Ambulatory surgery centers (ASCs) are about to find themselves more deeply connected with the communities they serve than ever before.

Under the latest Centers for Medicare and Medicaid Services (CMS) rule setting out conditions for coverage, ASCs must join their hospital colleagues in publishing disaster preparedness plans.

The Medicare rule, which takes effect May 18, goes beyond fire drills and patient transfer agreements. ASCs must work with state and local emergency management authorities to determine where each facility and organization fits in with its community’s response plan.

One option: shut the doors

Many surgery centers, especially those in locations at risk for hurricanes, fires, earthquakes, and other recurring dangers have long had emergency response plans. The 3 surgery centers owned by BayCare Health System, Tampa, Florida, have a simple plan: shut the doors and release staff to help in the main hospitals.

That is still fine under the new rule, according to Jerry Gervais, an engineer with the Joint Commission. “In an ASC, it is common in large-scale disasters to simply shut down,” he says. “We will accept that, as long as it has been reviewed with the community.”

However, the updated Medicare rules and the Joint Commission and other guidelines that followed provide an opportunity for ASCs to rethink their policies regarding disaster preparedness. Many will decide to participate more fully in protecting the communities they serve by offering to share their facilities, skilled staff, and supply stores when disaster strikes.

The Joint Commission encourages that choice as well. “We’d like to see ASCs work closely with hospitals,” Gervais says. “It represents a unique opportunity to them to be of service to their community.”

The new condition for coverage is simple and short: Under Subpart C, Section 416.41, it states: “The governing body...develops and maintains a disaster preparedness plan.”

The section specifies the components of an ASC disaster plan, which must include:

- provision for emergency care of patients, staff, and visitors
- coordination with state and local emergency response authorities
- annual drills to test the plan’s effectiveness and revise it as necessary.

The Joint Commission standards are more comprehensive, filling a 16-page chapter in the 2009 Standards for Ambulatory Care. The Accreditation Association for Ambulatory Health Care (AAAHC) was expected to issue its 2009 standards by the end of February. In general, the AAAHC standards require a written emergency plan.
What is an emergency?

An emergency can be anything from a temporary power failure to the Sept 11 terrorist attacks, from an ice storm that keeps staff from getting to work to a hurricane that destroys an entire city.

For an ASC or hospital, an emergency can result in loss of the ability to serve its own patients or in added demand for its resources from other facilities. When an emergency is so severe or widespread that the local community can no longer deal with it and must ask for outside help, it has become a disaster.

The Joint Commission standard also spells out the steps an ASC should take in designing its plan. First, the top leadership must participate. In this and other critical policy issues, experience has shown that if development is left to a lower-ranking committee, the plan will collect dust on a shelf and be useless when the time comes for implementation or the annual drills that now are required.

What are your vulnerabilities?

Next comes what many experts term the “hazard vulnerability analysis.” Working with community emergency management officials, the ASC considers what kinds of incidents are most likely to affect it. In addition to the obvious perils of hurricanes in Florida and earthquakes in California, more subtle hazards should be identified. In large cities, for example, there may be a threat of urban unrest or street violence. The Department of Homeland Security has compiled probability studies that indicate which cities and regions are most at risk for terrorism, whether by bombing or chemical or biological attacks, and has shared the information with communities throughout the nation.

Other vulnerabilities include location near a nuclear power plant or chemical plant, toxic waste site, or, as fire-ravaged western states have learned in recent years, a forest or grassland in a dry climate.

In mountainous or very rural areas, roads blocked by flood or avalanche may prevent supplies and emergency vehicles from getting to or from a surgery center. Agricultural areas, already ill-served by health care facilities, face disasters from hazardous materials spills on the farm or in transportation accidents.

In the third step, planners take the list of possible emergencies and prioritize them. In the deep South, “snowstorm” might be at the bottom, while in Minnesota “blizzard” might top the list.

Participating in community response

The fourth step is to decide to what extent the ASC wishes to participate in the community response plan. By “community,” the Joint Commission means the city, county, state, or even region where the ASC is located and that has its own response plan.

That decision will determine the details of the ASC’s own plan: Will it accept overflow patients from nearby hospitals? Will it be a decontamination or quarantine site? Will it close and let the staff don first responder badges and report to the actual disaster site? Will it provide blankets and bandages to community shelters?

In working with community officials, the ASC must communicate its own capabilities and needs. The general public is not aware of the limits of health care providers, Gervais notes.
“Citizens have an expectation that if there are desperately injured or ill, they will simply report to the nearest hospital,” he says. “Anyone who works at a hospital or an ASC understands what their capabilities are. But communities don’t. There’s a disconnect.”

**Lessons from Katrina**

Gervais saw the problem firsthand when he made the first of many trips to the region devastated by Hurricane Katrina. “People were trapped in buildings, including hospitals.” Evacuees later were sent to shelters in other states, and some have never returned.

“It impacted the whole country,” he says. “It was our first test of a nationwide response.”

As it turned out, no amount of planning would have covered all contingencies, he says, because there were so many unexpected events.

In New Orleans, the city was prepared for the hurricane itself but not for the breach of levees or the breakdown of law and order, with police and firefighters unable to respond effectively.

“It was total anarchy,” he says. “There was no 911. Many things happened there that were not anticipated. The Joint Commission calls it a catastrophe, defined as an event that immobilizes a whole community. We spent 2½ years debriefing, and the lessons we learned are already in the 2008 standards.”

Among those lessons is the importance of having emergency power available. In New Orleans, hospitals with backup generators on the first floor lost them immediately when flooding occurred. That meant no air conditioning in temperatures up to 110°F.

Without functioning water and sewer systems, sanitation became a problem.

Another lesson was the vulnerability of the supply chain. Most hospitals use just-in-time delivery, with 90% of supplies delivered by truck. Supplies had to be brought in by helicopter, a very expensive alternative.

“Emergency management in health care must be an all-hazards approach,” Gervais says.

**Designing the plan**

According to the Joint Commission standard, which is based on best practices developed in other industries and organizations, ASC plans should address the following areas:

- communications
- resources and assets
- safety and security
- staff responsibilities
- utilities
- patient care.

A good plan, according to the standard, will be “scalable” so that, for example, a communication network that works for a minor emergency will also perform in a major disaster. In addition, the components of the plan should be generic enough to apply in any type of emergency. The Joint Commission calls this the “all hazards” approach.

“Although emergencies have many causes,” it states, “the effects on these areas of the organization and the required response effort may be similar.”

Karen Ketchie, RN, PMD, uses the all hazards approach when helping
clients design emergency plans. She is president of Disaster Management Consultants, Jacksonville, Florida, and team commander of a state medical response team and of a Florida-based unit of the National Disaster Medical System (DMAT).

“There are certain elements that you do no matter what kind of event it is,” Ketchie says. “An example is a flood. It would affect staffing and utilities. Look at the big picture.”

While the standard contains detailed criteria for each of the standards (backup utilities, for example) it devotes the most space to staff responsibilities.

In emergency mode, staff may be assigned responsibilities that have nothing to do with their job titles. The office manager could be assigned to escort patients.

**A role for volunteers**

The issue of volunteers becomes critical for a health care facility because any volunteer giving patient care must have appropriate credentials. In the confusion of an emergency, determining who may legally perform what services can be difficult. The standard encourages use of precredentialing through agencies such as the Emergency System for Advance Registration of Volunteer Health Professionals, a division of the Health Resources and Services Administration, and the Medical Reserve Corps.

Volunteers whose credentials are not proven can be used if their services are considered critical, but the ASC must perform detailed checks, including performance supervision and evaluation, and document their efforts to be sure patients are treated only by qualified caregivers.

Once on the job, staff and volunteers should be easily identified by color-coded hats, wristbands, badges, or similar means.

Ketchie says ASC staff not needed on site would be good candidates to serve on emergency response or DMAT teams. “During planning, they should encourage staff to register in one of the programs that would precredential them.”

For ASCs that opt to stay open in an emergency, the Joint Commission standard calls for including in the plan a procedure for restocking medications and other patient supplies. It also calls for establishing backup communications in case normal methods, such as cell phones and fax machines, are not operable.

As part of their responsibility to maintain safety and security, ASCs need to outline specific responses to chemical and biological emergencies. A separate Joint Commission standard identifies criteria for dealing with outbreaks of infectious diseases.

**Writing the plan**

Ketchie advises using spreadsheet software such as Microsoft Excel for drafting the plan.

“The standards tell you every critical element they’re looking for. List the standards and what it takes to be in full compliance. Use it as a checklist.”

In separate columns, she says, planners should indicate for each standard whether the ASC is already in compliance and if not, who is responsible for compliance. “That way, everybody is on the same page—literally.”
Whoever will be responsible for approving the plan, such as the CEO, should take part in writing it, with input from nursing and all other departments, she adds.

An ASC looking for a model plan to copy will not get one from the Joint Commission.

“We don’t give out plans per se,” Gervais says. “Look at the services you give and decide what you want to continue if there is a disaster. Planning and analysis are most important. The key to success is planning, planning, planning.”

—Paula DeJohn

Paula DeJohn is a freelance writer in Denver.