Chapter 12 Emergency Management NFPA Crosswalk		
12.1.2	This chapter shall be the source for emergency management in health care facilities and is based on the foundations of NFPA 1600, Standard on Disaster/Emergency Management and Business Continuity Programs.	
		Documents and Comments
Table 12.3	Emergency Management Categories	
	Emergency Management Category Definition	
1	Those inpatient facilities that remain operable to provide advanced life support services to injured responders and disaster victims. These facilities manage the existing inpatient load as well as plan for the influx of additional patients as a result of an emergency	
2	Those inpatient or outpatient facilities that augment the critical mission. These facilities manage the existing inpatient or outpatient loads but do not plan to receive additional patients as a result of an emergency or do not plan to remain operable should essential utilities or services be lost.	
12.5	Emergency Management Category 1 and Emergency Management Category 2 Requirements.	
12.5.1	All emergency management Category 1 and emergency management Category 2 health care facilities shall be required to develop and maintain an emergency management program that addresses all program elements as prescribed in	
12.5.3	Program Elements.	
12.5.3.1 Hazard Vulnerability Analysis (HVA).	12.5.3.1.1 A hazard vulnerability analysis (HVA) shall be conducted to identify and prioritize hazards that pose a threat to the facility and can affect the demand for its services.	See DIS M -46
	12.5.3.1.2* The hazards to be considered shall include, but	
	not be limited to, the following:	
	(1) Natural hazards (geological, meteorological, and biological (2) Human-caused events (accidental or intentional) (3) Technological events	
	12.5.3.1.3 The analysis shall include the potential impact of the hazards on conditions including, but not limited to, the following:	
	(1)*Continuity of operations (2) Care for new and existing patients/residents/clients (3) Health, safety, and security of persons in the affected area (4) Support of staff (5) Property, facilities, and infrastructure (6) Environmental impact (7) Economic and financial conditions (8) Regulatory and contractual obligations (9) Reputation of, or confidence in, the facility identified in the HVA with input from the community	
	. 12.5.3.1.4 The facility shall prioritize the hazards and threats	Participation with Onodaga County EM committee and the CNY HEPC
12.5.3.2	Mitigation.	

	12.5.3.2.1 The facility shall develop and implement a strategy to eliminate hazards or mitigate the effects of hazards that cannot be eliminated.	See AAR improvement item tracking
	12.5.3.2.2 A mitigation strategy shall be developed for priority hazards defined by the HVA.	
	12.5.3.2.3 The mitigation strategy shall consider, but not be limited to, the following:	
	(1) Use of applicable building construction standards	See Hosptial planning and EHS
	(2) Hazard avoidance through appropriate land-use practices	
	(3) Relocation, retrofitting, or removal of structures at risk	
	(4) Removal or elimination of the hazard	See MCN System for EOP hazard specific annexes
	(5) Reduction or limitation of the amount or size of the hazard	
	(6) Segregation of the hazard from that which is to be protected	
	(7) Modification of the basic characteristics of the hazard	
	(8) Control of the rate of release of the hazard	
	(9) Provision of protective systems or equipment for both cyber or physical risks (	
	10) Establishment of hazard warning and communications procedures (	
	11) Redundancy or duplication of essential personnel, critical systems, equipment, information, operations, or materials	
12.5.3.3	Preparedness.	
	12.5.3.3.1 The facility shall prepare for any emergency as determined by the HVA by organizing and mobilizing essential resources.	See DIS M -46 and other resposne annexes for top hazards
	12.5.3.3.2 The facility shall maintain a current, documented inventory of the assets and resources it has on-site that would be needed during an emergency, such as medical, surgical, and pharmaceutical resources; water; fuel; staffing; food; and linen.	DIS M 17 COOP Plan, DIS M -49 Emergent Supplies
	12.5.3.3.3 The facility shall identify the resource capability shortfalls from 96 hours of sustainability and determine if mitigation activities are necessary and feasible.	DIS M 17 COOP plan
	12.5.3.3.4 The facility shall establish a protocol for monitoring the quantity of assets and resources as they are utilized.	DIS M 49 Emergent Supplies
	12.5.3.3.5 The facility shall write an emergency operations plan (EOP) that describes a command structure and the following critical functions within the facility during an emergency:	
	(1) Communications	DIS J-00
	(2) Resources and assets	DIS M 49 & all response annexes
	(3) Safety and security	DIS M-15 Bomb Threat , DIS M -82 Shelter In Place, DIS M 78 Lockdown

	(4) Clinical support activities	See EOP on MCN all are realted
	(5) Essential utilities	DIS M-70 Untility Failure, DIS M 75 Water Plan
	(6) Exterior connections	
	(7) Staff roles	DIS M-80 Core Knowlage Matrix, DIS M-37 Employee recommondations
12.5.3.3.6 Critical Function Strategies. During the development of the EOP, the facility shall consider the strategies required in 12.5.3.3.6.1 through 12.5.3.3.6.8 in order to manage critical functions during an emergency within the facility.		
	12.5.3.3.6.1 Communications. The facility shall plan for the following during an emergency:	
	(1) Initial notification and ongoing communication of information	See DIS J-00
	and instructions to staff	
	(2) Initial notification and ongoing communication with the	
	external authorities	
	(3) Communication with the following:	
	(a) Patients and their families (responsible parties)	
	(b) Responsible parties when patients are relocated to alternative	
	care sites	
	(c) Community and the media	
	(d) Suppliers of essential materials, services, and equipment	
	(e) Alternative care sites	DIS M 79
	(4) Definition of when and how to communicate patient information to third parties	DIS J-00
	(5)*Establishment of backup communications systems	
	(6) Cooperative planning with other local or regional health care facilities, including the following:	
	(a) Exchange of information relating to command operations, including contact information	CNY HEPC MOU and NYSDOH Healthcare Data System (HCS) and Efinds NYSDOH
	(b) Staffing and supplies that could be shared	
	(c) System to locate the victims of the event	
the following during an emergency:12.5.3.3.6.2 Resources and Assets. The facility shall plan for		
	(1) Acquiring medical, pharmaceutical, and nonmedical supplies	See DIS M -17 COOP Plan
	(2) Replacing medical supplies and equipment that will be used throughout response and recovery	
	(3) Replacing pharmaceutical supplies that will be consumed throughout response and recovery	
	(4) Replacing nonmedical supplies that will be depleted throughout response and recovery	

	(5) Managing staff support activities, such as housing, transportation, incident stress debriefing, sanitation, hydration, nutrition, comfort, morale, and mental health	See spiritual care and social work procedures & Family Care Annex DIS M 86
	(6) Managing staff family support needs, such as child care, elder care, pet care, and communication to home	DIS M-40 Evacuation Planning
	(7) Providing staff, equipment, and transportation vehicles needed for evacuation	
12.5.3.3.6.3* Safety and Security. The facility shall plan for the following during an emergency:		
	(1) Internal security and safety operations	See UPD procedure
	(2) Roles of agencies such as police, sheriff, and national guard	
	(3) Managing hazardous materials and waste	DIS M 45, and EHS policies
	(4) Radioactive, biological, and chemical isolation and decontamination	See DIS M 30
	(5) Patients susceptible to wandering	See policy M-04
	(6) Controlling entrance into the health care facility during emergencies	DIS M 78 Lockdown
	(7) Conducting a risk assessment with applicable authorities if it becomes necessary to control egress from the health care facility	See UPD procedure
	(8) Controlling people movement within the health care facility	
	(9) Controlling traffic access to the facility	
12.5.3.3.6.4 Clinical Support Activities. The facility shall plan for the following during an emergency:		
	(1) Clinical activities that could need modification or discontinuation during an emergency, such as patient scheduling, triage, assessment, treatment, admission, transfer, discharge, and evacuation	DIS M 40 Evacuation plan
	(2) Clinical services for special needs populations in the community, such as pediatric, geriatric, disabled, and chronically ill patients, and those with addictions (Emergency Management Category 1 only)	See internal policies as well as DIS M 69 Mass Casualty Annex and all resposne annexes in the EOP
	(3) Patient cleanliness and sanitation	See ES procedures
	(4) Behavioral needs of patients	See social work procedures
	(5) Mortuary services	DIS M 41 Mass Fatality Planning
	(6) Evacuation both horizontally and, when required by circumstances, vertically, when the environment cannot support care, treatment, and services	DIS M 40 Evacuation Plan
	(7) Transportation of patients, and their medications and equipment, and staff to an alternative care site(s) when the environment cannot support care, treatment, and services	
	(8) Transportation of pertinent patient information, including essential clinical and medication-related information, to an alternative care site(s) when the environment cannot support care, treatment, and services	
	(9) Documentation and tracking of patient location and patient clinical information	
12.5.3.3.6.5* Essential Utilities. The facility shall plan for the following during an emergency:		
	(1) Electricity	

	(2) Potable water	DIS M-70 Untility Failure, DIS M 75 Water Plan
	(3) Nonpotable water	
	(4) HVAC	
	(5) Fire protection systems	
	(6) Fuel required for building operations	
	(7) Fuel for essential transportation	
	(8) Medical gas and vacuum systems (if applicable)	
12.5.3.3.6.6 Exterior Connections. For essential utility systems		
in Emergency Management Category 1 facilities only, and based on the facility's HVA, consideration shall be given to the installation of exterior building connectors to allow for the attachment of portable emergency utility modules.		See Physical Plant documents
12.5.3.3.6.7 Staff Roles.		
	(A) Staff roles shall be defined for the areas of communications, resources and assets, safety and security, essential utilities, and clinical activities.	DIS M-80 Core Knowlage Matrix, DIS M-37 Employee recommondations
	(B) Staff shall receive training for their assigned roles in the EOP.	
	(C) The facility shall communicate to licensed independent health care providers their roles in the EOP.	DIS J-00
	(D) The facility shall provide staff and other personnel with a form of identification, such as identification cards, wrist bands, vests, hats, badges, or computer printouts.	See Upstate Policy
	(E) The facility shall include in its plan the alerting and managing of all staff in an emergency.	DIS J-00
12.5.3.3.6.8 The facility shall include the following in its EOP:		
	(1)*Standard command structure that is consistent with its community	DIS C-00
	(2) Reporting structure consistent with the command structure	
	(3) Activation and deactivation of the response and recovery phases, including the authority and process	
	(4) Facility capabilities and appropriate response efforts when the facility cannot be supported from the outside for extended periods in the six critical areas with an acceptable response, including examples such as the following:	DIS M 40 Evac plan
	(a) Resource conservation	DIS M 17 COOP Plan
	(b) Service curtailment	DIS M 40 Evac plan
	(c) Partial or total evacuation consistent with the staff's designated role in community response plan	
	(5) Alternative treatment sites to meet the needs of the patients	
12.5.3.3.7 Staff Education.		
	12.5.3.3.7.1 Each facility shall implement an educational program in emergency management.	See training program numbers on hand with dept.
	12.5.3.3.7.2 The educational program shall include an overview of the components of the emergency management program and concepts of the incident command system (ICS).	

	12.5.3.3.7.3 Individuals who are expected to perform as incident commanders or to be assigned to specific positions within the command structure shall be trained in and familiar with the ICS and the particular levels at which they are expected to perform.	
	12.5.3.3.7.4 Education concerning the staff's specific duties and responsibilities shall be conducted.	
	12.5.3.3.7.5 General overview education of the emergency management program and the ICS shall be conducted at the time of hire.	
	12.5.3.3.7.6 Department-/staff-specific education shall be conducted upon appointment to department/staff assignments or positions and annually thereafter.	
12.5.3.3.8* Testing Emergency Plans and Operations.		
	12.5.3.3.8.1 The facility shall test its EOP at least twice annually, either through functional or full-scale exercises or actual events.	See Exercise based AARs and real event AARs
	12.5.3.3.8.2 Exercises shall be based on the HVA priorities and be as realistic as feasible.	
	12.5.3.3.8.3 For Emergency Management Category 1 only, an influx of volunteer or simulated patients shall be tested annually, either through a functional or full-scale exercise or an actual event. (See Table 12.3.)	
	12.5.3.3.8.4 Annual table top, functional, or full-scale exercises shall include the following:	
	(1) Community integration	
	(2) Assessment of sustainability	
	12.5.3.3.8.5 For Emergency Management Category 1 only, if so required by the community designation to receive infectious patients, the facility shall conduct at least one exercise a year that includes a surge of infectious patients. (See Table 12.3.)	
	12.5.3.3.8.6 The identified exercises shall be conducted independently or in combination.	
12.5.3.3.9 Scope of Exercises.		
	12.5.3.3.9.1 Exercises shall be monitored by at least one designated evaluator who has knowledge of the facility's plan and who is not involved in the exercise.	SUNY Upstate meets or exceeds HSEEP FEMA guidance
12.5.3.3.9.2 Exercises shall monitor the critical functions.		
	12.5.3.3.9.3 The facility shall conduct a debriefing session not more than 72 hours after the conclusion of the exercise or the event.	SUNY Upstate meets or exceeds HSEEP FEMA guidance
	12.5.3.3.9.4 The debriefing shall include all key individuals, including observers; administration; clinical staff, including a physician(s); and appropriate support staff.	
	12.5.3.3.9.5 Exercises and actual events shall be critiqued to identify areas for improvement.	
	12.5.3.3.9.6 The critiques required by 12.5.3.3.9.5 shall identify deficiencies and opportunities for improvement based upon monitoring activities and observations during the exercise.	
	12.5.3.3.9.7 Opportunities for improvement identified in critiques shall be incorporated in the facility's improvement plan.	

	12.5.3.3.9.8* Improvements made to the emergency management program shall be evaluated in subsequent exercises.	
12.5.3.4 Response.		
	12.5.3.4.1* The facility shall declare itself in an emergency mode based on current conditions that leadership considers extraordinary.	
	12.5.3.4.2 Once an emergency mode has been declared, the facility shall activate its EOP.	
	12.5.3.4.3 The decision to activate the EOP shall be made by the incident commander designated within the plan, in accordance with the facility's activation criteria.	
	12.5.3.4.4 The decision to deactivate the EOP shall be made by the incident commander in the health care organization in coordination with the applicable external command authority.	
	12.5.3.4.5* The organization shall make provisions for emergency credentialing of volunteer clinical staff.	
	12.5.3.4.5.1 At a minimum, a peer evaluation of skill shall be conducted to validate proficiency for volunteer clinical staff.	
	12.5.3.4.5.2 Prior to beginning work, the identity of other volunteers offering to assist during response activities shall be verified.	
	12.5.3.4.5.3 Personnel designated or involved in the EOP of the health care facility shall be supplied with a means of identification, which shall be worn at all times in a visible location.	
	12.5.3.4.6 The command staff shall actively monitor conditions present in the environment and remain in communication with community emergency response agencies during an emergency response.	
	12.5.3.4.7 When conditions approach untenable, the command staff, in combination with community emergency response agencies, shall determine when to activate the facility evacuation plan.	
	12.5.3.4.8 Evacuation to the alternative care site shall follow the planning conducted during the preparedness phase.	
	12.5.3.4.9* Crisis standards of care shall be developed through a community-wide approach.	
	12.5.3.4.10 The decision to implement crisis standards of care shall be coordinated with the community leadership.	
	12.5.3.4.11 Upon implementation of crisis standards of care in a community, the following shall be considered:	
	(1) The triage process	
	(2) The allocation of medical services across the population	
12.5.3.4.12 Medical Surge Capacity and Capability. The requirements of 12.5.3.4.12.1 and 12.5.3.4.12.2 shall apply only to those facilities designated as Emergency Management Category 1 as defined by the HVA.		
12.5.3.4.12.1* The facility shall plan for medical surge capacity and capability.		
	12.5.3.4.12.2 The triage process shall be implemented as follows:	See DIS M 69
	(1) The arriving victim shall be assessed into the following cohorts:	
	(a) Risk to others, as follows:	
	i. Mentally unstable	
	ii. Contaminated	
	iii. Infectious	

	(b) Risk to self, as follows:	
	i. Emotionally impaired	
	ii. Suicidal	
	(c) Risk of death or permanent injury, as follows:	
	i. Walking wounded	
	ii. Severely injured but stable	
	iii. Suffering from life-threatening injury	
	iv. Beyond care	
	(2) Patients shall be admitted for treatment depending on facility capacity, the facility's specialty, and clinical need.	
	(3) Creation of ancillary clinical space shall have adequate utility support for the following:	DIS M-70 Untility Failure, DIS M 75 Water Plan
	(a) HVAC	
	(b) Sanitation	
	(c) Lighting	
	(d) Proximity to operating room (OR)	
	12.5.3.4.13 Recovery from controlled reduction in care standards shall be reversed at the earliest feasible time.	DIS M 69
	12.5.3.4.14 Health care facilities shall have a designated media spokesperson to facilitate news releases during the response process.	DIS J-00
	12.5.3.4.15 An area shall be designated for media representatives to assemble where they will not interfere with the operations of the health care facility.	See Public Relations procedures
12.5.3.5* Recovery.		
	12.5.3.5.1 Plans shall reflect measures needed to restore operational capability to pre-disaster levels.	DIS M 17 COOP
	12.5.3.5.2 Fiscal aspects shall be considered with respect to restoration costs and possible cash flow losses associated with the disruption.	per NYS guidelines
	12.5.3.5.3 Facility leadership shall accept and accommodate federal, state, and local assistance that will be beneficial for recovery of operations.	per NYS guidelines
	12.5.3.5.4 No party to recovery shall take action to unfairly limit lawful competition once recovery operations are completed.	per NYS guidelines
	12.5.3.5.5 Recovery shall not be deemed complete until infection control decontamination efforts are validated.	Yes
12.5.3.6 Administration.		
	12.5.3.6.1 The facility shall modify its HVA, EOP, supply chain (including the current emergency supplies inventory), and other components of the emergency management program, as a result of exercises, real event, and annual review.	Yes
	12.5.3.6.2 The facility shall maintain written records of drills, exercises, and training as required by this chapter for a period of 3 years.	AARs are kept for a period of 10 years