HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA®

Briefs Focus: Is Your Facility in Compliance With CMS Emergency Preparedness Rule?

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In 2016, the Centers for Medicare & Medicaid Services (CMS) instituted its final rule on emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers. The deadline to implement and comply with the rule was November 2017. While many facilities may have taken steps toward emergency preparedness, it's believed there are many that do not meet the requirements and as a result are not prepared to safeguard those in their care in the event of an emergency or disaster. This could jeopardize patients and put the facility's future at risk. Those that do not comply could risk termination from the CMS program.

The purpose behind the rule is to establish national emergency preparedness requirements and ensure "coordination with federal, state, tribal, regional, and local emergency preparedness systems." The importance of being prepared and having a plan in place is strikingly clear, especially considering recent extreme weather conditions and natural disasters from the California wildfires to Hurricanes Irma and Harvey.

The rule impacts the following 17 provider types: hospitals, religious nonmedical health care institutions, ambulatory surgical centers, hospices, psychiatric residential treatment facilities, all-inclusive care for the elderly, transplant centers, long-term care facilities, intermediate care facilities for individuals with intellectual disabilities, home health agencies, comprehensive outpatient rehabilitation facilities, critical access hospitals; clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services; community mental health centers, organ procurement organizations, rural health clinics and federally-qualified health centers, and end-stage renal disease facilities.

Compliance Requirements

Being compliant means that as of Nov. 15, 2017, the 17 provider and supplier types that the rule applies to have a plan in place to keep operations underway in a medically safe-environment and are able to meet the needs of patients. The issues providers face in an emergency can be enormously challenging and include: information sharing, managing the supply chain, protecting and preserving patient records, planning for sheltering in place, having essential equipment available, evacuation plans, anticipating a patient surge, and managing facilities.

Four Core Elements

There are four core elements that must be included in order to comply with the CMS Emergency Preparedness Program, and these must be reviewed and updated annually:

1. Risk Assessment and Planning

CMS (and The Joint Commission) require that each facility conduct a risk assessment (also known as a hazard vulnerability assessment (HVA)). The risk assessment or HVA is an integrated approach that focuses on capacities and capabilities critical to preparedness for any emergency or disaster. This approach takes into account the particular types of hazards most likely to occur where the facility is located. Examples of these may include, but are not limited to: care-related emergencies, equipment and power failures, interruptions in communications such as a cyberattack, loss of a portion or the entire facility, natural risks such as volcanos and earthquakes as well as interruptions in the normal supply of essentials such as water and food.

An emergency plan is developed based on the facility risk assessment (HVA) utilizing an all hazards approach. An emergency plan is the foundation for how a facility prepares for an emergency and includes details about how the response will unfold. It needs to include strategies for addressing emergency events identified by the risk assessment. Some details that need to be included are information about the patient population, continuity of operations, delegation of authority and succession plans in addition to emergency patient care coordination, and a process for primary and alternate means for internal and external (local, tribal, regional, state, and federal emergency preparedness officials) communication.

2. Communication Plan

The emergency preparedness communication plan must comply with federal, state and local laws. A key element of the communication plan identifies who to contact, what the contact is

able to provide, and how to reach them. This will include contact information for staff, physicians, volunteers, other hospitals/clinics, entities that provide services under your arrangement as well as contact information for federal, state, tribal, regional, and local emergency management agencies. This information needs to be regularly updated so that it remains current.

In addition to the contact information, the communications plan must entail primary and alternative means for communicating with the individuals/organizations listed above. The communication plan should also outline what information is to be shared such as the general condition and location of the patients under the facility's care, location of incident command center with contact info, etc.

3. Policies and Procedures

Policies and procedures must be developed that are based on the emergency plan, the risk assessment, and the communication plan which must be reviewed and updated annually. Some of what they need to address includes safe evacuation (including signage, staff responsibilities, and needs of patients) as well as a policy/procedure should your facility have to shelter in place, which takes into account the needs of patients, staff, volunteers during that time (supplies, food, water, equipment such as oxygen). A major policy or procedure that must be included is a system for medical documentation that preserves patient information, protects confidentiality and secures records. Also, emergency staffing strategies need to be referred to such as volunteers, including the process and integration of healthcare professionals that have assisted in addressing surge needs during prior emergencies, and that are locally designated, such as the Medical Reserve Corps, or state-designated, such as Emergency System for Advance Registration of Volunteer Health Professionals.

4. Training and Testing

A training and testing program, based on the risk assessment, the emergency plan, the communication plan, and the policies and procedures needs to be developed, and maintained. The program needs to address and identify who needs to be trained, how often to train, and the staff's knowledge of emergency procedures. This section of the CMS emergency preparedness rule requires that one full-scale community based exercise be conducted and a second full-scale exercise that is community-based, individual or facility-based, and if that is not possible, a

tabletop exercise that challenges the facility's emergency plan. All training and exercises must be documented, analyzed and incorporated into the facility's emergency plan.

Are you in Compliance?

If you are concerned that your facility may not be in compliance with the emergency preparedness rule, here are a few questions to ask to see if you need assistance meeting the requirements:

- Have you conducted a risk assessment/hazard vulnerability assessment (HVA)?
- Do you have a current emergency plan and a communication plan?
- Have you considered all the types of hazards that could occur?
- Does your communication plan have a current list of contacts who can provide services in an emergency or disaster?
- Do all plans provide for the well-being of patients in your care?
- Are all plans updated annually?
- Have you conducted full-scale, community-based emergency training exercises, or an individual facility-based exercise? If so, how many exercises have you participated in?
- Have you documented your training and exercises?
- Does the staff at your facility have Healthcare Incident Command System (HICS) training?

Learn more at: www.hfsconsultants.com/pdf/Emergency-Preparedness-2017-12-06.pdf

About the Authors

Kimberly Baldwin has extensive experience assisting health care facilities prepare for disasters. She was previously the emergency preparedness manager for Lake County, Calif., and was responsible for ensuring that health care facilities were prepared, able to respond, mitigate and recover from a disaster. She assisted in various full and partial hospital evacuations as well as LTC facility evacuations and relocation during wildfires. Baldwin currently provides emergency preparedness and response consulting services, including development and execution of plans, training and exercises. Kim holds a master of public administration from California State Dominguez Hills, and a bachelor of science from California State University, East Bay. She can be contacted at kbaldwin@wipfli.com.

Michael Davis works with Medicare and Medicaid participating providers and suppliers on meeting CMS Emergency Preparedness requirements and HIPAA Regulatory Mandates. He has over 15 years of experience as an IT director in the health information technology area, serving as a HIPAA Security Officer for 10 years. He is highly skilled in developing CMS compliant emergency preparedness programs and performs information technology audits to ensure proper safeguards are in place to protect the confidentiality and integrity of information. Michael performs emergency preparedness assessments, HIPAA security risk assessments, HITRUST validated assessments, breach investigations, and develops governance programs to maintain regulatory compliance. He holds a bachelor's degree in cognitive science with a minor in computer science from UC Berkeley. Davis can be contacted at mcdavis@wipfli.com.