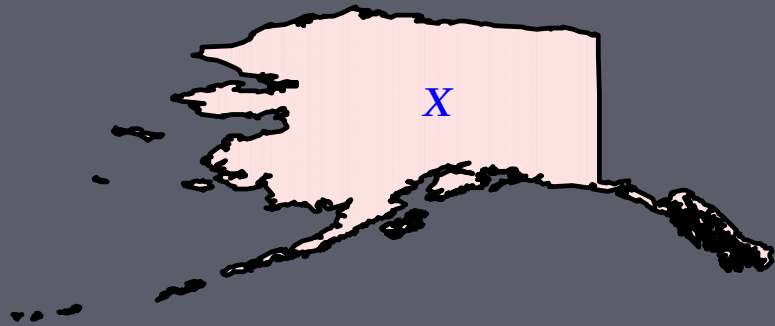# Analysis

Analysis

- ► Challenges
- ► Duplicate responses
- ► Cleaning up the entries
- ► The "Others"
- ► Multiple facilities in single response
- ► Multiple states in single response
- ► Free text information

Results

► Survey Period -- August 13 to Sept. 28, 2007 (46 days)

► 1429 Total Individual Surveys

► 1055 Total Acceptable Individual Surveys

Percent Total Responses by ESF-8 Region
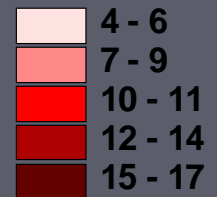
Results & Discussion
Response Profile - % of Total (n=1429)

- "Other" 6%
- Acad. Med. Ctr. 7%
- Health Syst 10%
- Trauma Ctr. 10%
- Child. Hosp. 4%
- Psych. Hosp. 3%
- Long Term Care 19%
- Comm. Hosp. 34%
- Comm. Health Ctr. 6%
- Specialty Hosp. 1%
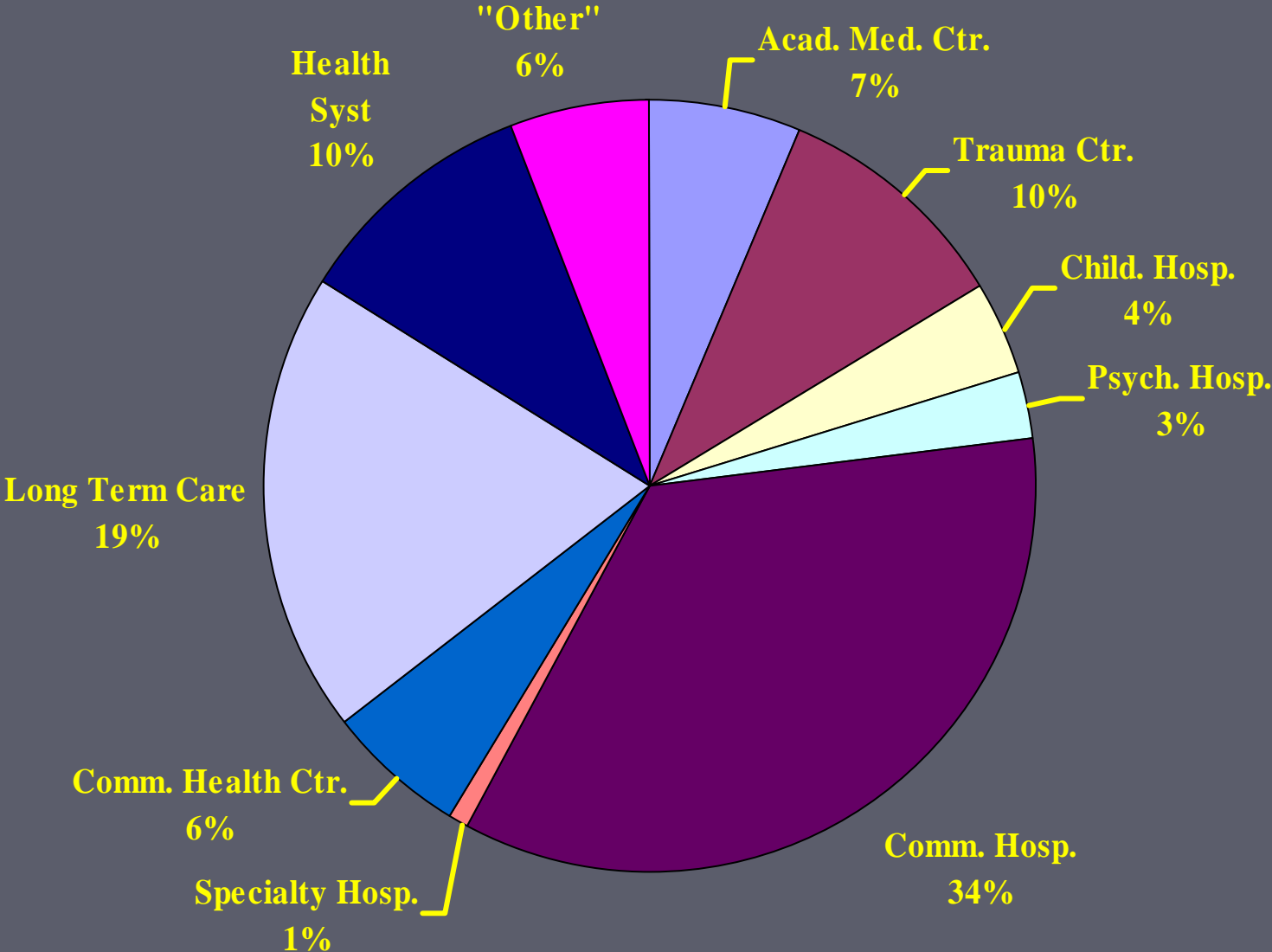
Results and Discussion

Key observations

► A Standardized Framework for Healthcare Emergency Management Does Not Exist

► Significant Gaps and Inequity Exist Weakening the Preparedness of the *Overall* Health System

► Business Continuity Planning/Disaster Recover Planning is Not Standard Practice in Healthcare

► Emergency Management Communications in Healthcare is Fractured

Tying it all together

Key Observations

► A Standardized Framework for Healthcare Emergency Management Does Not Exist

AMA/APHA Report

► Research

► Education and training

► Funding

► Legislation and regulation

Tying it all together

Key Observations

► Significant Gaps and Inequity Exist Weakening the Preparedness of the *Overall* Health System

AMA Report

► Collaboration, coordination and planning

► Health system surge capacity

Tying it all together

Key Observations

► Business Continuity Planning/Disaster Recover Planning is Not Standard Practice in Healthcare

AMA Report

► Disaster recovery and health systems

Tying it all together

Key Observations

► Emergency Management Communications in Healthcare is Fractured

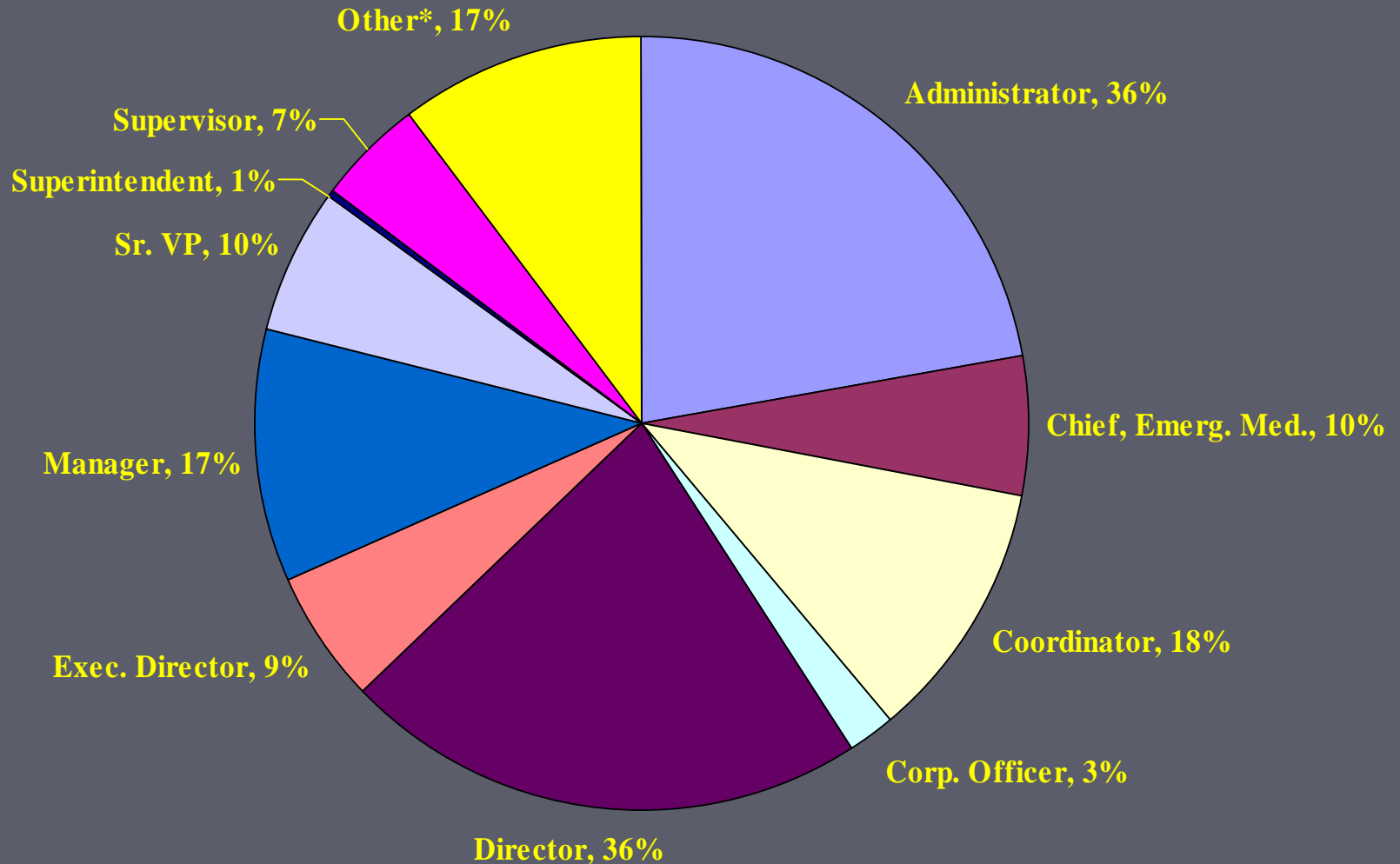AMA Report

► Communications and information exchange

Key Observation #1

A Standardized Framework for Healthcare Emergency Management Does Not Exist

Titles Responsible for EM Functions Across Survey Respondents

Other*, 17%
Supervisor, 7%
Superintendent, 1%
Sr. VP, 10%
Manager, 17%
Exec. Director, 9%
Director, 36%
Corp. Officer, 3%
Coordinator, 18%
Chief, Emerg. Med., 10%
Administrator, 36%
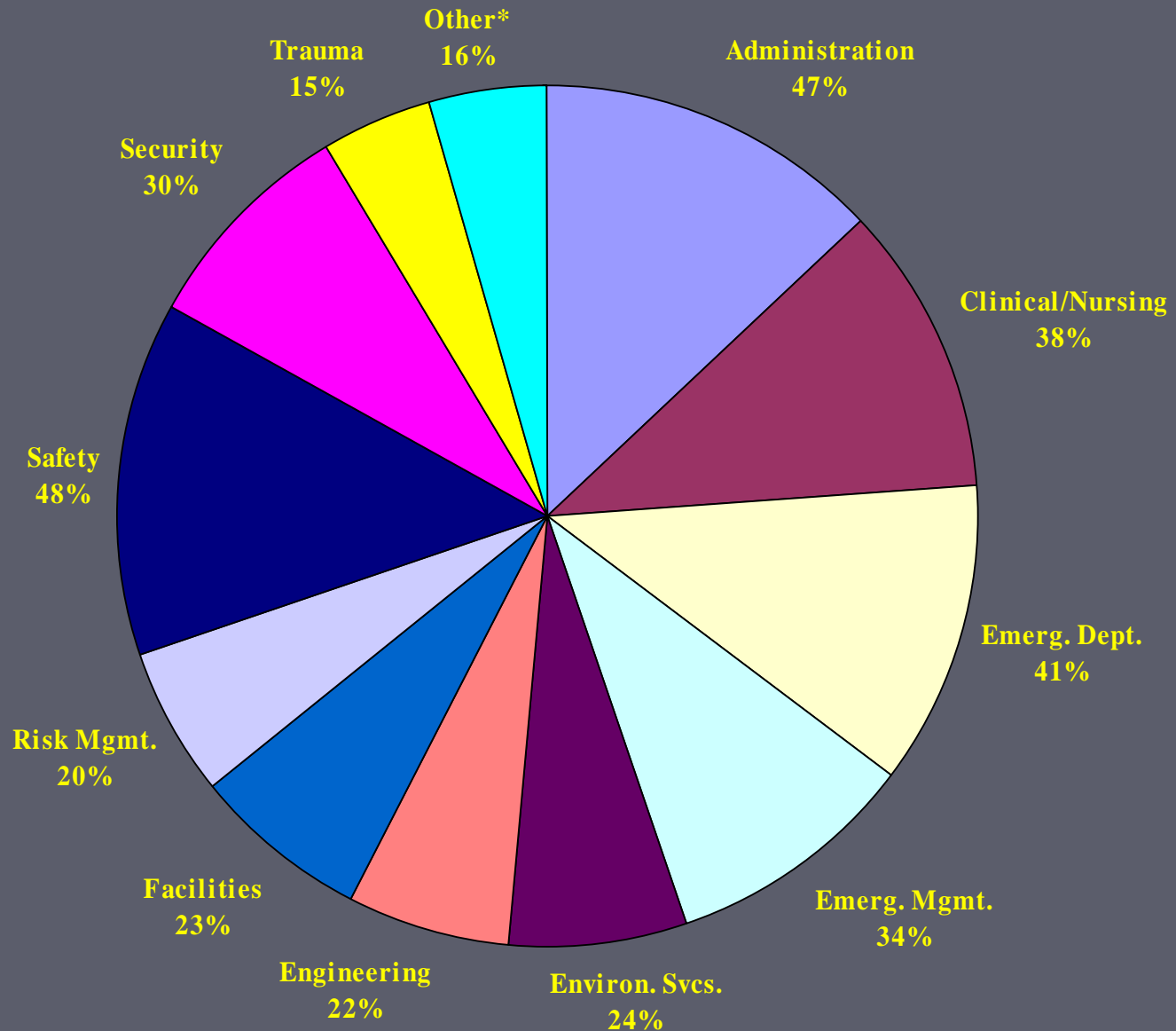
Emergency Management Committee that Meets on a Regular Basis

- "Other" 60%
- Acad. Med. Ctr. 92%
- Trauma Ctr. 93%
- Child. Hosp. 91%
- Psych. Hosp. 95%
- Comm. Hosp. 81%
- Specialty Hosp. 71%
- Comm. Health Ctr. 78%
- Long Term Care 62%
- Health Syst 91%
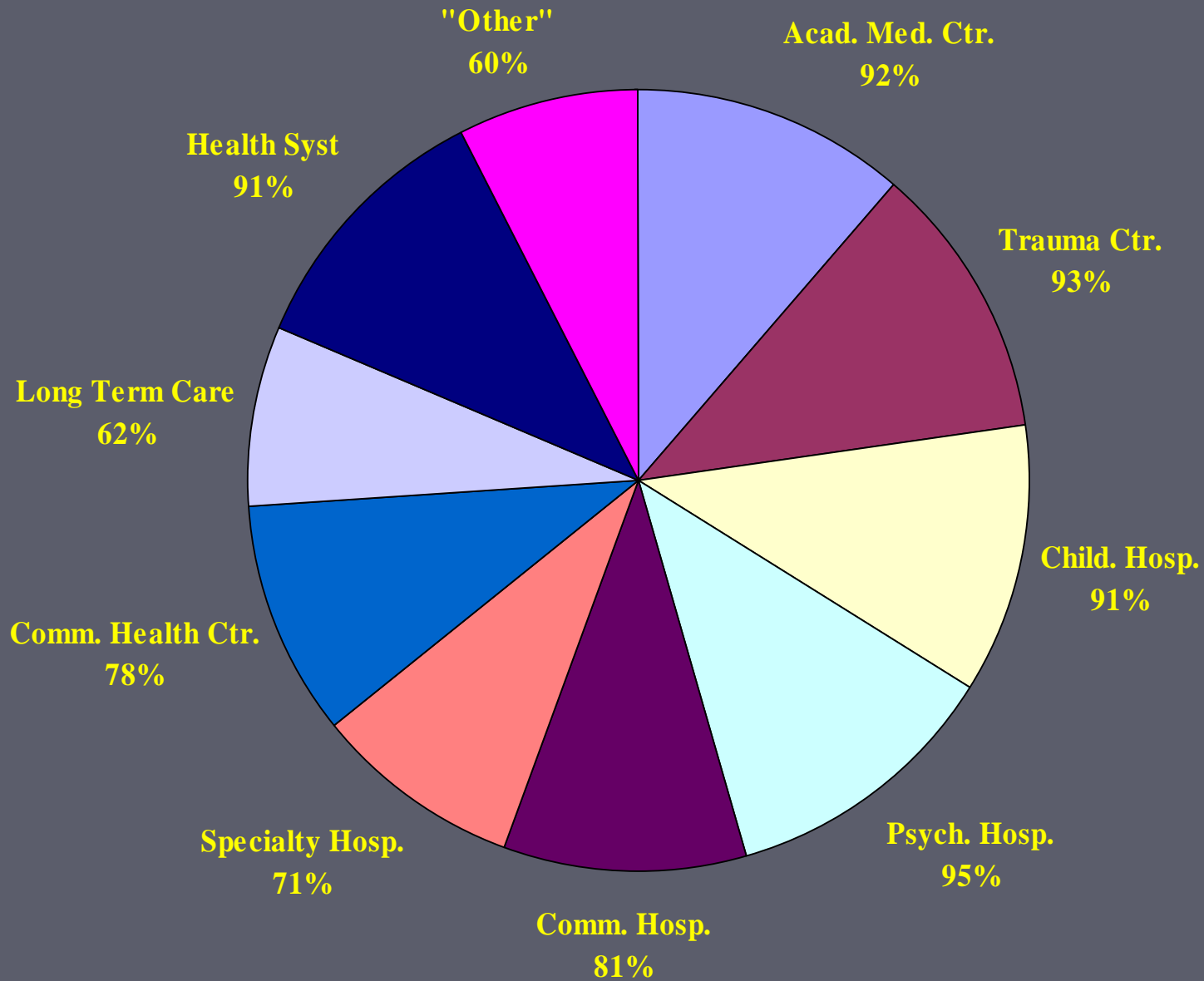
Key Observation #2

Significant Gaps and Inequity Exist Weakening the Preparedness of the *Overall* Health System

Facility has Emergency Management Program

- "Other" 69%
- Acad. Med. Ctr. 89%
- Trauma Ctr. 87%
- Child. Hosp. 91%
- Psych. Hosp. 95%
- Comm. Hosp. 86%
- Specialty Hosp. 71%
- Comm. Hlth. Clinic 83%
- Long Term Care 75%
- Health Syst. 91%
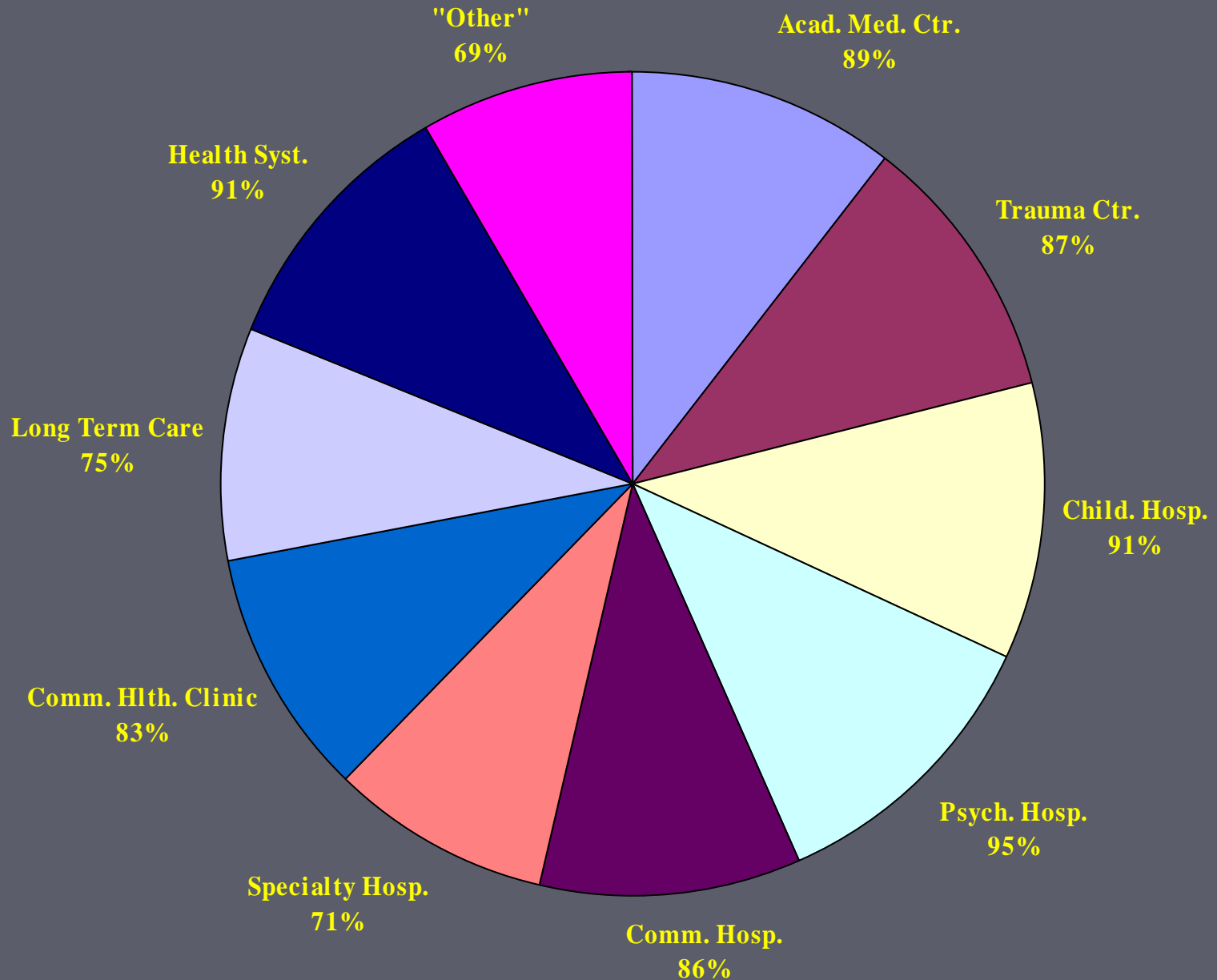
EM staffing by Percent of Respondents

Don't Know, 6%

Outside Consultants, 1%

No FTEs, 18%

>3 FTEs, 8%

3 FTEs, 1%

1-3 FTEs, 11%

1 FTE, 16%

<1FTE, 35%
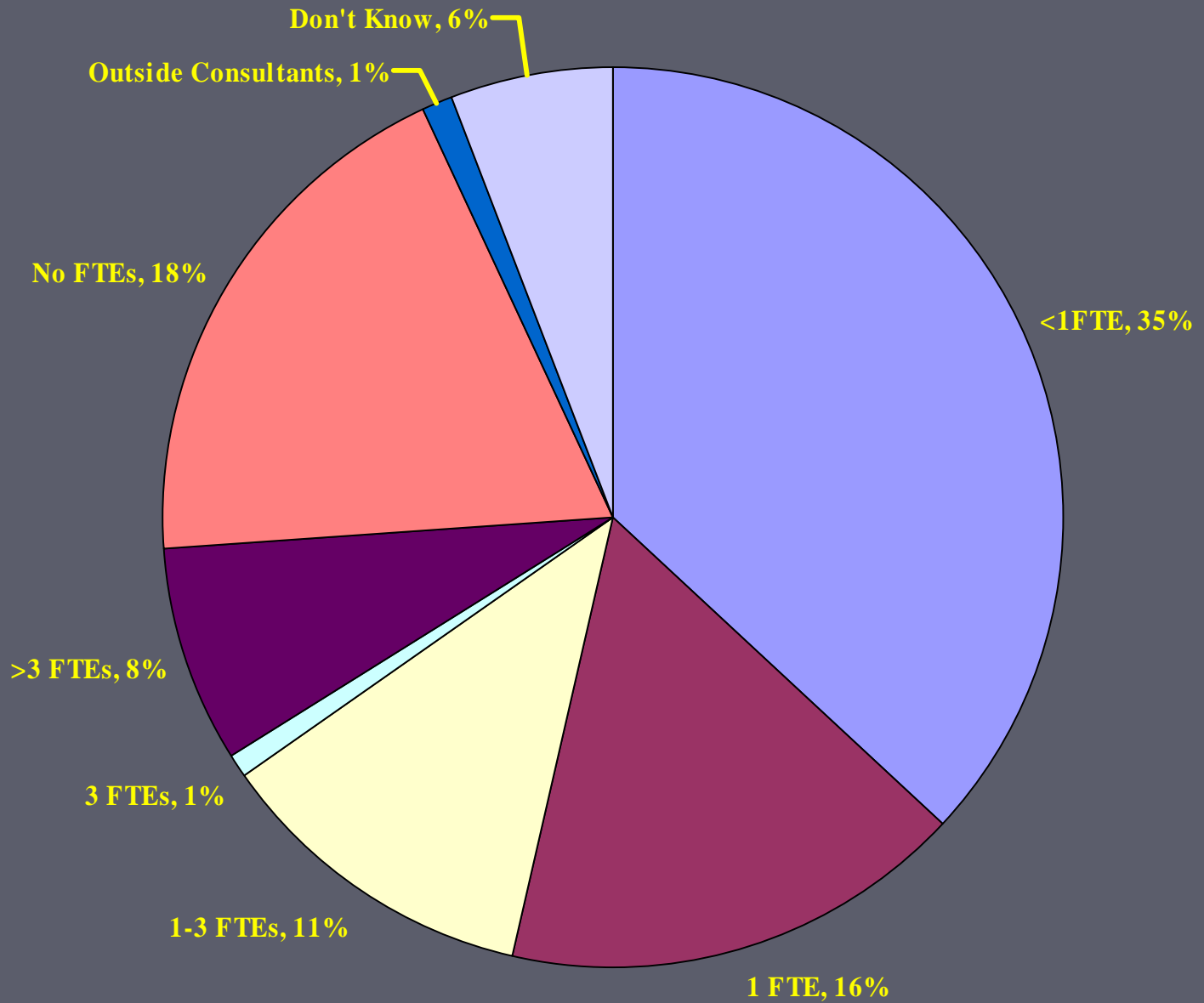
Staffing of EM Responsibility Reported by JC Accredited Facilities

Don't Know 4%

Outside Consultants 1%

No FTEs 18%

<1FTE 45%

>3 FTEs 5%

3 FTEs 0%

1-3 FTEs 10%

1 FTE 17%
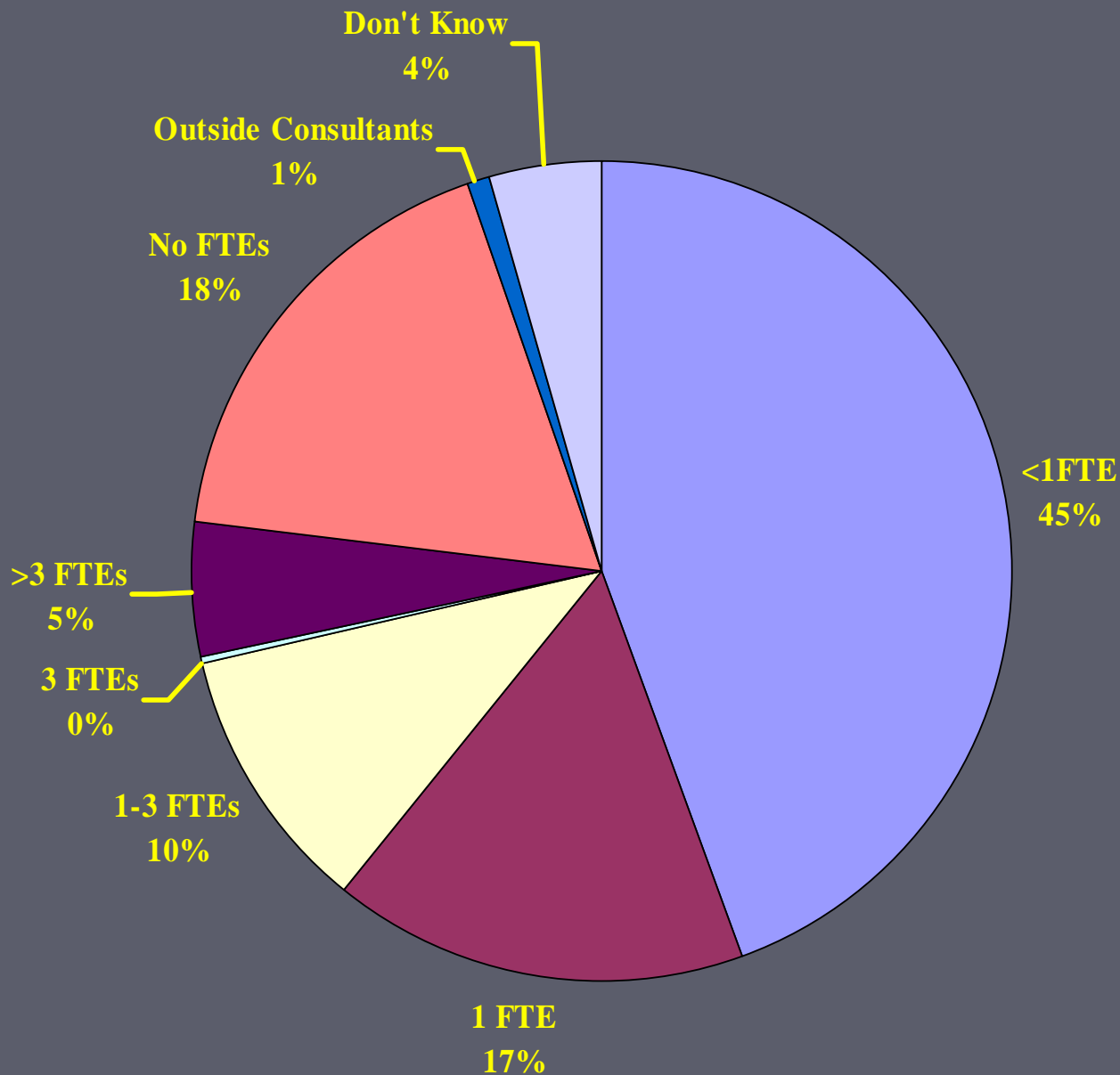
NIMS

NIMS Compliance required for funding but not all respondents were candidates or recipients of funding. Also only 65% were compliant at the time of the survey.

Drills & Exercises

Drills/Exercises

Within past month	10%
Within past 6 months	35%
Within past year	20%
Within past 2 years	4%

Duration

Less than 1 hr.	13%
1 to 2 hr.	20%
2 to 4 hr.	36%
More than 4 hr.	13%

Activated EOC in Past 3 Years

Natural	**43%**
Technological	**42%**
Human-caused	**25%**

Key Observation #3

Business Continuity Planning/Disaster Recover Planning is Not Standard Practice in Healthcare

45% have a Business Continuity Plan (BCP)

► **69% BCP and Emergency Management Program by same group**

► **62% have an IT Disaster Recovery Plan (DRP)**

► **81% BCP and DRP by same group**

- ▶ **81% have conducted HVA and/or BIA**

- ▶ **75% have an HVA**

- ▶ **78% done with local EM**

Key Observation #4

Emergency Management Communications in Healthcare is Fractured

Results – Communications
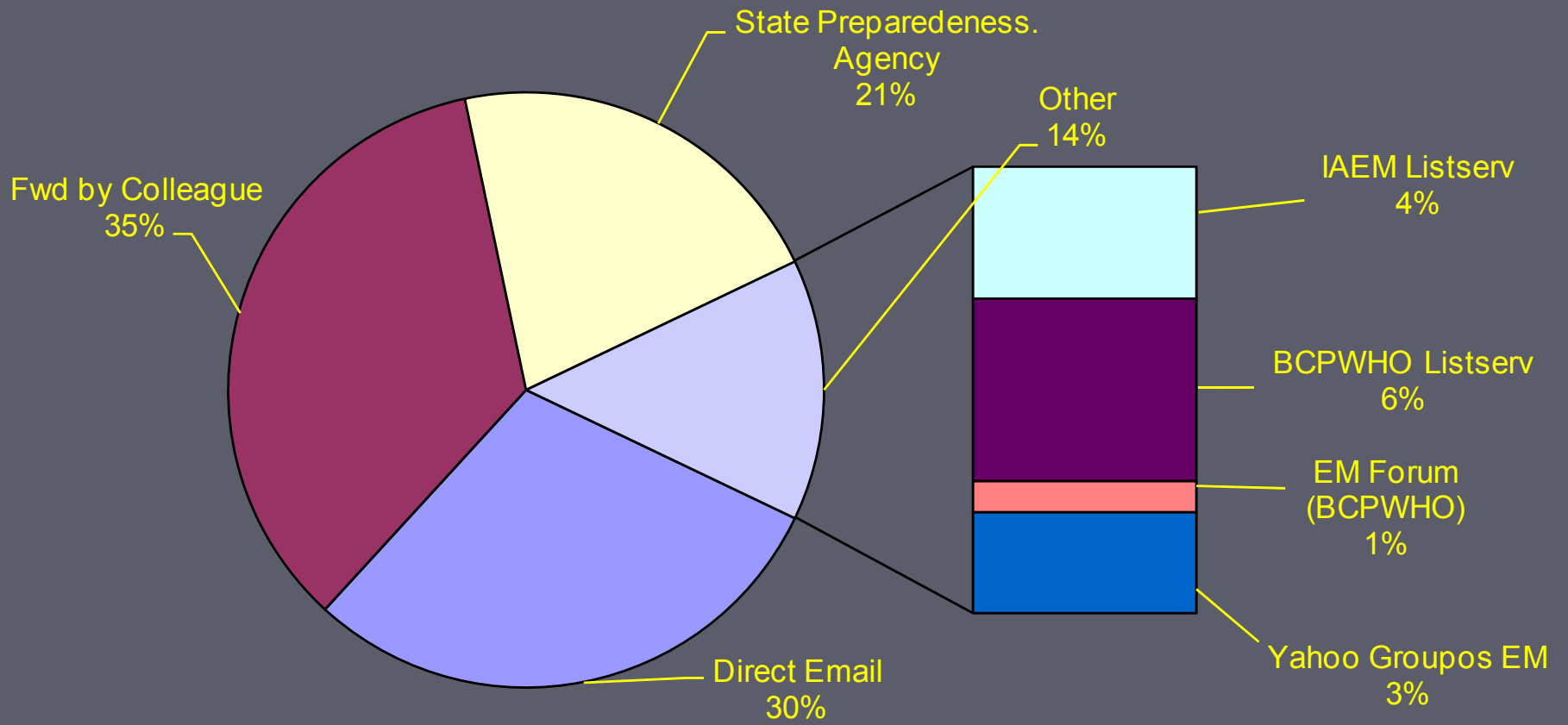
How Emergency Managers Stay in Contact within Health facilities
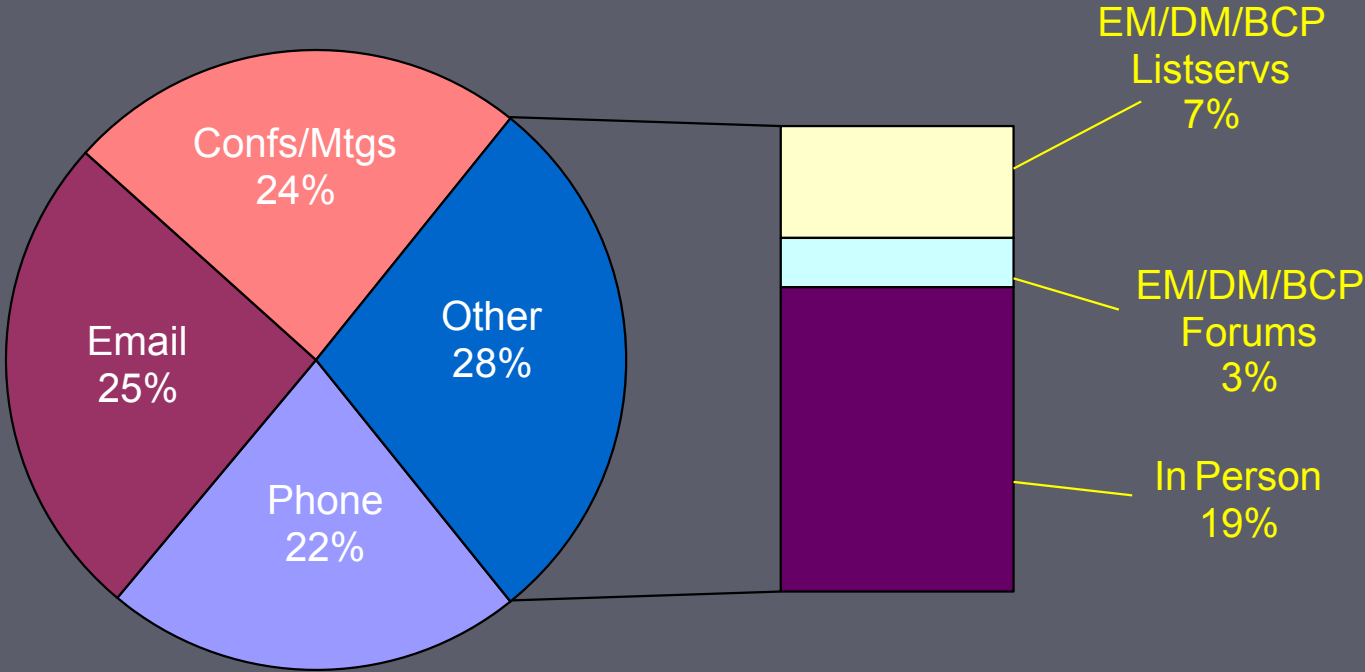
Conclusions

Looking to the Future: The following are required using the AMA/APHA recommendations & a National Workgroup to carry out deliverables

► A Standardized Framework

► System Wide Planning & Funding

► BCP/DRP Integration

► Communications Framework & Forum

Observation	Conclusion	Recommendation
A Standardized Framework for Healthcare Emergency Management Does Not Exist	A Standardized Framework	*Form National Work Group on Hospital/Healthcare Preparedness -- involve key stakeholders: AMA, APHA, hospitals, healthcare facilities* ►Standardize healthcare preparedness terminology ►Standardize HVA tools and processes
Significant Gaps and Inequity Exist Weakening the Preparedness of the *Overall* Health System	System Wide Planning & Funding	►Advocate for improvements in funding sources and funding administration
Business Continuity Planning/Disaster Recover Planning is Not Standard Practice in Healthcare	BCP/DRP Integration	►Educate on need for integration of HVA, BCP, DRP, BIA
Communications in Healthcare is Fractured	Communications Framework & Forum	►Establish a single national communications/collaboration portal ►Identify ways to improve interoperability within and between healthcare facilities

Healthcare Workgroup Portal

<u>Healthcare Preparedness Collaboration Portal</u>

- ► Productivity: by doing more consensus communications virtually

- ► Interoperability: for processes and potentially different systems

- ► Contact management/maintenance where needed, ie, the portal would keep the contact info fresh and feed it to different systems, ie, notification

- ► Continuous improvement lifecycle: (with above productivity) get the leads to review, test and then continually upgrade collaboration, i.e., plans, interoperations, etc.

- ► Topical Forums and Listservs linked to others

- ► Clearinghouse for grants, AARs, lessons learned, best practices

	A	B	C	D	E	F	G
G18				f_x			

KAISER PERMANENTE. Medical Center Hazard and Vulnerability Analysis   **KAISER PERMANENTE.** Medical Center Hazard and Vulnerability Analysis

This document is a sample Hazard Vulnerability Analysis tool. It is not a substitute for a comprehensive emergency preparedness program. Individuals or organizations using this tool a... compliance with applicable la...

Issues to consider for **preparedness** include, but are not limited to:
1. Status of current plans

INSTRUCTIONS:

Evaluate potential for event an... the hazard specific scale. Ass... possible time (e.g. during pea...

Please note specific score cri...

Issues to consider for **probab...**
1. Known risk
2. Historical data
3. Manufacturer/vendo...

Issues to consider for **respon...**
1. Time to marshal an...
2. Scope of response
3. Historical evaluation...

Issues to consider for **human...**
1. Potential for staff de...
2. Potential for patient...

Issues to consider for **proper...**
1. Cost to replace
2. Cost to set up temp...
3. Cost to repair
4. Time to recover

Issues to consider for **busine...**
1. Business interruptio...
2. Employees unable t...

Instructions | Natura...

Ready

Kai_Perm_HVA_11-29-01.xls [Compatibility Mode] - Microsoft Excel

Home | Insert | Page Layout | Formulas | Data | Review | View | Acrobat

| F6 | | f_x | 0 = N/A | 1 = High | 2 = Moderate | 3 = Low or none |

	A	B	C	D	E	F	G	H	I
	EVENT	**PROBABILITY**	**SEVERITY = (MAGNITUDE - MITIGATION)**						**KAISER PERMANENTE.**
			HUMAN IMPACT	**PROPERTY IMPACT**	**BUSINESS IMPACT**	**PREPARED-NESS**	**INTERNAL RESPONSE**	**EXTERNAL RESPONSE**	**RISK**
		Likelihood this will occur	Possibility of death or injury	Physical losses and damages	Interuption of services	Preplanning	Time, effectivness, resouces	Community/ Mutual Aid staff and supplies	Relative threat*
SCORE		0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
7	Hurricane								0%
8	Tornado								0%
9	Severe Thunderstorm								0%
10	Snow Fall								0%
11	Blizzard								0%
12	Ice Storm								0%
13	Earthquake								0%
14	Tidal Wave								0%
15	Temperature Extremes								0%
16	Drought								0%
17	Flood, External								0%
18	Wild Fire								0%
19	Landslide								0%
20	Dam Inundation								
21	Volcano								0%
22	Epidemic								0%
23	**AVERAGE SCORE**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

NATURALLY OCCURRING EVENTS

Threat increases with percentage.

RISK = PROBABILITY * SEVERITY

Start

"Making the Case for an Interoperable, Multi-Scale Healthcare/Hospital Information Domain"

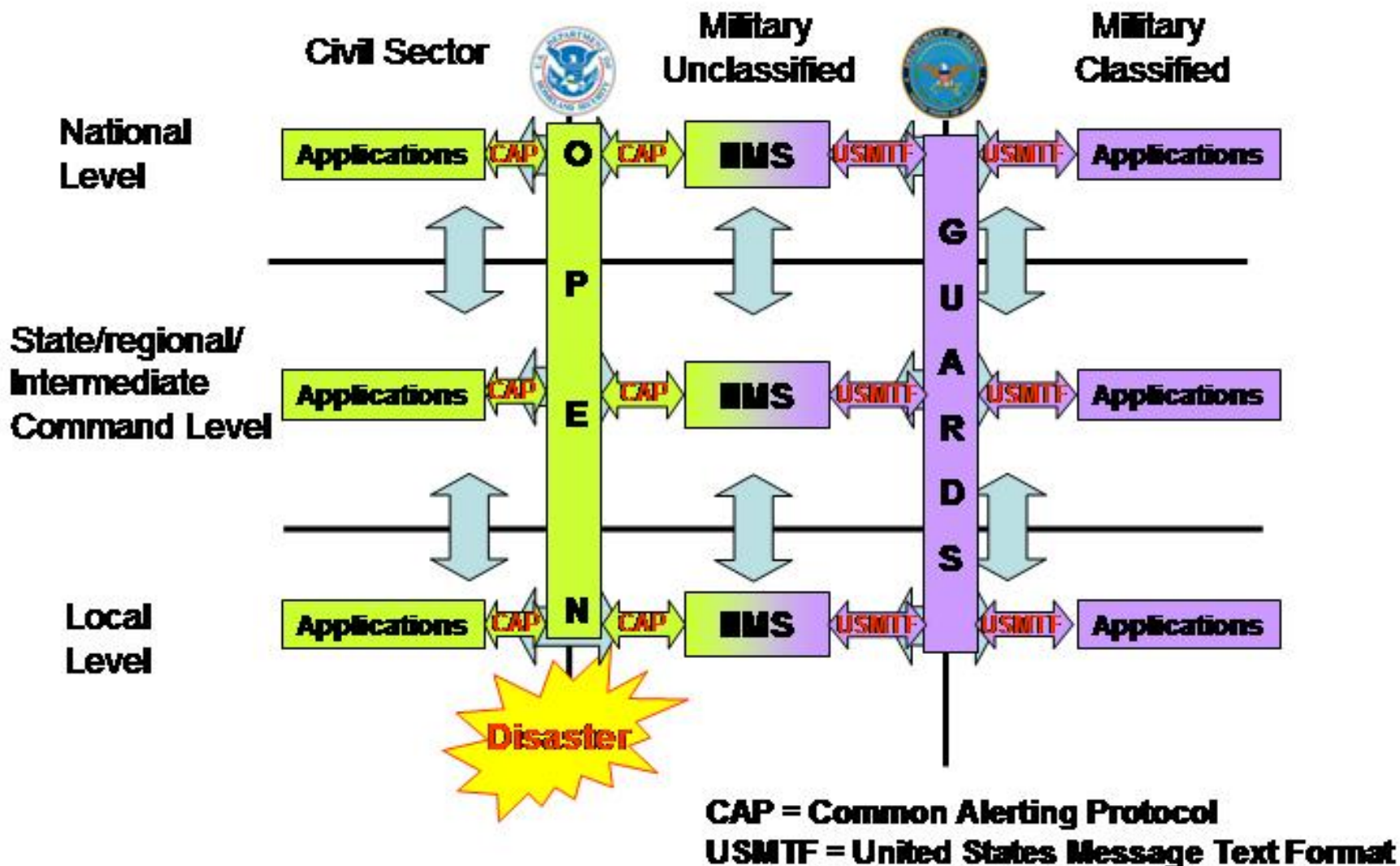*For want of a bed, a hospital was lost*

For want of a hospital a community was lost

For want of a community a region was lost

For want of a region a Nation was lost.

… And all for the want of a hospital bed.

Trial 3.27 Integrated Information Management System Operational and Systems View

The purpose of this survey is <u>not</u> …

<u>*to make a statement*</u>

The purpose of this survey is …

<u>*to make a difference!*</u>