



Recent Changes to Emergency Preparedness Mandates and Funding

Introduction

Coordinating emergency medical services involves ensuring sufficient surge capacity, staffing, equipment, and supplies. It also requires compliance with increased regulations and mandates, as well as monitoring available funding streams. In fact, increased regulations are affecting personnel decisions at public hospitals; the growth in additional regulations was among the most important factors driving many public hospitals to hire full-time EP coordinators.

The federal government recently made several important modifications to hospital preparedness regulations, such as the focus on an “all-hazards” approach to preparedness. There have also been recent changes to the administration of the HRSA grant (now called the “Assistant Secretary of Preparedness and Response,” or ASPR grant), which provides important emergency preparedness funding for hospitals. This Research Brief provides an update on upcoming and

recent changes in hospital preparedness regulations, as well as changes in federal grant administration, including:

- An upcoming federal mandate for National Incident Management System compliance;
- New Joint Commission emergency management standards; and
- Changes in federal preparedness funding.

Upcoming National Incident Management System Compliance Deadline: September 30, 2008

The National Incident Management System (NIMS), a national coordination system developed in 2003 by the Federal Emergency Management Agency (FEMA), seeks to homogenize emergency response across the country by standardizing efforts between states.^{1,2} To this end, all hospitals receiving federal preparedness and response grants were to have reached the first set of NIMS compliance requirements (i.e., integration of NIMS into emergency plans and com-

pletion of four training courses) by September 30, 2007.³

To maintain NIMS compliance and be eligible for continued federal funding, hospitals must complete additional mandates by **September 30, 2008**. (The full list of requirements is available in Figure 1.)

The following government-provided online resources may be helpful to help hospitals maintain compliance:

- The NIMS Independent Study Course;⁴
- The Incident Command System Resource Center;⁵ and
- The Hospital Incident Command System Guidebook.⁶

2008 Joint Commission Standards on Emergency Management

Effective **January 1, 2008**, the Joint Commission imposed more stringent emergency preparedness requirements on hospitals, including:

- An increase in the number of hospital preparedness standards;
- A new focus on an all-hazards (versus event-specific) approach to hospital readiness;
- A 96 hours stand-alone guideline (up from 72 hours);
- A mandate for community participation in hospital drills; and

FIGURE 1 September 2008 NIMS Requirements

To remain in compliance with federal NIMS mandates, by September 30, 2008, hospitals are expected to:

1. Track NIMS implementation annually as part of the organization's emergency management program.
2. Adopt NIMS at the organizational level for all appropriate departments and business units, as well as promote and encourage NIMS adoption by associations, utilities, partners and suppliers.
3. Develop and implement a system to coordinate appropriate hospital preparedness funding to employ NIMS across the organization.
4. Manage all emergency incidents, exercises, and preplanned (recurring/special) events in accordance with Incident Command System (ICS) organizational structures, doctrine, and procedures, as defined in NIMS. ICS implementation must include consistent application of Incident Action Planning and Common Communication Plans.
5. Coordinate and support emergency incident and event management through the development and use of integrated multiagency coordination systems (MACS). This will require the organizations to develop and coordinate connectivity capability with Hospital Command Center (HCC) and local Incident Command Posts (ICPs), local 911 centers, local Emergency Operations Centers (EOCs), the state EOC, and others, as applicable.
6. Implement processes and/or plans to communicate timely and accurate information through a Joint Information System (JIS) and Joint Information Center (JIC).
7. Participate in and promote interagency mutual-aid agreements, such as agreements between public and private sector and/or nongovernmental organizations.
8. Incorporate NIMS/ICS into internal and external local, regional, and state emergency management training and exercises.
9. Participate in an all-hazard exercise program based on NIMS that involves responders from multiple disciplines, agencies and organizations.
10. Incorporate corrective actions into preparedness and response plans and procedures.
11. Maintain an inventory of organizational response assets.
12. Apply standardized and consistent terminology, including the establishment of the plain English communication standards across the public safety sector.
13. To the extent permissible by law, ensure that relevant national standards and guidance to achieve equipment, communication, and data interoperability are incorporated into acquisition programs.⁷

SOURCE NIMS Online www.nimsonline.com

■ Significant changes to the Joint Commission's emergency management tracer exercise (described below).

MORE EMERGENCY MANAGEMENT STANDARDS INCLUDE AN ALL-HAZARDS FOCUS

The Joint Commission recently conducted a five-year national survey among hospitals to identify activities that indicate how hospitals may best survive a disaster.⁸ This resulted in nine standards, which clarify and

expand upon the existing two standards (EC.4.10 and EC.4.20). All of these new standards are based upon six key elements in emergency management:

1. Communication;
2. Resources and assets;
3. Safety and security;
4. Staff responsibilities;
5. Utilities management; and
6. Patient clinical support activities.⁹

Please note that, while the Joint Commission will recognize compli-

ance with these new standards in their hospital evaluations, *lack of compliance will not affect 2008 accreditation decisions.*¹⁰

In particular, the Joint Commission is calling upon hospitals to increase flexibility and react to escalating or multiple events during a disaster in each of the aforementioned six emergency management elements.¹¹ This all-hazards approach to preparedness (as opposed to preparing only for the most-likely emergency scenarios) is a result of lessons learned from September 11th, Hurricane Katrina, and Hurricane Rita.¹² While FEMA and other emergency management organizations have been encouraging all-hazard preparedness, the Joint Commission has only recently required this comprehensive scope.¹³ The Joint Commission now defines these capabilities as essential to react to any type of emergency and simultaneous failures.¹⁴

HOSPITALS ENCOURAGED TO PREPARE FOR LONGER STAND-ALONE TIME

As part of the new January 1, 2008 standards, the Joint Commission is encouraging hospitals to increase the amount of time they are able to “stand alone” and maintain operations during an emergency—up to 96 hours, replacing the former 72-hour guideline. The change is intended to better prepare hospitals to handle crises like Hurricane Katrina, which left hospitals to maintain operation for extended periods without external assistance.

A related lesson learned from Hurricane Katrina is the need for comprehensive evacuation plans.

Many hospitals may be unable to continue operations during a disaster and, therefore, must be prepared to safely evacuate staff and patients. Under the new 2008 standards, the Joint Commission is promoting (but not yet mandating) that hospitals include evacuation plans as a part of their 96-hour plan.

COMMUNITY PARTICIPATION IN HOSPITAL PREPAREDNESS DRILLS

Because no single government department or health care provider has all the resources necessary to respond to a large scale disaster, the Joint Commission now requires hospitals to include community participation in their drills. This will coordinate a hospital's efforts with those of the local department of public health, the fire department, the police, and other agencies. Drills themselves have also changed to reflect the new all-hazards approach. Hospitals are now encouraged to "drill until failure" in order to identify weaknesses in preparedness plans and to realistically prepare hospital staff to handle an emergency event.¹⁵

One important resource in aiding the planning, conducting, and evaluating of these drills is the Homeland Security Exercise and Evaluation Program (HSEEP).¹⁶ Considered the national standard for preparedness exercises, HSEEP provides a framework, toolkit, and other resources for conducting drills.¹⁷ All of these materials can be accessed through FEMA's website.¹⁸

EMERGENCY MANAGEMENT TRACER CHANGES

The final major Joint Commission update on hospital emergency requirements affects the emergency management "tracer" (i.e., an exercise conducted by the Joint Commission during a site visit to assess a hospital's response plan). Before January 2008, the tracer involved declaring "an emergency" and evaluating, step-by-step, how a hospital responded. The new tracer exercise requires the hospital to demonstrate "reaction to a catastrophic event" with a new focus on the all-hazards approach. Hospitals are only allowed to respond using those staff on duty at the time of the drill.

In sum, with the 2008 regulations in place, hospitals will have to expand efforts to remain compliant with Joint Commission mandates.

Changes in Federal Funding for Emergency Preparedness

Historically, NAPH member hospitals have relied on funding from the Health Resources and Services Administration (HRSA) for preparedness efforts. These monies are dispersed to the states, which then distribute grants to support hospitals and other health care infrastructure. According to the *2006–2007 NAPH/NPHHI Emergency Preparedness Study*, HRSA was the most common source of external funding for preparedness in public hospitals.¹⁹

Recently, administration of those dollars was switched to a new office within the U.S. Department for Health

In particular, the Joint Commission is calling upon hospitals to increase flexibility and prepare to react to escalating or multiple events during a disaster.

and Human Services: the Office of the Assistant Secretary for Preparedness and Recovery (ASPR), which was created by the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006.²⁰ ASPR was established to coordinate leadership for all federal public health and medical preparedness and response functions.²¹ This new office now administers money for emergency management services and health care, while HRSA continues to oversee preparedness activities for police and fire.²²

FEDERAL MONEY SPREAD TO ALL HEALTH CARE AGENCIES

Historically, the HRSA money for medical response primarily was allotted to hospitals, but ASPR plans to broaden its focus to the entire community, distributing funds to all health care agencies, including nursing homes and community health centers. Without increases in total grant dollars, funds that were mostly focused on hospitals will now be shared by multiple agencies, thereby shrinking the hospitals' share.

GRANT APPLICATION PROCESS

The grant process has not changed since the transition of the grant ownership changed from HRSA to ASPR, and monies are scheduled to be dispersed

on **August 8, 2008**. In the past, application guidelines had been released to the states in July, giving the state 30 to 45 days to complete the application. In response to complaints, ASPR is working to release the guidelines earlier to give states more time to complete the application, but no further information is available at this time.²³

Some NAPH members report that the current grant application process is cumbersome. Planning activities within the grant have been evolving to include more and more topics, such as mass fatality, evacuation planning, interoperable communications, and pandemic flu planning.²⁴

ASPR ADMINISTRATION DIFFERS BETWEEN STATES

Because each state administers ASPR funds, the way hospitals receive these dollars differ from state to state. In some cases, a state's department of health completes the grant application. For example, the Arkansas Department of Health completes the grant application with input from hospitals, thereby allowing hospitals to have input on how the money will be spent.

Other states appoint a specific ASPR grant administrator. In some cases, the state will send a grant application to regional or local governments,

which then work with the hospitals to submit funding requests. States can also designate mandates and funding for larger regional projects. For example, Georgia required Atlanta's Grady Memorial Hospital to put hospital incident command information into an electronic regional coordinating system, "Live Process," as a condition to receiving ASPR grant money.²⁵ Because each state works differently, it is important for each hospital to understand the process and become involved with the agency administering the ASPR grant application.

Conclusion

Hospital emergency readiness has been a major focus for both federal and Joint Commission regulations in recent months. As described above, hospitals are increasingly required to work with local agencies in preparing for and responding to multiple catastrophic emergencies. Meanwhile, emergency readiness standards and funding guidelines are continuing to move to an all-hazards and community focus. This represents a significant culture change from an independent to an interdependent, nationally-consistent approach to preparedness that will affect all NAPH member facilities. ■

This is the third in a series of research briefs published by the National Association of Public Hospitals and Health Systems (NAPH) and its affiliated research arm, the National Public Health and Hospital Institute (NPHHI), on emergency preparedness (EP) in safety net hospitals. (The other briefs were *Hospital Staffing and Surge Capacity during a Disaster Event* [May 2007] and *Designated Coordinators Boost*

Preparedness Efforts in Safety Net Hospitals [October 2007].) In June 2008, NAPH will publish a monograph presenting the results of its comprehensive study on the topic. Together with EP experts from member hospitals, NAPH's research staff have presented these findings at various conferences around the country.

The authors would like to recognize the following NAPH members for their valuable time and expertise: Ronald Crane, Jr., Emergency Preparedness Manager at the University of Arkansas for Medical Sciences; Charlotte S. Clark, Emergency Management Manager at Grady Memorial Hospital in Atlanta, Georgia; and Lann Wilder, Emergency Management Coordinator, San Francisco General Hospital.

Notes

1. Homeland Security Presidential Directive Five www.whitehouse.gov/news/releases/2003/02/20030228-9.html (accessed 4-02-2008).
 2. National Incident Management System www.fema.gov/emergency/nims/index.shtm (accessed 10-16-2007).
 3. National Association of Public Hospitals and Health Systems Annual Meeting 2007. The University of Mississippi Medical Center NIMS Implementation Presentation. Pam Hemphill. Emergency Preparedness Coordinator University of Mississippi Medical Center.
 4. NIMS Independent Study Course, www.training.fema.gov/NIMS/.
 5. The Incident Command System Resource Center, <http://training.fema.gov/EMIWeb/IS/ICSRResource/index.htm>.
 6. The Hospital Incident Command System Guidebook, www.emsa.ca.gov/hics/hics%20guidebook%20and%20glossary.pdf.
 7. Information from Lann Wilder, Emergency Management Coordinator, San Francisco General Hospital.
 8. Saruwatari M. "National Emergency Management Regulations and Standards—2008." Live Process Articles. www.liveprocess.com/lparticles/2008comp.php (accessed 3-24-2008).
 9. "Alert Regarding Emergency Management Section of the Environment of Care Standards." The Joint Commission. www.jointcommission.org.
 10. "Joint Commission approves grace period for new standard." *American Hospital Association News*. April 28, 2008. See: www.ahanews.com/ahanews_app/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann_080428_JCo&domain=AHANEWS (accessed: May 12, 2008).
 11. Joint Commission Online May 2007. www.jointcommission.org/Library/jconline/jo_05_07.htm (accessed 3-24-2008).
 12. Joint Commission Online May 2007. www.jointcommission.org/Library/jconline/jo_05_07.htm (accessed 3-24-2008).
 13. Interview, March 19, 2008, Lann Wilder, Emergency Management Coordinator, San Francisco General Hospital.
 14. Ibid.
 15. Interview, March 18, 2008, Ron Crane, Emergency Preparedness Manager, University of Arkansas for Medical Sciences.
 16. Ibid.
 17. Homeland Security Exercise and Evaluation Program (HSEEP) see https://hseep.dhs.gov/pages/1001_HSEEP7.aspx (accessed 4-02-2008).
 18. FEMA's website https://hseep.dhs.gov/pages/1001_HSEEP7.aspx.
 19. National Public Health and Hospital Institute. *2006–2007 Emergency Preparedness Study*.
 20. Statement by Kevin Yeskey, MD, before the U.S. Senate Committee on Homeland Security and Governmental Affairs, November 15, 2007. See www.hhs.gov/asl/testify/2007/11/t20071115a.html (accessed 3-24-2008).
 21. Ibid.
 22. Interview, March 19, 2008, Charlotte Clark, Emergency Management Manager, Grady Health System.
 23. Interview with Ron Crane, March 2008.
 24. Interview with Charlotte Clark, March 2008.
 25. Ibid.
-