

Advanced Emergency Management Workshop

Day 1

Introduction and History of Emergency Management

History of Joint Commission's Emergency Management Standards

Prior 2001 – “Emergency Preparedness”

- Static plans (provided no flexibility),
- Were created in a vacuum, and
- Emphasized initial response to major trauma events.

History of Joint Commission's Emergency Management Standards

Prior 2001 – “Emergency Preparedness”

- Static plans (provided no flexibility),
- Created in a vacuum, and
- Emphasized initial response to major trauma events.

In 2001 – “Emergency Management”

- Requires dynamic and flexible system,
- Integrates with community to maximize resources, and
- Addresses on-going emergencies.

Revised Emergency Management Standards

- ▶ In development for the past three years
- ▶ Incorporated lessons learned since 2001 Studies and feedback from affected organizations indicate:
 - ▶ Not sufficient for organizations to plan for managing the immediate effects of one single event, but
 - ▶ Organizations need to be flexible to respond to series of escalating events.

Disasters Studied through Hospital/Community Debriefings:

- ▶ Tropical Storm Allison-June 2001
- ▶ Power Outage- Summer 2003
- ▶ S. California Wild Fires-Summer 2003
- ▶ Hurricane Isabel-Fall 2003
- ▶ SARS (Asia/Toronto)-Spring 2003
- ▶ Hurricane Katrina & Rita -2005
- ▶ Terrorist Attacks-September 2001.....

...and our World View Changed Forever!



Major Issues Began to Surface

- Problems with communication
- Inadequate utility plans (esp. emergency generator backup).
- Faulty Incident Command Systems.
- Lack of involvement with community's Emergency Operations Center (EOC).
- The extent of an hospital's planning effort was dictated by the impact of their most recent; worst disaster.

The Common Characteristics

- Sustained, (Multiple Days),
- Affected multiple communities,
- Impacted public services,
- Stressed federal response, and
- Threatened entire healthcare delivery system.

What Happened to local Health Care?

- Home Care closed
- Long-Term Care closed
- Physician Offices closed
- Outpatient Pharmacy closed
- Dialysis Center closed (no generators)
- Outpatient Cancer Center closed
- Ventilator & other special need patients
- Discharged patients (wouldn't leave)

How Did These Pressures Affect Hospitals?

- ▶ Increase admissions.
- ▶ Decreased discharges.
- ▶ Traditional Out Patient services performed.
- ▶ Citizens seeking non-healthcare services
- ▶ Increasing pressure on limited resources
- ▶ “Shelter in Place” or to “Evacuate”?

Goal of 2008 Emergency Management Standards

- ▶ The healthcare organizations should be an important resource available to the community during an emergency; and not itself become a victim.

2009 Emergency Management Standards

- ▶ Identify capabilities and responses when not supported by community for 96 hours.
- ▶ “Scalable approach” to manage response to combination of escalating events.
- ▶ Planning, and testing response plans for emergencies during conditions when the local community cannot support the healthcare organization
- ▶ Management of six critical functions during emergencies.

Emergency Management Administrative Section

Part 1

Scoring 2009 Standards EM Survey Process

2008 compared with 2009

- ▶ 2009: EM is now an accreditation manual chapter
- ▶ All Standards and EP's are incorporated into the 2009 Emergency Management Chapter
- ▶ No new Standards or EP's in 2009
- ▶ This new chapter contains some standards that were in HR, EC and MS
- ▶ Survey process is similar to 2008

EM Chapter Outline

- Foundation for the Emergency Plan [EM.01.01.01]
- Plan for Emergency Operations Plan
 - General Requirements [EM.02.01.01]
 - Specific Requirements
- Evaluation
 - Evaluating the planning [EM.03.01.01]
 - Evaluating the plan through exercises [EM.03.03.03]

Scoring the 09 Standards

Standard

- ▶ A statement that defines the performance expectations and/or structures or processes that must be in place in order for a healthcare organization to provide safe, high-quality care, treatment, and services.

- ▶ An organization is either “compliant” or “not compliant” with a standard.

Element of Performance (EP)

- The specific performance expectation and/or structure or process that must be in place in order for a healthcare organization to provide safe, high-quality care, treatment, and services. The scoring of EP compliance determines an organization's overall compliance with a standard.

2009 Scoring/Accreditation Decision Model - Summary

- ▶ Elements of Performance (EP) will be categorized by common scoring characteristics (e.g., Category A - yes/no, Category C - multiple observations of non-compliance).
 - ▶ The use of Category B EPs (qualitative and quantitative components) will be discontinued.
- ▶ The frequency of “Bulleated” (multi-concept) EPs will be reduced.
- ▶ Elements of Performance and other accreditation requirements will be tagged based on their “criticality” – immediacy of the impact on quality of care and patient safety as the result of non-compliance.
 - ▶ Direct Impact requirements.
 - ▶ Indirect Impact requirements.
- ▶ EPs will be evaluated on a 3-point scale - satisfactory compliance, partial compliance, or insufficient compliance.

2009 Scoring/Accreditation Decision Model - Summary

- All partially compliant and insufficiently compliant EPs must be addressed via the Evidence of Standards Compliance (ESC) submission process - No “Supplemental” findings.

- Potentially multiple submission deadlines based on the “immediacy” of risk.
 - Direct Impact Requirements: ESC due within 45 days.
 - Indirect Impact Requirements: ESC due within 60 days.

- If partial compliance or insufficient compliance is not resolved, a progressively more adverse accreditation decision may result: Provisional, Conditional, Preliminary Denial of Accreditation.

2009 Scoring/Accreditation Decision Model - Summary

- Program specific “screening points”, based on the number of less than fully compliant “Direct Impact” requirements (e.g., Standards and National Patient Safety Goal) serve as a quantitative measure for identifying organizations whose survey findings should be subject to more intensive review by Central Office staff members.
- In programs where it is statistically justified, “bands” of screening points have been established to adjust for differences in size and complexity of surveyed organizations (as determined by surveyor days).
- The 2009 Hospital Program “screening points” for Central Office review are:

<u>Surveyor Days</u>	<u># Not Compliant Direct Impact Standards</u>
1-4	7
5-6	8
7-9	9
10-13	11
= > 14	13

- Program specific “screening points” will be distributed.

2009 Scoring/Accreditation Decision Model - Summary

- Internal review of survey findings will focus on the resolution of instances in which pre-established decision rules were actually met but not recognized at the time of survey.
- The review will also include evaluation of the magnitude and nature of the survey findings to determine if systemic non-compliance exists within the organization (similar issues across multiple departments or key systems - e.g., Medication Management and Infection Control) or if the findings would result in “Condition” level deficiencies, in programs for which the Joint Commission has been granted deemed status by CMS.

2009 Scoring/Accreditation Decision Model - Summary

- ▶ Internal review of survey findings will result in:
 1. Requirements for Improvement to be addressed via the submission of Evidence of Standards Compliance (ESC).
 2. Recommendation for Conditional Accreditation – The magnitude and nature of the survey findings warrants the more intensive follow-up, including a focused survey, that is associated with the Conditional Accreditation process.
 3. Recommendation for Preliminary Denial of Accreditation (PDA) – An Immediate Threat to Life exists within the organization or a rule for PDA was met, as evidenced by the survey findings, but the threat or need to apply the decision rule was not identified at the time of survey.

2009 Scoring/Accreditation Decision Model - Summary

- The report which is presented to the organization at the conclusion of the survey will be modified, as follows:
 1. The title will change to – “Summary of Survey Findings”;
 2. The report will be sorted by chapters in the applicable Accreditation Manuals (additional sorting functionality will be developed).
 3. The content will include the standards, elements of performance, and other accreditation requirements which have been found to be less than fully compliant at the time of survey, as well as the associated survey team observations.
 4. The report will not include a potential accreditation decision. The “official” version of the report which is posted to the organization’s extranet site post-survey will contain the potential accreditation decision.
 5. The report will no longer include “Supplemental Findings”.

2009 Scoring/Accreditation Decision Model

Immediacy of risk to patient care and the organization's accreditation status

Higher

Lower

"Sharp End"

Immediate Threat To Life
(PDA until resolved)

"Situational"
Decision Rules
(Conditional Accreditation and Preliminary Denial of Accreditation)

Direct Impact Requirements
"Implementation" Based Requirements
(Short Resolution Timeframe)

Indirect Impact Requirements
"Planning" and "Evaluation" Based Requirements
(Longer Resolution Timeframe)

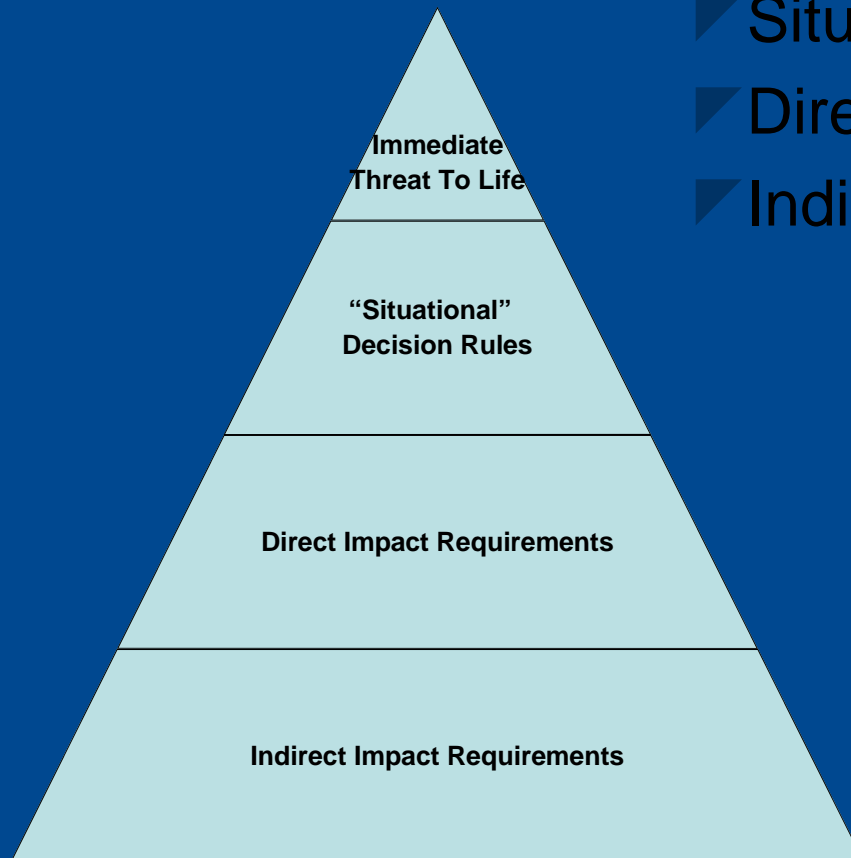
"Blunt End"

Timeline for resolution of non-compliant findings

Shorter

Longer

2009 Scoring/Accreditation Decision Model



- ▶ Immediate Threat to Life
- ▶ Situational Decision Rules
- ▶ Direct Impact Requirements
- ▶ Indirect Impact Requirements

Direct Impact Requirements (Tier 3) - Examples

- ▶ **EM.02.01.01, EP 8**— If the hospital experiences an actual emergency, the hospital implements its response procedures related to care, treatment, and services for its patients.
- ▶ **EM.02.02.13, EP 5**- Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification and at least one of the following (ID from healthcare organization identifying professional designation, a current license, etc.)
- ▶ **EM.02.02.15, EP 5**- Before a volunteer practitioner who is not a licensed independent practitioner is considered eligible to function as a practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and one of the following (ID from a health care organization that clearly identifies professional designation, a current license, certification, or registration, etc.)

Emergency Management Structure and Process

Emergency Management Structure- Example



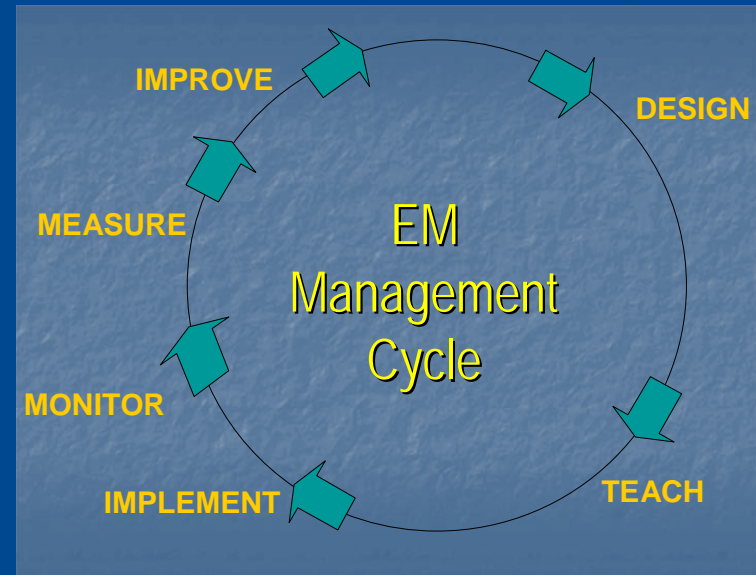
EM Survey Process

■ For Hospitals Only (???)

■ 1 ½ hour Group Discussion

- Plan
- Teach
- Implement
- Respond
- Monitor
- Improve

■ Location of EC Document Review



Emergency Management Survey

- ▶ Review of the organizations Emergency Operations Plan (EOP)
- ▶ Two themes:
 - ▶ Discussion (40%)
 - ▶ Observation (60%)
- ▶ The subject matter will be based on a review of the Hazard Vulnerability Analysis

Discussion Phase

Surveyor initiates discussion around the four EM categories:

- ▶ Mitigation
- ▶ Planning
- ▶ Response
- ▶ Recovery

Surveyor examines:

- ▶ organization's overall EM structure
- ▶ operations
- ▶ planning activities

Discussion Phase

Based On:

- ▶ Survey Activity Guide (SAG)
 - ▶ Facility information
- ▶ Based on HVA
 - ▶ Select a scenario
 - ▶ Trace all appropriate EP's
 - ▶ Discuss identified strengths

Discussion Phase

- ▶ Discuss Emergency Management Program
- ▶ Compliance with EM Standards
 - ▶ EC documents (EOP/HVA)
 - ▶ Staff responsibilities to reduce risk
 - ▶ Assessing physical & building systems

Observation Phase

- Evaluate compliance with following standards:
 - EOP, updated and working
 - Exercises are conducted
 - Surge Capacity/ Handling of Infectious Patients (IC)
 - Back-up of critical data (IM)
 - Leadership's Role/Knowledge in emergency management (LD)
 - Medical Staff Role/Knowledge in emergency management (MS)

Surveyor concentrates on:

- ▶ How the facility handles actual emergencies:
 - ▶ Compliance with EOP
 - ▶ Management of 6 critical areas
 - ▶ Organization's role in community plan
 - ▶ Training efforts
 - ▶ Staff Knowledge

Emergency Management Administrative Section

Part 2

EM Document Review

EM Documents

- ▶ Hazard Vulnerability Analysis
- ▶ EOP
- ▶ Emergency Management Annual Evaluation
 - ▶ Documented inventory of assets
- ▶ Emergency Exercise Critiques

Hazard Vulnerability Analysis (HVA)

- ▶ Conducted by EM Committee/Team
 - ▶ Current
 - ▶ Appropriate
- ▶ Use Multi-disciplinary Approach
 - ▶ Experts within your facility
 - ▶ Community
- ▶ Share information with:
 - ▶ Community-prioritizes events
 - ▶ Hospital Leadership

Conduct a Hazard Vulnerability Analysis

- ▶ Site specific: one or many
- ▶ For each emergency, the organization defines:
 - ▶ Mitigation
 - ▶ Preparation
 - ▶ EP 8 Documented inventory of resources & assets
 - ▶ Fuel
 - ▶ Personal Protective Equipment (PPE)
 - ▶ Water
 - ▶ Medical/surgical supplies
 - ▶ Other
 - ▶ Response
 - ▶ Recovery

4 Phases of EM Planning

- Mitigation- activities used to lesson a potential event potential adverse occurrences
 - Hard activities- uninterruptible power supply, fire suppression systems, standby power generators
 - Soft activities- sandbagging
- Preparation- activities that will organize and mobilize essential resources
 - Creating an inventory of resources that may be needed in an emergency, MOU's, Exercises

4 Phases of EM Planning

- ▶ Response- strategies & actions that are activated during emergency operations
 - ▶ RACE
 - ▶ ICS
- ▶ Recovery- moving from the emergency operations back to normal operations
 - ▶ Financial, staffing & service implications
 - ▶ Insurance coverage/ inventory records
 - ▶ Repair of Facility

Foundation for the Emergency Plan

EM.01.01.01

EP's 1-8

Emergency Management Development

- ▶ Hospital Leadership (including medical staff) participate in planning
- ▶ EM.01.01.01 HVA
 - ▶ EP 2 identify potential emergencies
 - ▶ EP 3 prioritize the HVA with community
 - ▶ EP 4 communicates needs/vulnerabilities
 - ▶ EP 5 mitigate
 - ▶ EP 6 preparedness

Emergency Management Development

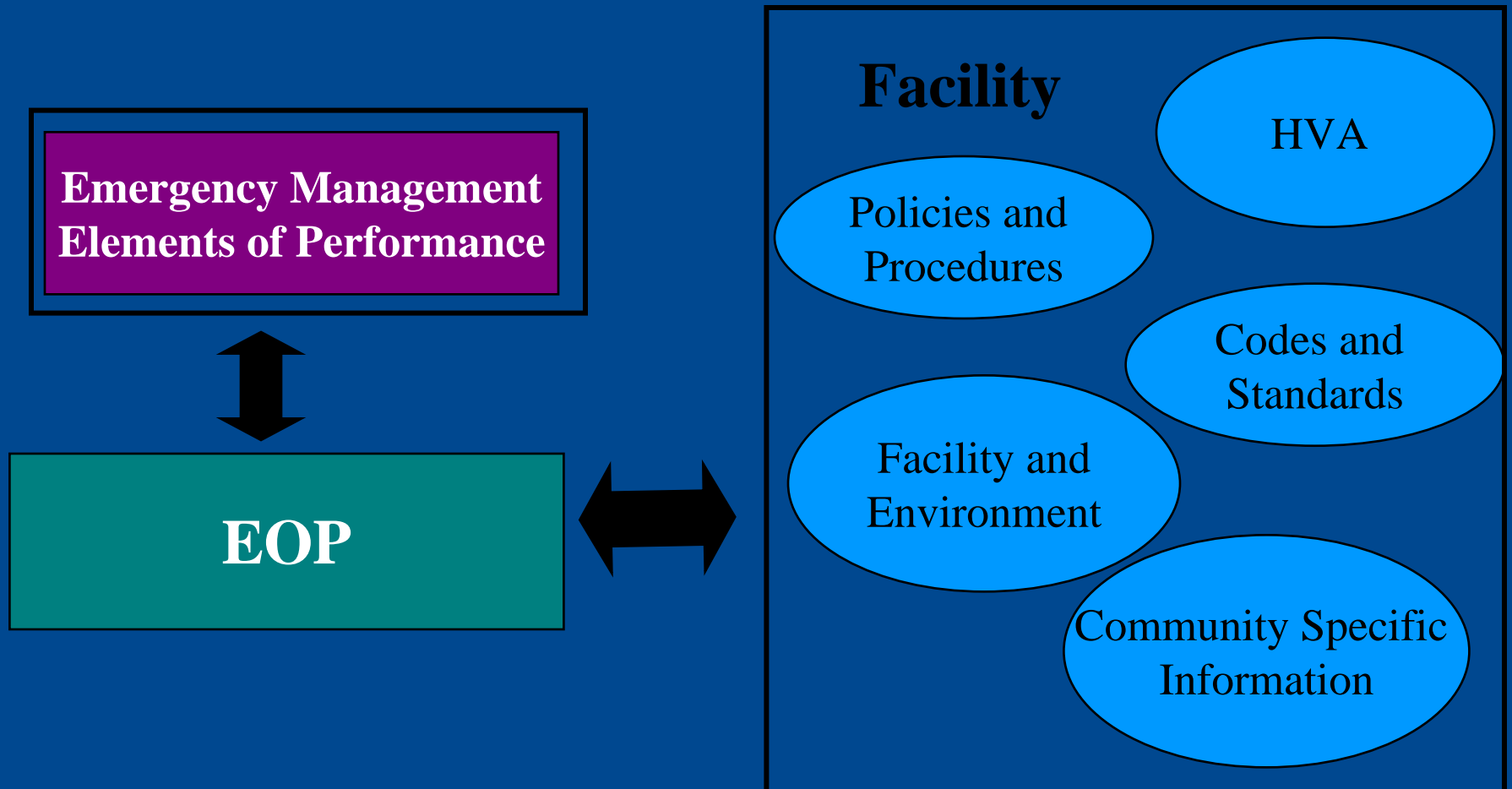
- ▶ EP 7 Established ICS
 - ▶ Consistent with community
 - ▶ Scalable

- ▶ EP 8 Documented inventory of resources & assets
 - ▶ Fuel
 - ▶ PPE
 - ▶ Water
 - ▶ Medical/surgical supplies

Addressing Emergency Planning

General Requirements
EM.02.01.01

Emergency Operations Plan



Six Critical Components

- ▶ Communication [EC.02.02.01]
- ▶ Staff Responsibilities [EC.02.02.07]
- ▶ Safety & Security [EC.02.02.05]
- ▶ Resources & Assets [EC.02.02.03]
- ▶ Utilities Management [EC.02.02.09]
- ▶ Patient, clinical & support activities [EC.02.02.11]

Emergency Operations Plan

EM.02.01.01

- ▶ EP 1- Hospital leaders participate in the development
- ▶ EP 2- Emergency Operations Plan (EOP) describes response procedures:
 - ▶ Maintaining/Expanding Services
 - ▶ Conserving Services
 - ▶ Curtailing Services
 - ▶ Supplementing Resources from outside local community
 - ▶ Closing the hospital to new patients
 - ▶ Staged evacuation
 - ▶ Total evacuation

Emergency Operations Plan

EM.02.01.01

- ▶ EP 3- Capabilities for at least 96 hours
 - ▶ Six critical areas
- ▶ EP 4- Recovery strategies
 - ▶ Restoration of systems
- ▶ EP 5- Initiation and termination of response and recovery phases
- ▶ EP 6- Defines authorities
- ▶ EP 7- Alternative care sites
- ▶ EP 8- Actual implementation is documented

Addressing Emergency Planning

Specific Requirements

Communications EM.02.02.01

Resources & Assets EM.02.02.03

Communication EM.02.02.01

- ▶ EP 1-7 Notify & Communicate with:
 - ▶ Staff
 - ▶ LIP's
 - ▶ External authorities
 - ▶ Patients & families
 - ▶ Notification of evacuation
 - ▶ Community/Media
 - ▶ Purveyors of essential supplies, services & equipment

Communication EM.02.02.01

- ▶ EP 8- Healthcare organizations in geographic area
 - ▶ Command Structure-names/roles/telephone numbers
 - ▶ Command Center
 - ▶ Resources & Assets that can be shared
- ▶ EP 11- Communicating names of patients/deceased
- ▶ EP 12- Communicating patient info to third parties
 - ▶ State Health Dept.
 - ▶ Police
 - ▶ FBI

Communication EM.02.02.01

- ▶ EP 13- Communicating with alternate care sites
- ▶ EP 14- Establishes backup communication systems and technologies for communication activities identified in EPs 1 – 13
- ▶ EP 17- Implements components of EOP requiring advance preparation to support communications during an emergency

Resources & Assets EM.02.02.03

- ▶ The EOP describes how to obtain/replenish:
 - ▶ EP 1- Meds & related supplies
 - ▶ Access/distribution of caches
 - ▶ EP 2- Medical supplies
 - ▶ Includes PPE
 - ▶ EP 3- Non-medical supplies
 - ▶ EP 4/5- Sharing resources & assets with other healthcare organizations
 - ▶ Within community
 - ▶ Outside community

Resources & Assets EM.02.02.03

▶ EOP describes:

- ▶ EP 6- Monitoring quantities of resources and assets
- ▶ EP 9/10- Arrangements for:
 - ▶ transporting some/all patients, meds, supplies, equipment, and staff to an alternative care sites
 - ▶ transferring pertinent info with patients moving to alternative care sites
- ▶ EP 12- The hospital implements components of EOP requiring advance participation to provide for resources and assets during emergency

Lessons Learned:

Addressing Emergency Planning

Specific Requirements

Safety & Security EM.02.02.05

Staff Roles & Responsibilities EM.02.02.07

Safety & Security EM.02.02.05

▶ EOP describes:

- ▶ EP 1- Internal security and safety procedures
- ▶ EP 2- Community security agencies
 - ▶ Roles
 - ▶ Coordination
- ▶ EP 4- Managing hazardous materials and waste
- ▶ EP 5- Provide for radioactive, biological, and chemical isolation and decontamination

Safety & Security EM.02.02.05

- EOP describes:
 - EP 7- Controlling ingress/egress of facility
 - EP 8- Controlling movement of individuals within facility
 - EP 9- Controlling vehicles that access the facility
- EP 10- Implementing components of EOP requiring advance preparation to support security and safety during an emergency

Staff Roles & Responsibilities

EM.02.02.07

▶ EOP describes:

▶ EP 2- Staff's roles and responsibilities:

- ▶ Communications
- ▶ Resources and assets
- ▶ Safety and security
- ▶ Utilities
- ▶ Patient management

▶ EP 3- The process for assigning staff to all essential staff functions

▶ EP 4- Identifies the individual(s) to whom staff report in the hospital's incident command structure

Staff Roles & Responsibilities

EM.02.02.07

- ▶ EP 5- managing staff support
 - ▶ Housing
 - ▶ Transportation
- ▶ EP 6- managing family support needs of staff
 - ▶ Child care
 - ▶ Elderly care
 - ▶ Communication
- ▶ EP 7- Training staff on assigned emergency response roles
- ▶ EP 8- Communicates in writing with each LIP's regarding his/her role(s) in emergency response and to whom he/she reports during an emergency

Staff Roles & Responsibilities

EM.02.02.07

- ▶ EP 9- how the facility will identify licensed independent practitioners, staff, and authorized volunteers during emergencies
- ▶ EP 10- Implements the components of EOP requiring advance preparation to managing staff during an emergency

Lessons Learned: Staff Roles & Responsibilities

Addressing Emergency Planning

Specific Requirements

Utilities EM.02.02.09

Patients EM.02.02.11

Utilities EM.02.02.09

- ▶ EP 2-7 As part of EOP identifies alternative means of:
 - ▶ Electricity
 - ▶ Water needed for consumption & essential care activities
 - ▶ Water needed for equipment & sanitary purposes
 - ▶ Fuel required for building operations, generators, and essential transport services
 - ▶ Medical gas/vacuum systems
 - ▶ Essential utility systems:
 - ▶ Vertical/Horizontal Transport
 - ▶ Heating/Cooling Systems
 - ▶ Steam for sterilization
- ▶ Implements components of EOP that require advance preparation to provide for utilities during an emergency

Patients EM.02.02.11

▶ The EOP describes:

- ▶ EP 2- Managing activities required as part of patient scheduling, triage, assessment, treatment, admission, transfer, and discharge
- ▶ EP 3- Evacuation
 - ▶ Horizontal
 - ▶ Vertical
- ▶ EP 4- Managing potential increase in demand for vulnerable populations:
 - ▶ Pediatric
 - ▶ Geriatric
 - ▶ Disabled
 - ▶ Serious Chronic Conditions/Addictions

Patients EM.02.02.11

- ▶ EP 6- Managing mental health service needs of patients
- ▶ EP 7- Managing mortuary services
- ▶ EP 8- Documenting & tracking patients' clinical information
- ▶ Implements components of EOP that requires advance preparation to manage patients during an emergency

Addressing Emergency Planning

Specific Requirements

EM.02.02.13

EM.02.02.15

Volunteer Licensed Independent Practitioners (LIP's) EM.02.02.13

- ▶ Grants disaster privileges to volunteer LIP's only when EOP has been activated (EP 1)
- ▶ The medical staff identifies in bylaws, individuals responsible for granting disaster privileges to volunteer LIP's
- ▶ The hospital determines how it will distinguish LIP's from other LIP's (EP 3/EM.02.02.07, EP 9)
- ▶ The medical staff describes in writing, how it will oversee the performance of volunteer licensed independent practitioners who are granted disaster privileges (for example, by direct observation, mentoring, or medical record review) EP 4

Volunteer Licensed Independent Practitioners (LIP's) EM.02.02.13

- ▶ **EP 5** Before a volunteer is eligible to function as LIP, the hospital obtains gov- issued photo ID and at least one of the following:
 - ▶ Current pic from health organization, identifying professional designation
 - ▶ Current license
 - ▶ Primary source verification of licensure
 - ▶ DMAT/MRC/ESAR-VHP, other recognized state/federal response hospital or group identification
 - ▶ ID indicating individual has been granted authority by government entity to provide patient care in disaster circumstances
 - ▶ Confirmation by currently privileged LIP with staff knowledge of volunteer practitioner's ability to act as a LIP during disaster

Volunteer Licensed Independent Practitioners (LIP's) EM.02.02.13

- ▶ During disaster:
 - ▶ The medical staff oversees performance of each volunteer LIP (EP 6)
- ▶ Based on oversight of each LIP:
 - ▶ The hospital determines within 72 hours of the volunteer LIP's arrival if granted disaster privileges should continue (EP 7)
- ▶ Primary source verification of licensure occurs as (EP 8):
 - ▶ As emergency is under control
 - ▶ Within 72 hrs from when LIP presents, whichever comes first
 - ▶ If not completed, document:
 - ▶ Reasons
 - ▶ Evidence of ability
 - ▶ Evidence of hospital's attempt to perform primary source verification

Volunteer Licensed Independent Practitioners (LIP's) EM.02.02.13

- ▶ If primary source verification cannot be complete within 72 hours of LIP's arrival, it is performed as soon as possible (EP 9)
 - ▶ Primary source verification of licensure is not required if the volunteer LIP has not provided care, treatment or services under the disaster privileges
 - ▶ Only during extraordinary circumstances

Non-LIP Volunteers

EM.02.02.15

- The hospital assigns disaster responsibilities to volunteers practitioners who are not LIP's only when EOP is activated or unable to meet immediate pt needs (EP 1)
- Document individuals responsible for assigning responsibilities to Non-LIP volunteers (EP 2)
- Determine process for distinguishing Non-LIP's from staff (EP 3/EM.02.02.07 EP 9)
- Document performance oversight of Non-LIP's assigned disaster responsibilities (observation, mentoring, med record review, etc.) EP 4

Non-LIP Volunteers

EM.02.02.15

- ▶ **EP 5** Before a volunteer is eligible to function as non-LIP, the hospital obtains gov- issued photo ID and at least one of the following:
 - ▶ Current pic from health organization, identifying professional designation
 - ▶ Current license, certification or registration
 - ▶ Primary source verification of licensure, certification or registration
 - ▶ DMAT/MRC/ESAR-VHP, other recognized state/federal response hospital or group identification
 - ▶ ID indicating individual has been granted authority by government entity to provide patient care in disaster circumstances
 - ▶ Confirmation by hospital staff with personal knowledge of volunteer practitioner who is not a LIP

Non-LIP Volunteers

EM.02.02.15

During disaster:

- ▶ The hospital oversees performance of each volunteer practitioner who is not a LIP (EP 6)

Based on oversight of each Volunteer:

- ▶ The hospital determines within 72 hours of the volunteer arrival if granted disaster privileges should continue (EP 7)

Primary source verification of licensure, certification or registration occurs as (EP 8):

- ▶ As emergency is under control
- ▶ Within 72 hrs from when volunteer presents, whichever comes first
- ▶ If not completed, document:
 - ▶ Reasons
 - ▶ Evidence of ability
 - ▶ Evidence of hospital's attempt to perform primary source verification

Non-LIP Volunteers

EM.02.02.15

- ▶ If primary source verification cannot be complete within 72 hours of practitioner's arrival, it is performed as soon as possible (EP 9)
 - ▶ Primary source verification of licensure is not required if the volunteer practitioner has not provided care, treatment or services under the disaster privileges
 - ▶ Only during extraordinary circumstances

Lessons Learned: Volunteers