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JCR's 2024 Emergency Management Conference

Preparing for a Cyberattack

In his keynote address, cybersecurity expert John Riggi warned of increasing cyberattacks on health care and outlined strategies to identify and mitigate vulnerabilities

John Riggi began his keynote address with the fact that 2023 was a record year for cyberattacks on health care, with 591 hacks affecting 136 million individuals. This year, as of July 1, more than 300 hacks had been reported to the US Department of Health and Human Services Office for Civil Rights, affecting more than 30 million individuals.

Emergency management professionals must work together with the C-suite, information technology (IT) staff, and all other health care organization (HCO) departments that use technology—from human resources to nuclear medicine to nutrition and dietary services—to identify and address all of an enterprise's cybersecurity vulnerabilities, emphasized Riggi during the Joint Commission Resources Emergency Management Conference in Orlando, Florida, in June.

Three key risk areas

The ubiquitous use of technology in health care creates risk in three primary ways, explained Riggi. First, "all technology comes to us insecure by default," he said, "because technology companies are incentivized to release products quickly. They will fix the bugs after [the technology] has gone to market." This is why any new computer, smartphone, or other electronic device—and each application it runs—have to be updated continually throughout the life of the device. The updates are primarily security patches.

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"This [security vulnerability] creates a very expansive digital attack surface, and the bad guys are taking advantage of that," Riggi said.

Second, the cybercriminals understand all the technologies—the hardware, software, and platforms—and their major vulnerabilities. "They quickly design malware to exploit those vulnerabilities, to disrupt health care delivery and steal the data," Riggi said.

Third, and most dangerous, according to Riggi, is "our dependency on the availability of that technology to do our jobs."

Preparing for impact

Cyber risk is the number one concern of the nation's largest health systems, said Riggi, the American Hospital Association's national advisor for cybersecurity and risk. Although these health systems have substantial resources, "no matter how much in financial, human, and technical resources we devote to cybersecurity, we can never prevent 100% of all attacks," he said. "We have to be prepared—to prepare for impact."



"No matter how much in financial, human, and technical resources we devote to cybersecurity, we can never prevent 100% of all attacks." —John Riggi

And that impact can be devastating. "When organizations are hit with ransomware, which forces them to shut down their internal network and disconnect from the Internet, the most significant risk to patient safety is the loss of diagnostic technology," Riggi said. As he pointed out, without imaging technology, a stroke couldn't be diagnosed, for example, and all trauma patients would need to be diverted to other hospitals.

Riggi also noted that a cyberattack on one health system can have an overwhelming ripple effect on other HCOs in the communities served. For instance, California-based Scripps Health—which operates three Level 1 trauma centers in San Diego County—fell prey to a ransomware attack in 2021 and lost access to all of its technology. By going on ambulance diversion for 3½ weeks, the health system caused other hospitals in the area to become overloaded.

"This shows that when you do emergency management planning, you need to do it on a regional basis," Riggi emphasized. "The target is hit, and there are cascading shock waves throughout the region. There is collateral damage."

Having a robust communications plan "is another issue a lot of organizations don't think about," observed Riggi. "One of the impacts that overlaps the disruption of clinical technology is that you have a loss of communications," he said. "E-mail is down. Phones are down. Voice-over-the-Internet phone calls are down. Just when you need to call in humans to replace all the technology, your communication systems are disrupted."

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Cybersecurity Panel Discussion Provides Further Insights

After the keynote address, Michael DeGraff, The Joint Commission's enterprise IT security director, moderated a cybersecurity panel discussion featuring the following four health system leaders:

- Michael Mastrangelo, MBA, associate vice president–institutional preparedness for the University of Texas Medical Branch at Galveston
- William Rudolph, CHEP, CHSP, CHPCP, BA EDM, safety and emergency manager, Penn Medicine/Penn Presbyterian Medical Center, Philadelphia
- Jason Dantico, assistant vice president and deputy chief information security officer for health information technology, Endeavor Health, Skokie, Illinois
- Jason Williams, chief information officer and vice president of support services, CHA Hollywood Presbyterian Medical Center, Los Angeles

Here are some of their suggestions:

- Build the relationship between emergency management and cybersecurity teams now. Don't wait for a disaster to strike.
- Include cybersecurity teams in emergency management planning, design, and response.
- Design cyber incident response plans to support more than 30 days of systems and network unavailability. Legacy disaster recovery plans may not be sufficient.
- Ensure that there is a defined process to immediately shut down systems if needed. The plan must include a clear decision tree and delegate authority to the right people to make the call 7 X 24 X 365.
- Ensure that all systems and modalities are included in the cyber incident response plans, including heating, ventilating, and air-conditioning (HVAC) systems and controlled access systems.

If a hospital is considering a new mass notification system, make sure that it's "bidirectional," Riggi urged. Many parties will need to communicate with one another during a cyber outage.

Recommendations

Riggi shared the following recommendations with his audience:

- **Integrate and coordinate your plans.** An organization's cyber response plan, emergency management plan, business continuity plan, and disaster recovery plan should be integrated rather than developed in silos.
- **Create a map that shows every technology application and Internet connection in your enterprise.** Identify the critical functions on this map. Understand what the cascading effects would be from any disruption of a critical function.
- **Get input from every department and unit.** Talk to people in the emergency department, nurses, nutrition and dietary professionals, the laboratory, and so on. Find out how much of their work is network- or Internet-connected. Ask them, "How would you do your job if you didn't have access to that technology?"

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- **Determine a plan for coping with each type of technology loss.** Ask three questions:
  - What will work?
  - What won't work?
  - What's the plan to sustain high-quality and safe care for 30 days or longer?
- **Base the cyber incident response plan on the "4R concept": readiness, response, resiliency, and recovery.** The cyber incident response plan, which details downtime procedures, should be developed on an organizationwide basis. In the plan, define all facility-level and department-level actions and responses for both the duration of the incident and post-incident recovery, including all IT, operational, business, and critical functions.
- **Get involved in regional cyber response planning.** "You already have existing regional emergency preparedness plans, mass casualty agreements, and mutual aid agreements," Riggi observed. "Let those existing agreements and capabilities include cyber hazards and vulnerabilities that you will mutually respond to should there be a massive ransomware attack in your region—because you will be affected regionally."
- **Identify clinical and mission-critical services provided by third parties, including cloud and technology service providers.** Identify downtime procedures if these services are unavailable. "Establish compensating on-premises downtime procedures, including manual procedures and a backup strategy," Riggi suggested.
- **Designate downtime coaches and downtime safety officers for each department function and shift.** "During the incident, they would lead the charge in your department," Riggi said. "Without that EMR [electronic medical record], clinicians are very hesitant to make decisions, especially when it comes to drug dosages. So those downtime safety officers provide a second set of eyes."

Riggi and the American Hospital Association have been working with the US Department of Health and Human Services to develop a national cyber incident response plan. EML

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Following an active shooter incident, the University of Cincinnati (UC) Medical Center ramped up its active assailant and "Stop the Bleed" training, armed more of its campus security force, and installed more sophisticated weapons detection technology and other safeguards at the entrances to its Psychiatric Emergency Services facility and its main campus emergency department.

PHOTO COURTESY OF UC HEALTH. USED WITH PERMISSION.

Case Study

Good to Better: How the University of Cincinnati Medical Center Grappled with an Active Shooter

An incident on campus that left a security officer badly wounded and an armed intruder dead by suicide sparked insights and changes in security protocols, communication, and response at UC Health

Five days before Christmas, the University of Cincinnati (UC) Medical Center was bustling with holiday celebrations. No one expected that an armed intruder would suddenly bring the festivities to a standstill.

At 2:00 P.M., a man came into the Psychiatric Emergency Services (PES) building through the visitor entrance and asked for directions to the patient entrance. After passing through a metal detector, he pulled out a handgun and began shooting at an unarmed security officer on duty, inflicting a couple of wounds. The security officer managed to push past the gunman and ran outside, with the shooter following in pursuit. More shots rang out. A short time later, the intruder reentered the PES building and began shooting at a badge reader in an attempt to gain access to the locked entrance of the patient care area.

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Responding rapidly to UC Health's "Code Silver" public address messaging (activated after the first gunshots were heard) and multiple 911 calls, a Cincinnati Police Department officer stationed at the main campus emergency department (ED) soon arrived at the scene and confronted the gunman, who fired at the police officer and then turned his weapon on himself, taking his own life. By this time, two other Cincinnati Police officers on campus had also arrived.

Meanwhile, the injured security officer discovered outside the building was rushed to the main hospital ED and survived his wounds. It was later determined that the shooter had no connection to the hospital, the staff, or any patients.

Rapid response, inside and out

Luckily, a more horrific outcome was averted, says Maria Friday, senior director of facilities safety and emergency management for UC Health. "At the time, we had no one in the Psychiatric Emergency Services lobby area and no patients because they had all been triaged, which was a unique situation," she remembers.

As Friday points out, the immediate response of local law enforcement was swift and effective—a mere 30 to 45 seconds, as she recalls—but so was the response of UC Medical Center's clinical and emergency management teams. Within 5 minutes, the mass casualty incident (MCI) team and five operating rooms with 17 staff members were ready to handle multiple victims if necessary. MCI protocols were activated in a coordinated and rapid response to the incident, which resulted in just one person injured plus the death of the shooter by suicide, but could have been much worse.

At the PES building, "we knew that we would have to not only control the crime scene but also shelter in place and secure and clear the building," says Friday. Complicating factors included the building's mixed use; the facility contains both patient rooms and administrative functions.

"While administrative personnel needed to leave the building when they could, we still had to shelter our patients in place and care for them as well," she explains.

Throughout the incident, according to Friday, the hospital ensured appropriate communication with staff, patients and their families, law enforcement, and the media while complying with patient privacy requirements. That entailed preserving the integrity of the crime scene while making sure that any photos taken adhered to health care privacy guidelines. A UC Health public information officer managed interactions with the media and controlled the flow of information.

An unexpected challenge was the parking lot, which was considered part of the crime scene. Vehicles were not allowed to leave, which meant that staff had to leave their cars until the next day, when they were able to reenter the facility.

"Another immediate response was utilizing our employee assistance program to make sure that everyone was debriefed before they went home and had crisis support," Friday adds.

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Immediate observations drive subsequent changes

One of the first lessons Friday learned from the incident was the need to bolster UC Health's emergency communications infrastructure. "The almost overwhelming need for communication comes to mind whenever I think about this incident," she says. "Our dispatch and communication centers were flooded with both internal and external calls. How can we better share information about such an incident while making sure that redundancies are in place throughout communication channels to ensure that we're giving timely and accurate information about the incident to everyone concerned."

As a result, the UC Health marketing and communications team enhanced the medical center's Crisis Communications Plan and intensified the related training. Public information officers now carry an on-call phone called the "Media Hotline," which is available 24/7 for anything related to external or internal communications. To improve communications with external law enforcement, UC Health upgraded its radios on the Multi-Agency Radio Communications System (MARCS), which provides secure, reliable statewide public service wireless communication for public safety officers and first responders.



A new walk-through weapons detection system and package scanner were installed inside the visitors' entrance to the University of Cincinnati (UC) Medical Center's Psychiatric Emergency Services unit.

PHOTO COURTESY OF UC HEALTH. USED WITH PERMISSION.

In the weeks after the incident, after internal reviews and discussions, UC Health engaged a security consulting firm to assess security across the system. As a consequence, it was decided to beef up staffing in the Public Safety Department with more armed officers. Previously, the department operated as a hybrid that included both police officers, who were armed, and security officers (with two classification levels and skill sets), who were not. UC Health decided to add more armed Cincinnati Police Department officers to the Public Safety team, including a police post at Psychiatric Emergency Services.

The active shooter incident also led to significant changes in staff training, management protocols, and physical security features.

New enhancements to the physical environment improved the screening process for anyone entering Psychiatric Emergency Services and the main campus ED. These included the introduction of technologies such as a package scanner, which detects nonmetallic objects and organic materials, and a sally port entrance. A sally port consists of barriers that act as choke points to control the flow of people

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and vehicles. These security features provide a safer environment for everyone entering the facilities.

In addition, UC Health upgraded its security cameras from analog to digital throughout the health system to improve image quality, coverage, ease of maintenance, and storage requirements.

Improved training

"We also enhanced our active shooter training and assessment," Friday says. "We now conduct practical mini drills in actual departmental environments. These simulations in departmental spaces help everyone understand where they would barricade or, if they had to, run, hide, or fight." This more robust, proactive training replaced what were essentially presentations in conference rooms.

Besides participating in the drills, UC Health staff, take a one-hour active shooter/armed intruder course that teaches techniques for responding to active shooter incidents in health care settings. The course features a video focusing on "run, hide, fight" strategies along with a discussion among attendees about their emotional responses to the scenarios in the video. The course also includes a lecture on trends in active shooter incidents, types of assailants typically encountered in health care settings (such as disgruntled patients or domestic disputes that lead to violence), and effective response methods.

A session follows in which participants go through simulations of scenarios, each of which would best be handled by a different response: (1) no action, (2) run, (3) hide, or (4) fight. This part of the course enables learners to apply new knowledge in more realistic situations, with an emphasis on preparedness and decision-making under stress. The course ends with a Q&A session and wrap-up discussion.

'Stop the Bleed' campaign

UC Health also ramped up its participation in the American College of Surgeons' national "Stop the Bleed" initiative, a campaign to teach bystanders how to stop bleeding (using a tourniquet) in an emergency before professional responders arrive. The goal is to improve survival rates from MCIs and other trauma injuries.

Stop the Bleed kits have been strategically placed throughout every building on the UC Medical Center campus. Friday says that the program has been very successfully received in combination with the active shooter training. "It has been part of an evolution in how we continue to teach and prepare people to respond to emergencies," she notes. EML

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Managing Resources and Assets

ASPR-TRACIE Provides a Free Tool for Estimating Supplies Needed for MCIs

The Technical Resources, Assistance Center, and Information Exchange (TRACIE) of the US Department of Health and Human Services (HHS) Administration for Strategic Preparedness and Response (ASPR) offers modules to help calculate minimum pharmaceuticals, personal protective equipment, and other supplies needed during mass casualty incidents (MCIs)

In any significant mass casualty incident (MCI) or prolonged public health emergency (such as the COVID-19 pandemic), coordinating resources and assets is both extremely important and an immense challenge.

The Joint Commission addresses resource and asset management, considered part of an organization's emergency operations plan (EOP), in Emergency Management (EM) **Standard EM.12.02.09:** The [organization] has a plan for managing resources and assets during an emergency or disaster incident.

Note: *The [organization] considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for resources and assets.*

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The three elements of performance (EPs) under EM.12.02.09 clarify The Joint Commission's expectations. EP 1 states that organizations need to have a written plan for locating, monitoring, and documenting the following resources and assets:

- Medications and related supplies
- Medical/surgical supplies
- Medical gases, including oxygen and supplies
- Potable or bottled water and nutrition
- Non-potable water
- Laboratory equipment and supplies
- Personal protective equipment (PPE)
- Fuel for operations
- Equipment and nonmedical supplies to sustain operations

EP 2 requires an organization to describe in writing how it will do the following to obtain, allocate, conserve, and replenish its resources and assets during and after an emergency:

- Request and coordinate resources from within one's health system if part of a multi-site enterprise.
- Coordinate with local vendors or supply chains.
- Coordinate with local, state, or federal agencies for additional resources.
- Coordinate with regional health care coalitions for additional resources.
- Manage donations such as food, water, equipment, and materials.

EP 3 requires a hospital to explain in writing the actions it will take to sustain the needs of the organization based on the availability of resources and assets (such as staff, space, and supplies) for up to 96 hours. The plan should address conservation of resources and assets as a critical step, as well as whether the organization would be able to sustain/maintain operations and the critical juncture at which the organization would begin preparations to evacuate.

The DASH Tool can help with compliance

The US Department of Health and Human Services (HHS) offers a free, online, interactive Disaster Available Supplies in Hospitals (DASH) Tool that can help your organization calculate the minimum supplies needed during a disaster and comply with EM.12.02.09. The DASH Tool is available from the Administration for Strategic Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE).

"You may wonder, 'What are reasonable amounts of pain medications to have available? How many N95 respirators might my hospital need to get through

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a pandemic?' The DASH Tool can help," explains a video on the ASPR-TRACIE website.

The DASH Tool consists of four modules:

- The Hospital Pharmacy Module estimates the amounts and types of medications and intravenous fluids a hospital should have to meet the needs of seriously injured patients for 48 hours following an MCI. This module provides baseline inventories for medication categories (for example, analgesia, antibiotics). The user inputs inventory information for common drug formulations in stock within these categories and sees immediately whether the hospital has adequate or inadequate stocks of medications in a particular category.
- The Personal Protective Equipment Module estimates the minimum PPE for hospital staff managing patients suspected or known to be infected with a special pathogen or during a pandemic. Approximate minimum PPE needs are based on the type of pathogen and a number of facility-specific variables. PPE calculators are included for the following:
  - Viral hemorrhagic fever (Ebola virus disease, for example)
  - Special respiratory illnesses (such as Middle East respiratory syndrome [MERS] and severe acute respiratory syndrome [SARS])
  - Pandemic viral pathogens
- The Burn Supply Module estimates dressings and other supplies to care for critical burn patients.
- The Trauma Supply Module estimates airway, surgical, and other supplies to care for seriously injured patients.

The modules are designed to be complementary rather than used alone. As each module emphasizes, "it is intended as a starting point for facility planners to estimate the minimum quantities of supplies that may be needed based upon the role the hospital has in the community. The module is meant to be considered in conjunction with other planning tools, resources, information, and facility and community-wide preparedness efforts. It is not intended as a clinical tool and should be used for pre-incident planning and NOT during an incident."

ASPR-TRACIE and the nonprofit Healthcare Ready developed the DASH Tool in collaboration with the Region VII Disaster Health Response Ecosystem and the Health Industry Distributors Association. For more information, see this FAQs page on the ASPR-TRACIE website. EML

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Tips and Insights

Five Fundamentals for Managing At-Risk Populations During Emergencies

Health care organizations need to identify and communicate with individuals who have access and functional needs and should develop processes for their transportation, evacuation, shelter, and return to safe housing after a disaster

Natural disasters, public health emergencies, prolonged utility outages, and intentional human-caused crises (such as mass shootings or detonation of improvised explosive devices) can substantially threaten any individuals within an emergency's sphere of impact. But for at-risk populations—from the physically and cognitively disabled to the impoverished or unhoused—the dangers are significantly magnified. Health care organizations (HCOs) should consider the needs of vulnerable populations in their communities—as well as their current at-risk patients, residents, or clients and staff—when developing their emergency operations plans (EOPs).

The Joint Commission requires accredited organizations to work with community partners to address at-risk populations, per Emergency Management (EM) **Standard EM.12.01.01, Element of Performance (EP) 2:** The [organization's] emergency operations plan identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event.*

Note: *At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident, such as medical care, communication, transportation, supervision, and maintaining independence.*

The following five strategies provide guidance on how to meet the needs of individuals who may face additional challenges during emergencies.

1. Identify at-risk populations served by your organization.

The Federal Emergency Management Agency (FEMA) uses the term *individuals with access and functional needs* (AFNs) to describe populations that are more susceptible to harm during emergencies. It is vital for health care emergency managers to address AFN considerations in the planning process.

* Several accreditation programs still use the former numbering system for Emergency Management (EM) standards. All organizations should check their *Comprehensive Accreditation Manual* (or its E-dition counterpart) for the exact wording of requirements related to at-risk populations.

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The following are examples of at-risk populations:

- The very old and the very young
- Pregnant individuals
- Individuals with behavioral health issues, including those who have been identified as being at risk for suicide
- People with medical/medication issues (individuals with type 1 diabetes on insulin, for example) or physical or cognitive disabilities
- People with limited access to transportation or financial resources (this would include housing, education level, employment, income, and housing)
- Unhoused and other isolated individuals
- Individuals with limited English language proficiency
- LGBTQ+ individuals (who might face discrimination or open hostility in emergency shelters, for example)

Some state health departments have developed data collection tools useful for emergency planning. For each county, the state provides a description of the population, including the following:

- Age
- Disability status
- Supplemental Nutrition Assistance Program (SNAP) recipient status
- Personal assistance services (PAS) recipient status
- Dialysis use

State officials collect data at the county and zip code level from human services agencies and other sources (such as the US Census Bureau and the End Stage Renal Disease Network Program). Data are given to counties in a spreadsheet that can be accessed to help prepare for and navigate emergencies.

Another method, which the Centers for Disease Control and Prevention (CDC) recommends, is developing a Community Outreach Information Network (COIN). This is a group of trusted messengers that includes emergency managers, emergency coordinators, representatives from local service agencies, first responders, representatives from the disability community, and representatives from faith- and community-based organizations (CBOs).

CBO representatives can help with response planning and disseminating information during emergencies. Other entities that could be part of your network include durable medical equipment (DME) suppliers and national programs such as Meals on Wheels. These organizations can help educate potential enrollees about the benefits of participation in a network registry.

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Working with your network, you can begin to create a registry of at-risk individuals served by your health care facilities. Methods for collecting information on at-risk individuals include the following:

- Online form that people (including at-risk health care staff) can use to submit and update their information
- Central phone number that people can call to register
- Direct-mail registration forms that people can fill out and return

When enrolling people in registries, keep the following points in mind:

- Use language that protects privacy by limiting use to emergency preparedness planning.
- Have a consent form that offers flexibility for sharing information with other agencies during an emergency.
- Clarify the type of help likely to be available and potential limitations to that assistance (it is not guaranteed).
- Incorporate language that allows for caregivers of cognitively disabled adults to complete the form.

Registries must be updated regularly to account for changes among listed persons. From the registry information, you can then even create a visual representation of your patients, residents, clients, or staff—or neighborhoods within the communities you serve—with the greatest needs to help you allocate resources more efficiently during or in the aftermath of a disaster.

2. Determine how your organization will notify and communicate with at-risk patients, residents, and clients and other AFN populations in your service area.

During a natural or human-caused disaster, HCOs not only must communicate with individuals currently receiving care in their facilities, but they also need to get the word out to the public about available services. When a disaster such as a tornado or high-rise building collapse wreaks havoc on a community, hospitals and other types of HCOs often play a vital role in public outreach by, for example, distributing food and water or dispatching a mobile medical unit to a central gathering point. Home health agencies and telehealth providers in particular may want to reach out to patients/clients in their homes to find out if assistance is needed.

Many traditional emergency notification methods are not accessible to people with disabilities. Combining visual and audible alerts will reach a greater audience for both internal and external communications. Auto-dialed text telephone (TTY) messages in the main languages used in your community, text messaging, e-mails, and direct door-to-door contact with preregistered individuals may be incorporated into your procedures.

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Options for community outreach—whether to warn of an anticipated or ongoing emergency or to provide more general information on emergency preparedness or AFN assistance provided by your organization—include the following:

- Website and social media announcements
- Emergency notification phone calls to individuals in your COIN registry
- Television and radio public service announcements
- Community meetings that allow for updates and reminders about planning for emergencies
- Door hangers, flyers, and pamphlets (possibly using simple, picture-based messages) distributed door-to-door or posted in libraries, schools, post offices, grocery stores, restaurants, churches, or other community structures. These would be more appropriate for general information on preparing for emergencies and the services your organization would be able to offer to at-risk individuals affected by a disaster.

3. Establish policies and procedures related to the evacuation and transportation needs of at-risk populations.

HCOs can establish a multitiered process for evacuation that would allow critical care or organ transplant patients, for example, to be evacuated first from hospitals; followed by individuals with disabilities who need special assistance; and so on. A tiered process works best for planned evacuations such as the need to vacate a facility in advance of a hurricane.

Some hospitals and residential health care settings prepare go-bags for their patients or clients in advance for use during emergency evacuations. Be sure to keep the needs of at-risk individuals in mind when assembling these kits.

Although evacuated critical care patients ideally should be transported by ambulance or medical air transport to another health care facility, other options may need to be tapped during a disaster. Home health patients, for example, may need transportation to a disaster relief shelter. Hospital staff who don't drive may need rides home.

Organizations can reach out to community partners such as the following to provide transportation assistance during emergencies:

- Local public transit
- Airport shuttle bus operators
- School bus operators with lift-equipped buses
- Area agencies on aging
- Nearby places of worship that have passenger vans
- Dial-a-Ride transit services
- Rideshare services

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Be sure to have contracts with transit providers in place prior to an emergency or disaster. Address such issues as payment processes and the presence of service and emotional support animals.

4. Address shelter-in-place considerations for at-risk populations.

For some emergencies such as severe blizzards, sheltering in place may be the best option. Be sure to take the following into account in emergency planning:

- Potable water for those sheltering
- Nutritional needs of those sheltering
- Availability of sufficient accessible washroom facilities
- Accommodations for service animals
- Safe, comfortable places to sleep if sheltering at-risk individuals overnight
- The needs of pregnant or lactating individuals
- Prescription medication and portable oxygen needs
- Access to public telephones or mobile phone charging equipment
- The ability to recharge battery-powered assistive devices for mobility, including wheelchairs and scooters
- The need of some individuals for personal assistance services (PAS)
- Crisis counseling areas
- Toys for children, including fidget and calming toys for those on the autism spectrum or who have attention-deficit/hyperactivity disorder (ADHD)
- Translation services for those who don't speak English

5. Provide help with transition back home or into alternative housing options

Whether sheltering in a health care facility or at another site, at-risk individuals will need to return to their homes or alternative housing when the disaster is over. An HCO should consider what assistance it could provide to help ensure the safety of patients/clients and staff. The EOP and related policies and procedures can address the following:

- Reaching out to law enforcement, the local fire department, or the county emergency management agency to make sure that the at-risk individual's home is habitable
- Confirming that any prior in-home services are restored (for example, Meals on Wheels, PAS)
- Confirming access to essential local businesses (a grocery store and a pharmacy, for example)

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When at-risk individuals cannot return to their homes, HCOs can help connect them with appropriate temporary housing providers (such as motels/hotels with accessible rooms) and other community resources. These processes can be outlined in the EOP and related policies and procedures.

In summary, HCOs often play a key community leadership role during disasters and public health emergencies, beyond caring for their own patients, residents, or clients. Health care executives and emergency managers must keep the needs of vulnerable individuals top of mind in their EM planning, response, and recovery. EML

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Toolkit

Wildfire Preparation: A Burning Challenge

Is your health care facility ready to evacuate if necessary? The provided tabletop exercise playbook and scenario can help with your assessment

Wildfires have increased in severity, duration, and affected acreage in recent years due in part to climate change–related rising heat levels and drought, according to the US Environmental Protection Agency (EPA). On July 21, 2024, 63 large active wildfires were being managed and had burned more than 1 million acres in 10 states, reports the National Interagency Fire Center.

Wildfires pose a substantial public health threat to affected communities. As the EPA notes, the health effects can range from eye and respiratory tract irritation to exacerbation of asthma and heart failure and premature death. Individuals can also sustain severe injuries from the fire itself or from falling debris.

Wildfires, moreover, can cause significant structural damage to health care facilities, force closures due to the accumulation of soot and smoke, and impede access to care. They also can lead to public safety power shutoffs by utilities, points out Climate Central.

According to a May 2023 article in the *American Journal of Public Health*, wildfires have accounted for 8.4% of hospital evacuations in the twenty-first century.

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Health care organizations (HCOs) in western and northwestern states in particular should consider the risk of wildfires in their hazard vulnerability analyses (HVAs). If wildfires are a prioritized threat, then HCOs should address them in their emergency operations plans (EOPs) and evaluate their readiness with exercises.



Published in the new Joint Commission Resources book *The Joint Commission Emergency Management Toolkit*, the Wildfire Tabletop Exercise is available here as a free downloadable tool. The tool consists of two parts: Part 1—Playbook and Part 2—Scenario, which is a slide deck. The tool should be customized to the needs of your organization. EML

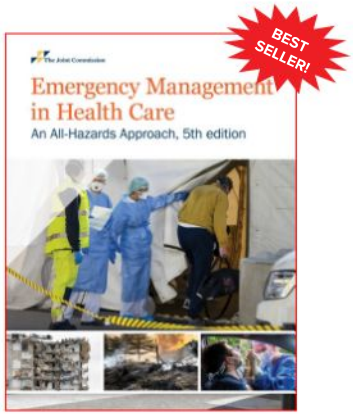
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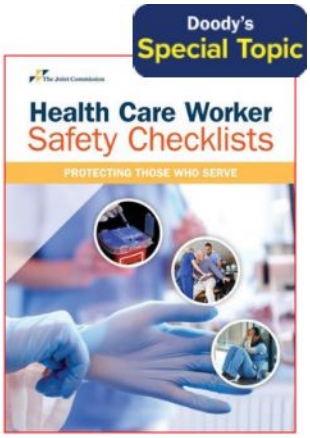
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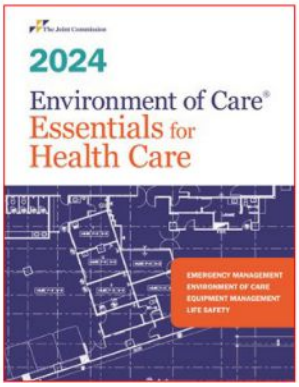
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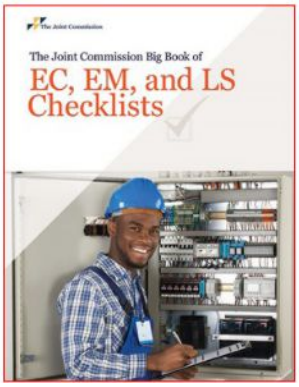
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