

## **2.0 OPERATIONS**

### **2.1 Internal Operations**

This section provides guidance to the Health Care Associate Director for developing, organizing, and planning for medical facility internal operations in preparation for Year 2000 contingencies. It includes guidance for the development of policies, procedures, and actions that are necessary to prepare VA Health Care Facilities (VAHCF) for potential Year 2000 failures and ensure continuity of operations.

There are three phases of Year 2000 contingency planning which are referenced throughout this and subsequent sections. These three phases are:

*Pre-Year 2000 Planning* – planning, training and drills leading up to transition of the century.

*Execution Phase* – the 72 hours prior and 72 hours after transition of the century.

*Post-Execution Phase* – procedures for returning to normal operations including a thorough review of all critical systems for functionality.

A review of the health care facility's most current internal and external disaster plan should be used as a starting point. Identify the health care facility operations that are likely to be affected by critical third party dependencies.

#### **2.1.1 Flowchart of Contingency Planning**

**Figure 1**, located on page 8, outlines the processes and sequence of events needed to develop the Patient-Focused Contingency Plan.

#### **2.1.2 Roles and Responsibilities**

Defined roles for leading the Year 2000 planning effort are required for successful contingency operations during sustained and prolonged disruptions. These roles must include responsibilities and lines of authority for managers and Year 2000 coordinators at the health care facility and network levels.

##### **2.1.2.1 Responsibilities**

VISN Directors are ultimately responsible for Year 2000 contingency planning and preparedness.

VISN CIOs are responsible for overall coordination of the contingency planning and preparedness.

Health Care Facility Directors are responsible for functional units, business impact analysis and continuum of patient care.

Associate Health Care Facility Directors are responsible for developing, organizing, and planning of health care facility internal operations in preparation for Year 2000 contingencies. They will assign lead individuals of each Functional Unit in the health care facility.



Functional Unit Managers are responsible for maintaining work processes within their assigned functional unit during the Year 2000 transition. They are also responsible for developing their specific Functional Unit Contingency plan.

The Chief of Staff or equivalent is responsible for the continuum of patient care through the Year 2000 transition.

Business Continuity Project Workgroup (BCPW) is responsible for the oversight and implementation of the Functional Unit Contingency plans. This committee may exist as a stand-alone committee, or be a subgroup of another VA health care facility; such as, Safety Committee, Emergency Preparedness Committee, or Environment of Care Committee.

Business Resumption Teams are the staff and vendors that are responsible for the actual resumption of failed systems. Membership of these teams may consist of staff from the functional units as outlined in 2.1.4.4.

The Emergency Preparedness Coordinator (EPC) and/or the Area Emergency Manager (AEM) should have a key role in external Year 2000 preparations.

### 2.1.2.2 Oversight

Internal oversight will be provided by Facility Health Care Directors, Network Directors, and VHA Year 2000 Project Office. External oversight will be by General Accounting Office (GAO), Inspector General (IG), Joint Commission on Accreditation of Health Care Organizations (JCAHO), Office of Management and Budget (OMB), Congressional Oversight Committee and the President's Council on Year 2000.

### 2.1.3 Initiation of Contingency Plan

This guidebook contains all the necessary components to develop the contingency plan for your needs. The contents of this guidebook include the development of functional unit contingency plans, that when compiled and evaluated, become the strategic plan for the health care facility.

The basic strategy includes:

- Step 1** Designating a Business Continuity Planning Workgroup (BCPW) and assigning responsibilities.
- Step 2** Identifying functional units and conducting functional unit assessments.
- Step 3** Reviewing functional unit assessments by BCPW to determine risk and priority.
- Step 4** Generating schedule for tracking critical events.
- Step 5** Developing, publishing and distributing the contingency plan.
- Step 6** Training staff for functional unit responsibilities
- Step 7** Testing the plan.
- Step 8** Critiquing and evaluating the test.
- Step 9** Modifying the plan based on lessons learned.

Each of these nine steps is discussed below. By following these steps, the staff of each VA health care facility will be able to develop a patient-focused contingency plan that will meet their individual needs as well as the requirements of JCAHO and GAO.

**Step 1: Designate a Business Continuity Project Workgroup (BCPW) to oversee operation and execution of health care facilitywide, patient-focused contingency plan.**

This workgroup should be chaired by the Health Care Associate Director or equivalent, and should include key managers at the facility who have major operational responsibilities. Composition should include personnel familiar with internal and/or external disaster activities. Listed below are the recommended members of the BCPW:

- Health Care Associate Director (Chair)
- Safety Officer
- Emergency Preparedness Coordinator (EPC) and/or Area Emergency Manager (AEM)
- Chief, Facility Engineering
- Risk Management
- Chief, Biomedical Engineering
- Chief, Information Resource Management
- Chief, Telecommunications
- Chief, Nursing
- Chief of Staff
- Chief, Purchasing
- Information Security Officer

**Step 2: Identify the functional units in the health care facility (core business processes) and conduct assessments of mission-critical systems for each functional unit.**

Functional units are areas of the health care facility that perform critical functions needed to operate the health care facility. Examples of functional units include the ICU, Fiscal, Clinical Laboratory, etc. The Health Care Associate Director or equivalent will designate functional unit managers if they don't already exist.

Section 4.0 provides sample templates and contingency plans for those functional units of a typical VA health care facility. These templates must be reviewed and adapted to reflect actual conditions for each health care facility. Also, each health care facility may have more or fewer functional units or have them defined differently. For example some VA health care facilities do not have Operating Rooms while some VA health care facilities have Spinal Cord Injury Programs. The key for each VA health care facility is to define the functional units that are relevant to their situation and then conduct an assessment of each functional unit.

**Step 3: BCPW reviews functional unit assessments and determines health care facilitywide risks and priorities.**

The BCPW must define and document health care facilities' Year 2000 failure scenarios. Common failure modes have been identified and are included in the sample templates. It is essential that the magnitude and likelihood of failure be measured for each of the critical systems in the functional units. When the magnitude and likelihood of failure are considered together, they form the basis of a business impact analysis. Business impact analysis is an essential step in contingency planning and can be accomplished through two stages.

The first stage involves the functional unit managers assigning a magnitude or consequence of failure for each one of their critical systems. In other words, for each one of their critical systems (lighting, electrical, communications, etc.), the functional unit manager determines what the impact would be if that critical system shut down. A suggested quantifiable scale for measuring the impact of system failure is: (1) low, (2) medium and (3) high. For example, the functional unit manager for the ICU would assign the critical system electricity a “high” value, meaning that if the ICU lost electricity the magnitude of impact would be severe.

The second stage involves the BCPW making a determination regarding likelihood of failure for each of the critical systems in the functional units. This assessment, coupled with an evaluation of the consequence of failure, yields an assigned value of risk or priority level. These risk values or priorities should be used in allocating resources for planning purposes. For example, a system with high impact and high risk of failure should receive first priority and be given close scrutiny during the Pre-Year 2000 Planning Phase.

The membership of the BCPW should be such that it possesses the necessary technical expertise to assign the probability of failure for the various critical systems. Functional unit managers should report their assessments from stage one to the BCPW, thereby creating a forum where the objective assignment of risk for critical systems can take place. In this forum the technical experts are able to provide insight regarding the probability of loss, while functional unit managers share insight regarding the magnitude of loss for critical systems.

By following step 3, the health care facility staff will also be meeting a critical GAO requirement, known as Business Impact Analysis (BIA). BIA is a top-down view of the hospital organization that prioritizes the functional unit data collected as defined in this guidebook. The data compiled and reviewed by the BCPW is the basis for allocating scarce resources. After consulting with the functional unit managers, the BCPW will identify critical priorities and recommend resource allocation to the Health Care Facility Director for approval.

It is important that all the measures described in step 3 are documented, so employees can understand what decisions were made and why. It also provides an excellent means of demonstrating that health care facility staff applied due diligence in prioritizing and allocating resources.

#### ***Step 4: Generating a schedule for tracking critical events***

Using the risk assessments from the various functional units, the BCPW will determine common needs of various functional units, critical activities to be tracked and priorities for the health care facility. It is very important that every functional unit manager participate in this process so no critical priorities are missed.

The BCPW will develop and apply criteria when conducting these reviews. This oversight is necessary to ensure that functional managers understand what is expected of them and that all critical systems are thoroughly and consistently assessed. The BCPW must establish a formal reporting system to senior management at the health care facility to review and monitor progress toward completing the patient-focused Year 2000 business continuity plan. The BCPW will also review and verify the appropriateness of milestones for all mission-critical systems.

The BCPW must also evaluate the Year 2000 related external risks. Using the external disaster planning process as a base, identify risks posed by customers, suppliers, information technology vendors and business partners. The EPC or AEM representative at each health care facility should be involved. Initiatives should also be launched that address internal, external and/or customer/supplier disruptions. Sample letters and a list of vendors are included to ascertain compliance from business partners. These samples are contained in Appendix B.

The critical events and priorities identified in step 3 and 4 should be organized into a schedule similar to the one illustrated in section 2.3.

### **Step 5: Developing, publishing, and distributing the Contingency Plan**

Contingency planning integrates and acts on the results of business impact analysis. The output of this process is the basis for the Year 2000 contingency plan, consisting of a set of contingency plans—with a single plan for each functional unit and infrastructure component. Each plan should provide a description of the resources, staff roles, procedures, and schedules needed for its implementation. An example of a typical outline for a Contingency Plan is as follows:

1. **Purpose** – a statement summarizing the purpose of the Year 2000 Contingency Plan.
2. **Policy** – a statement outlining the goals of the health care facility in the implementation of this plan.
3. **Responsibilities** – an outline of the various levels of responsibilities of key personnel throughout the health care facility. Refer to section 2.1.2.1 for guidelines on how to assign responsibilities.
4. **Procedure**
  - Functional Unit Templates (See Section 4.0)
  - Risk assessment/Business Impact statement (rationale for determining contingency planning priorities for the functional units and the health care facility as a whole.
  - Schedule of Critical Events (a customized version of the Schedule of Critical Events developed from the Functional Templates similar to that outlined in section 2.3)
  - Execution Phase Timeline (a customized version of the Execution phase timeline outlining the activities required 72 hours before and 72 hours after Jan 1, 2000. Refer to section 2.1.5.4 for an example of this timeline.)
5. **References** – (reference the health care facility's Disaster Policy and any other pertinent policies of the health care facility referenced in the plan)

Refer to Appendix C for a sample VA Year 2000 Contingency Plan.

### **Step 6: Train the VAHCF Staff**

**General Awareness** -- It is important that every employee is aware of Year 2000 and its possible effects. General awareness training for staff should continue through every phase of Year 2000 planning. Presentations may include Year 2000 general awareness events, computer-generated (Power Point) presentations, and status reports at all levels at the health care facility. These presentations should be conducted on a quarterly basis with increased training in the last quarter of calendar year 1999. Community awareness may include public service announcements, articles in patient newsletters and various presentations to Veterans Service Organizations and other key stakeholders.

**Specific Training** -- Employees should be given specific training to ensure they know the contingency plan for their assigned functional unit. This training should include the knowledge of what is in the plan and what their role is when the plan is activated. This training should be conducted around six months before the end of calendar year 1999 and repeated 30 days before December 31, 1999.

### **Step 7: Test the Plan**

Testing of the plan will assure that appropriate responsibilities are assigned and staff is trained on how to respond. This function is critical and will help health care facility staff establish quality assurance reviews. The health care facility should conduct at least one test of the emergency power system. The health care facility may also participate in a multi-hospital Year 2000 test in the VISN and/or with the local community. These tests will help the health care facility staff test both internal and external disaster preparedness as well as identify potential problems and areas for additional work. Section 5.0 of this guidebook provides additional information for testing the plan similar to that used for critiquing disaster drills.

### **Step 8: Critique and Evaluate Tests**

After each test, the health care facility staff should critique the drill as is done with any other internal or external disaster drill. Adjustments to the hospital as well as individual functional unit contingency plans should be made as quickly as possible. Appropriate functional unit staff must be retrained depending on how extensively the plan is modified.

### **Step 9 Modify the Plan based upon lessons learned**

The contingency plan will have to be modified periodically as new additional information is obtained from suppliers, vendors, the community, and other sources. It is essential that all staff be informed of any significant changes.

## **2.1.4 Issues to Consider in Developing Your Contingency Plan**

### **2.1.4.1 Involving Stakeholders**

Stakeholders including Veterans Service Organizations, medical school affiliates and employee unions are critical to successful contingency planning. Discussions should be initiated with these stakeholders by April 1999 and completed by August 1999.

Involving union partners early is particularly important so that sufficient time can be allotted for input, discussions and negotiations if necessary. There may be a number of issues requiring input including organizing labor pools, modifying leave schedules, call-back of employees, mandatory overtime, denial of annual leave, etc.

### **2.1.4.2 Managing the Inpatient Census and Clinic Workload**

Due to the inherent Year 2000 related risk of critical systems in patient care areas, VA health care facilities should seriously consider minimizing elective admissions and surgical procedures and curtailing outpatient appointments during the Execution Phase—72 hours prior and 72 hours after transition of the century. Additionally, some of the patients who are followed by the Home Based Health Care Program may need to be brought into the health care facility. For instance, the potential of a regional power failure may warrant Home Based Health Care staff bringing in ventilator-dependent patients.

Similarly, health care facilities should consider reducing clinic workloads during the Execution Phase. Clinical staff in these areas may be drawn upon to help support the staff on the Nursing Units or in the emergency room.

### **2.1.4.3 Staffing Issues**

Year 2000 Contingency Planning will lead to increased staffing needs during the Execution Phase. For many areas within the health care facility, staff should not be allowed to take annual leave and/or could be required to work overtime. Some of the functional units where additional staffing will be required include: Inpatient Wards, ICUs, Home Based Health Care, Health Care Facility management, Police, Central Supply, Radiology, Laboratory, Pharmacy, Operating Rooms, and Facility Engineering. The specific responsibilities that may lead to increased staff needs for these areas are covered in section 4.0.

Consider the following options when planning for staffing:

- Identify back-ups for key staff.

- Compile and distribute a list of key staff names and contact telephone numbers, plus back-up contact methods (mobile phones, cellular phones).

- Examine what processes could be employed to allow key staff to implement parts of contingency plan remotely.

- Establish a family refuge so family members and pets of key staff can be cared for at the health care facility. Experience has shown that family members make excellent volunteers during emergencies such as hurricanes.

- Determine the number of staff required to implement the contingency plan in each functional unit, as well as staff the Emergency Command Center.

- Ensure availability of transportation of staff to and from the health care facility.

- Plan for staff training, transportation, family member care, etc.

Health Care Facility management must notify union representatives that annual leave and use or lose leave may be denied and mandatory overtime will be required for many key employees at the health care facility. Unions and employees should be a part of the planning process and receive six months' notice.

#### **2.1.4.4 Business Resumption Team**

As in emergency preparedness planning, there is a need to organize a Business Resumption Team to respond quickly to any failure in critical systems. This team should consist of a group of technical experts who are prepared to respond to critical systems failures. For example, the monitor on a clinical workstation might go blank due to the loss of power, failure in the network, or malfunctioning of a *VISTA* program. Duties and responsibilities of this team are outlined in Section 3.0. Each health care facility should have at least one Business Resumption Team. A senior manager should be appointed to lead the team. The recommended membership is as follows:

- Chief, Biomedical Engineering
- Electronics Technician
- VISTA* Systems Manager
- Network Administrator
- Boiler Operator
- Electrician
- A/C Mechanic
- Telecommunications Specialist
- Information Security Officer

Others could be added as the need may dictate.

#### **2.1.4.5 Purchasing and Contracting**

Health Care Facilities must ensure that supplies and services necessary to provide for continuity of operations in the event of Year 2000 failures are identified to the Purchasing Department no later than Summer. While it is recognized that critical supply purchases will continue to occur during the entire planning period prior to December 31, 1999, health care facility internal operations planning must provide for contract negotiation and implementation in a timely manner to ensure Year 2000 readiness.

Each facility must determine the advance stocking level of supplies it should acquire for the Year 2000 transition. Bear in mind that with very few exceptions, stock on hand will be used before any applicable expiration dates. A two-week stock of critical supplies should ensure that any needed alternate sources will have time to provide the needed supplies.

In the first days or weeks following the beginning of the new century, even if vendors can provide necessary services, health care facilities must be prepared for problems related to processing of credit card orders. Consequently, health care facilities should have a supply of cash on hand to provide for emergency purchases of critical supplies and services in the two weeks immediately following the beginning of the New Year.

#### **2.1.4.6 Planning for Increased Expenses Due to Year 2000**

Undoubtedly, health care facilities will incur increased operational expenditures from implementation of Year 2000 contingency plans. Section 2.3 Schedule of Critical Events includes the types of activities that would likely increase expenses. Health care facilities should

build into their first quarter budget for FY 00 projected expenditures associated with the implementation of their Year 2000 contingency plan. These expenditures typically fall into three categories:

**Critical supplies** required for implementing contingency plans. Examples include batteries, bottled oxygen, and fuel oil.

**Additional inventories** in the event distribution systems fail. Examples include key pharmaceuticals, sterile supplies, and dietary items.

**Increased staffing costs** especially during the Execution Phase. Examples include mandatory overtime and unscheduled hours.

## **2.1.5 Activating the Execution Phase**

The Execution Phase is the 72 hours prior and 72 hours after transition of the century. The goal during this phase is to minimize any disruption in the delivery of patient care. If necessary, a Command Center similar to that used during a disaster drill, will be activated. The Command Center will direct the use of staff and coordinate communications between the health care facility's staff and the community and/or VISN.

### **2.1.5.1 Command Center Membership and Responsibilities**

**Suggested membership for the Command Center includes, but is not limited to:**

- Health Care Facility Director
- Health Care Associate Director or equivalent
- Chief, Nursing or Associate Director, Patient Care
- Chief of Staff
- Staff Assistant
- Year 2000 Site Coordinators (Technical and Management Representatives)
- The EPC or AEM
- PAO

**Responsibilities include, but are not limited to:**

#### **Health Care Facility Director:**

- The safety of patients and staff.
- The officer in charge and directs activation of Year 2000 activities.
- Declares Year 2000 activation and activates the Command Center.
- Contacts the VISN Director if problems result from Year 2000 and reports on the situation as indicated.

**Chief of Staff:**

Coordinates all medical activities during Year 2000 activation.

Meets with the Chiefs of Patient Care Services, briefs them on the disaster situation and coordinates their activities.

Determines and directs the discharge and/or admission of patients.

Designates the services, teams, and areas to be activated for receipt/treatment of emergency admissions.

Monitors the availability and needs for beds, and other services.

Stays informed about progress, needs and problems as they pertain to patient care.

Maintains close contact with the Associate Health Care Facility Director (Disaster Coordinator) to: provide information through the Associate Health Care Facility Director regarding the status and needs of Patient Care Services for interested outside sources.

**Associate Health Care Facility Director or equivalent:**

As the Disaster Coordinator, manages emergency operations and coordinates the interaction between the health care facility and outside agencies and the local community during the Year 2000 activation.

Receives reports from:

Chief of Facilities as to any physical damage to the facility.

Chief of Staff about the capability status of the medical functional units.

Functional Unit Managers on the status of hospital supplies and services.

Contacts local and state authorities to obtain assistance and information pertaining to any major community problems.

**2.1.5.2 Establishing a Labor Pool**

Establish, direct and control an employee labor pool to provide the manpower needed.

Normally the Chief or Product Line Manager of Human Resources takes the lead.

Responsibilities can include: receiving requests via telephone and/or hand held two-way radios from the Command Center, and sending employees as runners to coordinate between services.

Service Chiefs/Product Line Managers are responsible for sending updated lists of available personnel to serve in the labor pool.

**2.1.5.3 Establishing an Employee Refuge (Family Dependent Shelter)**

Each VAHCF might want to consider establishing an area within the facility; such as, an auditorium to house family of employees who are called back to work for an indefinite period of time. As with any large scale emergency lasting over a period of time, employees are less reluctant to return to duty or remain on duty if they know their loved ones are safe and close by. Other issues to consider are:

Registration - Every person in the shelter must be registered and sponsored by an employee. By accomplishing this, you know who is in your facility

Recreation - Have Recreation Section/Service oversee this operation to assure constructive activities are provided. A good source to check is your local American Red Cross because they offer Shelter Operations training.

#### 2.1.5.4 Execution Phase Timeline

Unlike most contingency plans, not only is it known that the Year 2000 Contingency Plan will be implemented, but the precise timing of the event is also known. Accordingly, medical facilities need to activate their plan no later than 72 hours prior to midnight, December 31, 1999. To ensure that necessary actions are accomplished in the days and hours prior to the end of the century, an Execution Phase Timeline should be developed that lists these final preparedness activities to ensure readiness. A sample timeline follows.

TIME	ACTION TO BE COMPLETED
<p><b>72 Hours Prior to transition of the century</b></p>	<ol style="list-style-type: none"> <li>1. The Command Center is set up.</li> <li>2. The BCPW ensures that Functional Unit Managers are familiar with their Year 2000 readiness plans, contingencies are in place and all supplies are available.</li> <li>3. Review Operating Room schedules.</li> <li>4. The Command Center notifies the health care facility that the Execution Phase has begun by telephone communication to all Service Chiefs and product Line Managers.</li> <li>5. Ensure additional cash is acquired for emergency purposes. (Minimum 2-week cash reserve.)</li> <li>6. Preliminary precautions include, but are not limited to the following: <ul style="list-style-type: none"> <li>• Facilities Management - will ensure adequate supplies of diesel fuel, oil, gasoline, and bottled gas.</li> <li>• Financial Resources Management in coordination with Nutrition &amp; Food Section, and the Canteen Service ensures that emergency rations and disposable utensils are, or can be made available.</li> </ul> </li> <li>7. All Services &amp; Product Lines will: <ul style="list-style-type: none"> <li>• Review emergency duty rosters for essential personnel coverage and send copy to the Director's Office.</li> <li>• Report names and number of employees available for emergency duties to the Health Care Director.</li> <li>• Submit all requests for assistance to the Command Center.</li> <li>• Turn refrigerators and freezers to the coldest practical setting in anticipation of an electrical outage.</li> </ul> </li> </ol>
<p><b>48 Hours Prior to</b></p>	<ol style="list-style-type: none"> <li>1. When rooms or areas are vacated for any period of time, disconnect all non-essential electrical equipment.</li> <li>2. For health care facilities in warm locations, buildings should be cooled to lowest temperature that does not compromise patient care. For health care facilities in cool locations, temperature should be heated to highest possible temperature that does not compromise patient care.</li> <li>3. Functional Unit Managers contact Command Center with readiness status.</li> <li>4. Consider establishing a public relations center to handle inquiries from the media and the general public.</li> <li>5. External community liaison is established.</li> </ol>

	<p>6. Emergency precautions include, but are not limited to the following:</p> <ul style="list-style-type: none"> <li>• The Command Center will make final determination on how to manage the Execution Phase including the scheduling, modification, or discontinuation of services, control of patient information, admission, transfer and discharge of patients.</li> <li>• Nutrition &amp; Food Section ensures emergency rations and disposable utensils are in the health care facility.</li> <li>• Facilities Support Section ensures emergency stocks of linen and other supplies are in the health care facility.</li> <li>• Facilities Management will deliver (if applicable) water bladders to designated areas, fill with potable water, and secure the water supply.</li> <li>• Nutrition &amp; Food Section and Nursing Service personnel will fill all other clean, sanitized containers with water for drinking purposes.</li> </ul>
<b>24 Hours Prior to</b>	<ol style="list-style-type: none"> <li>1. The Command Center is fully staffed.</li> <li>2. Human Resources Management assigns employees reported to be available by their Service/Product Line to any area requesting assistance.</li> <li>3. All unused fume hood and safety cabinet exhausts will be shut off after clearance from Facilities Management.</li> </ol>
<b>00:01</b>	<ol style="list-style-type: none"> <li>1. All Utility Systems should be tested and checked.</li> <li>2. Normal operations will resume as quickly as possible.</li> <li>3. All functional groups will call into Command Center with status.</li> </ol>
<b>Within 1 Hour after</b>	<ol style="list-style-type: none"> <li>1. Function Unit leaders call Command Center and report any critical system failures.</li> <li>2. All critical utility systems should be checked.</li> <li>3. The DEC servers and Network should be checked-out by the system manager.</li> <li>4. The phone system, Local Areas Network (LAN) and Wide Area Network (WAN) should be checked.</li> </ol>
<b>1<sup>st</sup> Business Day after</b>	<ol style="list-style-type: none"> <li>1. All critical medical devices should be tested and checked.</li> <li>2. Prioritize repairs and or replacements for all equipment and systems with transition of the century-related problems.</li> <li>3. In-service training day when all equipment is checked by users.</li> </ol>

## 2.2 External Operations

Year 2000-related problems have the potential of disrupting operations within VA health care facilities as well as critical services relied upon in the community. Because of the large scale implications of potential failures in key services, health care facilities should view their “community” in broad terms to include other nearby health care facilities, as well as regional utility suppliers and local and state governments. VA health care facilities should develop contingency plans for external dependencies that they rely on, such as electricity, water, transportation and supplies to name a few. VA health care facility Year 2000 contingency planning efforts cannot succeed if conducted in a vacuum. VA facility management must take a proactive approach to planning in concert with other VA health care facilities, local hospitals and city, county and state agencies.

VA health care facility management, specifically, the BCPW needs to perform three functions in order to assure that potential external hazards are fully considered and planned for.

- a. **Perform an assessment of hazard vulnerabilities.** The BCPW should consider what are the Year 2000 problems that are anticipated within the community. *The BCPW should use the spreadsheet outlined in Appendix D-1 to list those external services the health care facility relies on, along with the potential problem, the probability (low, medium or high) of the occurrence, and contingency actions to take in the event of a loss of service.*
- b. **Conduct an inventory of community resources to address these hazards.** *The BCPW should identify available community resources for the following key areas: people, money, clinical space, and supplies and equipment.*
- c. **Close the gap between vulnerabilities and capabilities.** *The BCPW should consider putting into place measures that will mitigate potential disruptions in critical services. This will require developing new working relationships with various governmental agencies, non-VA health care organizations, and vendors of critical supplies.*

### 2.2.1 Hazard Vulnerability Assessment

Similar to the business functional analysis of *internal* organization-wide risks and priorities, VA management must identify the most probable *external* Year 2000-related hazards that threaten the operation of the VA health care facility. Year 2000-related hazards have the potential of affecting most essential services that VA health care facilities rely upon including: telephone service, transportation systems (i.e., subways, trains, traffic lights), electricity, fuel supplies, and potable water. An assessment of each of the critical services and their probability of failure must be accomplished before any meaningful Year 2000 contingency planning can occur.

The degree with which local communities are assessing potential Year 2000-related disasters varies greatly across the country. However, most communities have initiated planning for Year 2000 to some extent. Some likely sources of information in the community are: the local fire department or Department of Public Safety; city, county, or state offices of emergency management; mayoral office (may have a Year 2000 committee established); Federal Executive Board/Association and metropolitan and state hospital associations, to name a few. Federal Emergency Management Agency (FEMA) and Public Health Service (PHS) regional offices can also provide valuable input. A major emphasis of FEMA during 1999 will be to promote

awareness and business continuity planning for Year 2000 by working with state and local emergency management officials.

From identifying what has already been accomplished within the community, valuable time can be saved in identifying potential Year 2000 hazards. AEM can facilitate these contacts and provide other assistance with external operations planning. These individuals have extensive community contacts and can facilitate the identification of potential Year 2000 hazards and assist with external operation planning. The AEM can assist with community outreach as a way of ensuring the integration and coordination of community and VA medical facility planning efforts. A list of AEMs is provided in Appendix D-2 which includes the name of the lead AEM for every network, and the responsible AEM for each medical facility—either assigned to the facility or as a preceptor/contact for the local EPC.

The matrix outlined in Appendix D-1 was created to assist VA health care facilities in identifying Year 2000 external threats and remedial planning. The BCPW should begin the planning process by using this matrix to list the external services that support their internal operations, the potential hazard, list the probability (low, medium or high) of the occurrence, and contingency actions to take in the event of a failure. Completing the matrix will assist VA health care facilities with planning for Year 2000 hazards external to the organization. Furthermore, a completed matrix will provide a quick and comprehensive reference that can be used by the Command Center and others in the event of specific Year 2000 emergencies.

### 2.2.2 Community Resources

Once potential hazards and their probability have been assigned, the next step is to identify community resources. Examples of community resources include: labor pools such as reserve units, emergency generators, secondary fuel supplies and transportation vehicles.

Effective and comprehensive emergency management depends on the identification of community resources for five key areas. These are information, people, money, clinical space, and supplies and equipment. Resource inventories should be organized according to these categories as discussed below:

**Information:** Information needs to be shared among community institutions for effective Year 2000 contingency planning to take place. Much of the groundwork for this resource category will be laid while assessing potential hazards in the community. Health care organizations and city agencies should have in place a mechanism for sharing information on system failures and available resources prior to, during, and after January 1, 2000. Information resources should include the development of a comprehensive contact listing with phones, cell phone and pager numbers of key points of contact within the community. (See Appendix D-3 for a sample listing.)

**People:** Acquiring, lending or exchanging personnel is an essential part of coordination. A resource listing should include sources for personnel in the community to assist in the recovery process, whether these be direct care providers, allied medical personnel, or non-medical professionals with critical skills such as engineering, IRM, or telecommunications.

**Money (Funds):** VA health care facilities must be prepared to reimburse suppliers, perhaps even with cash, to acquire critical resources. Accordingly, facilities should consider emergency contracts or MOUs with potential suppliers prior to Year 2000 to ensure that these mechanisms are in place.

**Clinical Space:** Health care facilities also need to ensure there are resources identified for the transfer of patients and patient care services, in the event their physical plant is not operational.

**Supplies and Equipment:** Normal sources of supplies, equipment, and repair parts may be unavailable, or will be so taxed that they will not be accessible when needed. The potential sharing of resources between other medical facilities in the community needs to be incorporated into this critical resource listing.

Think creatively when considering potential sources for assistance and actions to take to address resource problems. For example, in January, school systems are closed for the holiday. School buses, fuel, heating oil and other commodities may be available for use within school systems (although in many instances schools are already committed to sheltering populations), and this includes colleges and universities. In addition, industrial and manufacturing plants that might shut down or reduced to a skeleton work force during the Christmas and New Year's holidays might be utilized. Develop plans in advance to use these potential sources for supplies and equipment in an emergency.

### 2.2.3 External Contingency Actions (Closing the Gap)

A thorough hazard and vulnerability assessment, coupled with a comprehensive listing of community resources, will highlight areas where gaps exist. An especially valuable tool in assisting health care facilities in identifying gaps between hazards and resources in the community is a tabletop exercise with key community players. Section 5.0 Training and Drills provides guidance on conducting communitywide Year 2000 readiness exercises.

In an effort to bridge the gaps between potential hazards and available community resources, the BCPW should put into place measures to mitigate potential disruptions in critical services. Some examples of the types of measures that could be necessary are: Memorandum of Understanding with other health care providers, contract for back-up services, and additional inventories. Those VA health care facilities that have academic affiliations should seriously consider working closely with their affiliates on identifying avenues to pool resources where gaps between contingency needs and available supplies and services exist.

There may be competition with other institutions and activities for resources within the local community, so it is important to ascertain as to how these are being managed. VA health care facilities should begin planning at least six months prior to transition of the century. Appendix D-2 was developed to assist health care facility management with identifying potential threats for essential supplies and services for a typical health care facility along with actions that may eliminate or mitigate the threat in advance. Also, there is a place for identifying the points of contact associated with institutions and vendors of each of the supplies and services.

An essential part of the external operations will include liaison and communication connectivity with various Emergency Operations Centers (EOCs) in the local community (here again using "community" in a very broad sense). It is envisioned that many emergency operations centers, that are usually only activated in a disaster, will be up and running at least several days in advance of December 31, 1999.

Every VA health care facility needs to ensure connectivity to these EOCs. The Area Emergency Manager may be available to fill this role. VA management will be able to receive assessments and information to determine impact on the VA health care facility, as well as coordinating

resources that may be required to maintain continuity of operations. If normal communications are disrupted, these EOCs may also provide the VA medical facility a conduit for communications with the VISN and other outside sources of assistance if normal communications are disrupted.

VA health care facilities should also be an active participant in local planning efforts coordinated by the regional hospital association and local council of governments. VA health care facility management will find these forums beneficial in:

Assuring that hospitals are at the top of the list when utility companies are prioritizing resumption services for a regional outage.

Developing a close relationship with local emergency medical services (EMS).

Obtaining periodic updates on FEMA planning activities.

Obtaining status reports on Year 2000 compliance activities from local government agencies.

## **2.3 Schedule of Critical Events**

### **January 1999**

---

- ❑ Install *VISTA* patches related to Year 2000.
- ❑ Continue Renovation/Implementation Phase.

### **February**

---

- ❑ Review the VA Health Care Facility Y2K Utility Systems Guidebook, especially sections which pertain to contingency planning.
- ❑ Review the Year 2000 Medical Device: Guidebook, especially the section on Validation and Appendix D (See Appendix E for a copy of this publication).

### **March**

---

- ❑ The Health Care Associate Director or equivalent should review VHA Patient-Focused Contingency Planning Guidebook distributed by VAHQ.
- ❑ Form a BCPW to oversee the development and execution of a hospitalwide, patient-focused contingency plan. The BCPW could be a stand-alone or subcommittee of your current Emergency Preparedness Committee.
- ❑ Identify those functional units that are relevant to your facility and designate "Functional Unit managers" for each area.
- ❑ Functional Unit managers should perform a business impact analysis (customize their functional unit template).
- ❑ Attend Year 2000 Conference call (3<sup>rd</sup> Thursday of the month at 1:00 p.m. ET).

## April

---

- ❑ The BCPW should meet to review the business impact analysis of each of the functional units.
- ❑ Initiate community planning contacts.
- ❑ Initiate Union and other key stakeholder interfaces.
- ❑ Begin awareness “campaign” within and outside the health care facility. The PAO should be intimately involved with the development and implementation of the awareness campaign.
- ❑ Initiate planning for a Year 2000 disaster drill. The drill should include testing of emergency generators as outlined in the memo from the Chief Network Office (A copy of this memo is provided in Appendix D).
- ❑ Attend Year 2000 Conference call (3<sup>rd</sup> Thursday of the month at 1:00 p.m. ET).
- ❑ Health Care Facilities should finalize their contingency plans.

## May

---

- ❑ BCPW should meet to review Functional Unit Templates for consistency.
- ❑ Continue the awareness “campaign”.
- ❑ List all necessary critical supplies to acquire.
- ❑ List all critical services to contract.
- ❑ List alternate vendors for critical services and supplies.
- ❑ Plan health care facility and VISN-wide Year 2000 disaster drill.
- ❑ Attend Year 2000 Conference call (3<sup>rd</sup> Thursday of the month at 1:00 p.m. ET).

## June

---

- ❑ BCPW should review lists of critical supplies and services, and gaps in needs and available resources in the community.
- ❑ BCPW reviews the status of Functional Units with Functional Unit managers.
- ❑ Functional Unit managers train staff on their role in carrying out contingency plans.
- ❑ BCPW should submit prioritized list of needs for contracted supplies and services with specifications to A&MM.
- ❑ A&MM to identify alternate vendors for critical supplies and services.
- ❑ Begin conducting health care facility and VISN-wide disaster drills.
- ❑ Target date for completion of Renovation/Implementation Phase.
- ❑ Review all outstanding items (those items that have not been renovated to date) for contingency plan triggers.
- ❑ Attend Year 2000 Conference call (3<sup>rd</sup> Thursday of the month at 1:00 p.m. ET).

## July

---

- ❑ BCPW critiques the disaster drill and adjusts functional unit templates with the responsible managers. Refine contingency plans.
- ❑ Follow-up with A&MM on contract requirements and critical supply identification.
- ❑ Initiate procedures for reducing scheduled appointments of outpatient clinics for Execution phase.
- ❑ Attend Year 2000 Conference call (3<sup>rd</sup> Thursday of the month at 1:00 p.m. ET).

## August

---

- ❑ BCPW reviews the status of functional unit templates and unit readiness with Functional Unit managers.
- ❑ A&MM finalizes contracts with vendors of back-up services and supplies.
- ❑ Functional Unit managers reviews storage areas and distribution procedures for supplies.
- ❑ VAHCF Fiscal officers sends a budget request to their VISN for needs related to the implementation of Year 2000 contingency plans in the first quarter of FY 00.
- ❑ Attend Year 2000 Conference call (3<sup>rd</sup> Thursday of the month at 1:00 p.m. ET).

## September

---

- ❑ BCPW completes review of functional unit templates and unit readiness with Functional Unit managers.
- ❑ A&MM ensures all Year 2000 related contracting information is in place.
- ❑ VISN CFOs should set aside necessary funds to be distributed in October to cover additional expenses related to implementing Year 2000 contingency plans.
- ❑ A&MM to negotiate contracts with previously identified prime and back-up supply vendors.
- ❑ Health care facility finalizes list of external contacts in the community.
- ❑ Attend Year 2000 Conference call (3<sup>rd</sup> Thursday of the month at 1:00 p.m. ET).

## October

---

- ❑ BCPW reviews staffing and other resource needs for the Execution Phase.
- ❑ A&MM obligates contracts for critical supplies and services.
- ❑ Review storage and distribution procedures for critical supplies.
- ❑ Review acquisition and loan agreements for critical back-up equipment.
- ❑ Attend Year 2000 Conference call (3<sup>rd</sup> Thursday of the month at 1:00 p.m. ET).

## **November**

---

- ❑ BCPW meets with Functional Unit managers to review staff roles for contingency plans.
- ❑ Health Care Facility Director should hold a “Town Hall Meeting” with all staff regarding Year 2000 contingency plans.
- ❑ Inspect newly acquired equipment as part of back-up for critical systems, and train staff on use.
- ❑ Attend Year 2000 Conference call (3<sup>rd</sup> Thursday of the month at 1:00 p.m. ET).

## **December**

---

- ❑ BCPW meets with Functional Unit managers to review staff roles for contingency plans and reviews procedures for the Execution Phase.
- ❑ BCPW finalizes staffing plans for the Execution Phase.
- ❑ A&MM ensures all contracts/supplies are finalized.
- ❑ Post lists of critical contacts in each Functional Unit.
- ❑ Attend Year 2000 Conference call (3<sup>rd</sup> Thursday of the month at 1:00 p.m. ET).