CMS Emergency Preparedness Reg: New Framework to Help you Withstand Whatever Comes your Way

DECEMBER 14, 2016

Speakers

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CMS Emergency Preparedness Rule
CMS Session for NHCPC- December 14, 2016

Understanding the Emergency Preparedness Final Rule

The Basics

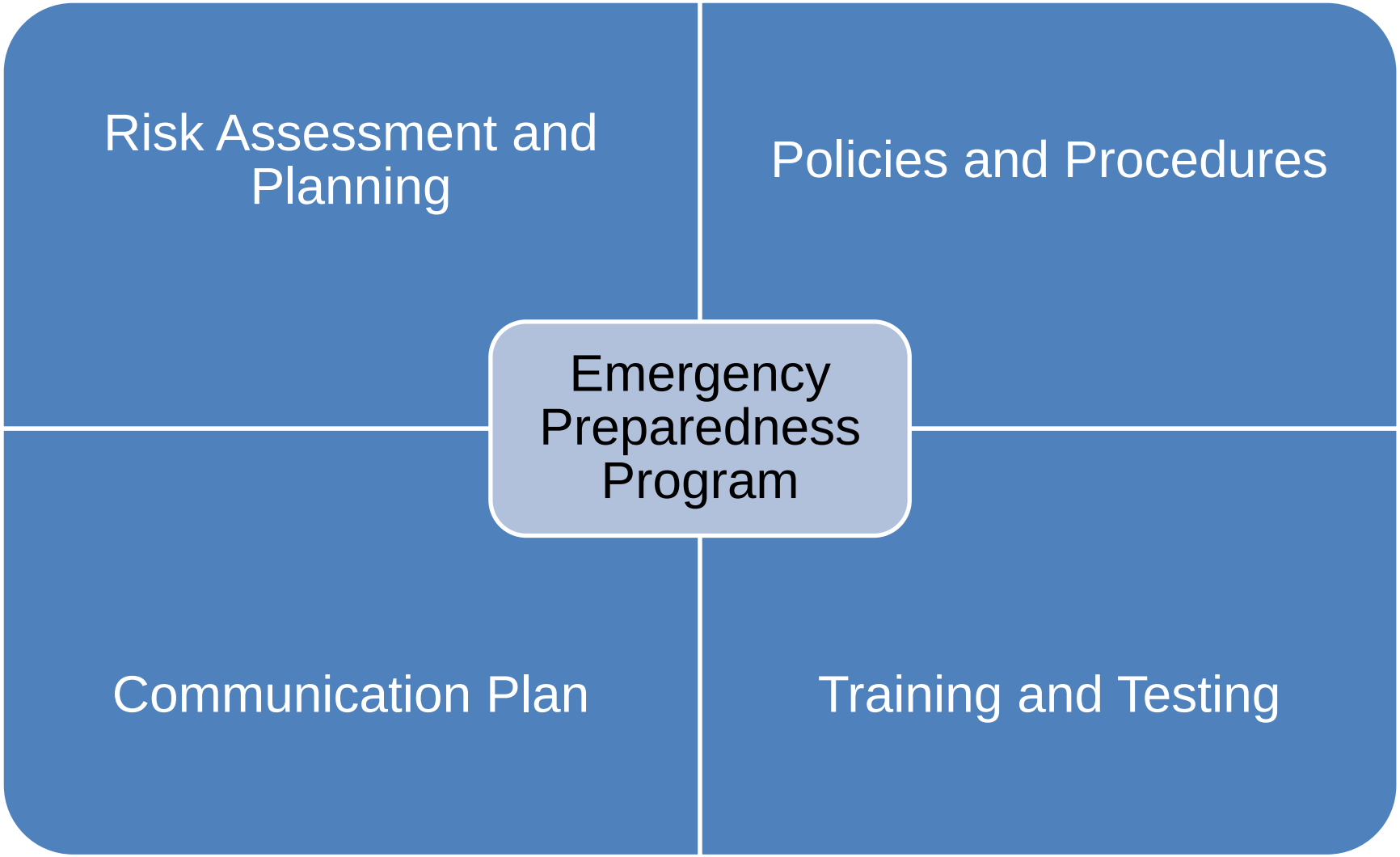
Lisa Marunycz
Caecilia Blondiaux

Survey & Certification Group
Centers for Medicare & Medicaid Services

Final Rule

- *Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers*
- Published September 16, 2016
- Applies to all 17 provider and supplier types
- Implementation date November 15, 2017
- Compliance required for participation in Medicare
- Emergency Preparedness is one new CoP/CfC of many already required

Four Provisions for All Provider Types



Risk Assessment and Planning

- Develop an emergency plan based on a risk assessment.
- Perform risk assessment using an “all-hazards” approach, focusing on capacities and capabilities.
- Update emergency plan at least annually.

Policies and Procedures

- Develop and implement policies and procedures based on the emergency plan and risk assessment.
- Policies and procedures must address a range of issues including subsistence needs, evacuation plans, procedures for sheltering in place, tracking patients and staff during an emergency.
- Review and update policies and procedures at least annually.

Communication Plan

- Develop a communication plan that complies with both Federal and State laws.
- Coordinate patient care within the facility, across health care providers, and with state and local public health departments and emergency management systems.
- Review and update plan annually.

Training and Testing Program

- Develop and maintain training and testing programs, including initial training in policies and procedures.
- Demonstrate knowledge of emergency procedures and provide training at least annually.
- Conduct drills and exercises to test the emergency plan.

Emergency and Standby Power Systems

- Additional requirements for hospitals, critical access hospitals, and long-term care facilities.
- Locate generators in accordance with National Fire Protection Association (NFPA) guidelines.
- Conduct generator testing, inspection, and maintenance as required by NFPA.
- Plan to maintain and keep emergency power systems operational

Requirements Vary by Provider Type

- Outpatient providers are not required to have policies and procedures for the provision of subsistence needs.
- Home health agencies and hospices required to inform officials of patients in need of evacuation.
- Long-term care and psychiatric residential treatment facilities must share information from the emergency plan with residents and family members or representatives.

Interpretive Guidelines (IGs)

"The IGs are sub regulatory guidelines which establish our expectations for the function states perform in enforcing the regulatory requirements. Facilities do not require the IGs in order to implement the regulatory requirements. We note that CMS historically releases IGs for new regulations *after* the final rule has been published.
This EP rule is accompanied by extensive resources that providers and suppliers can use to establish their emergency preparedness programs."

Federal Register /Vol. 81, No. 180 / Friday, September 16, 2016 /Rules and Regulations ***63873***

Interpretive Guidelines

- The Survey & Certification Group (SCG) is in the process of developing the Interpretive Guidelines (IGs) which will assist in implementation of the new regulation.

- We anticipate the guidelines to be completed by spring 2017.

- The IGs will be formatted into one new Appendix within the State Operations Manual (SOM) applicable to all 17 provider/supplier types

Compliance

- Facilities are expected to be in compliance with the requirements by 11/15/2017.
- In the event facilities are non-compliant, the same general enforcement procedures will occur as is currently in place for any other conditions or requirements cited for non-compliance.
- Training for surveyors is under development

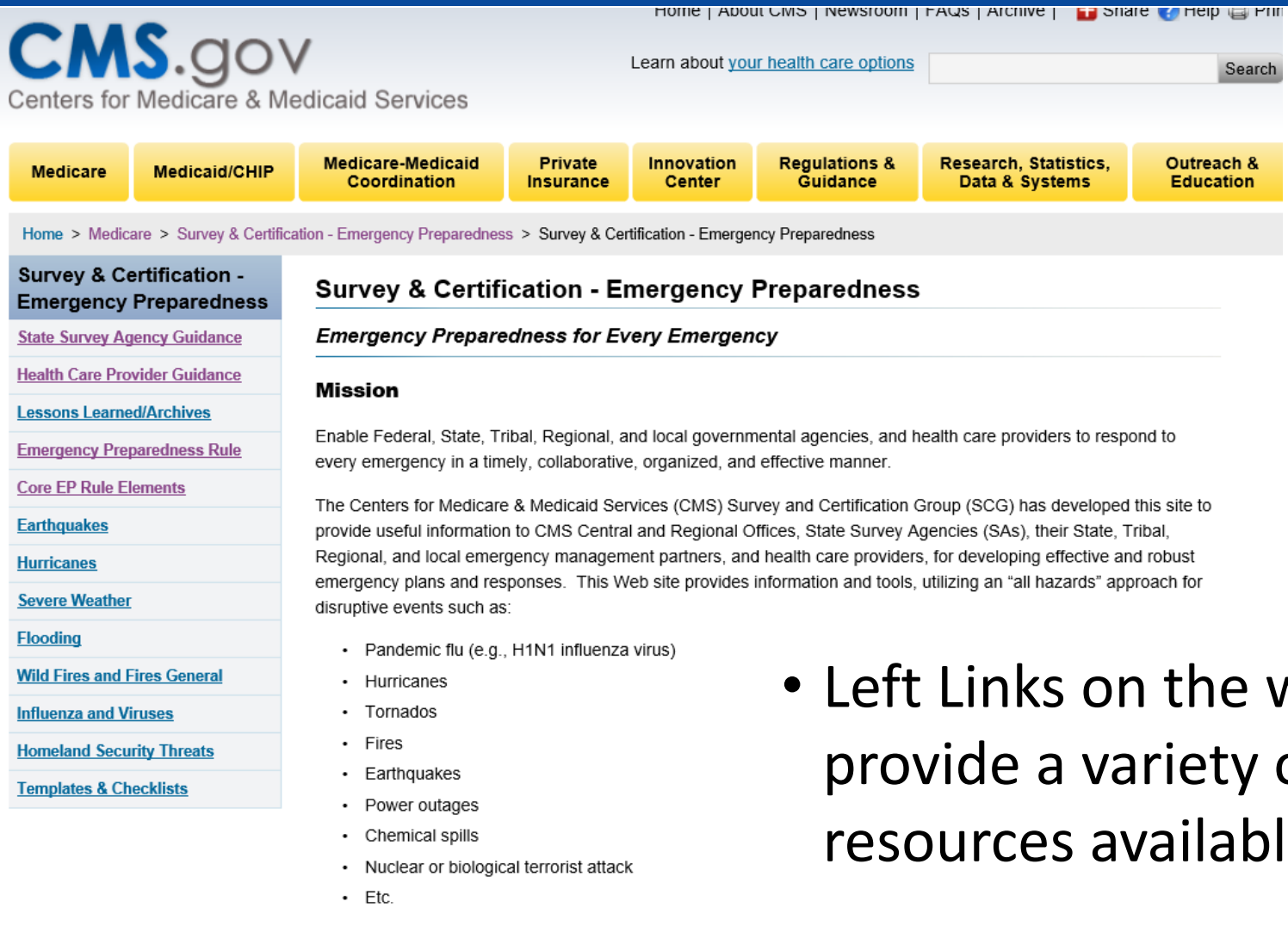
The SCG Website

- Providers and Suppliers should refer to the resources on the CMS website for assistance in developing emergency preparedness plans.

- The website also provides important links to additional resources and organizations who can assist.

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html

The SCG Website- Continued



- Left Links on the website provide a variety of resources available

The SCG Website- Continued

Survey & Certification - Emergency Preparedness

- State Survey Agency Guidance
- Health Care Provider Guidance
- Lessons Learned/Archives
- Emergency Preparedness Rule
- Core EP Rule Elements
- Earthquakes
- Hurricanes
- Severe Weather
- Flooding
- Wild Fires and Fires General
- Influenza and Viruses
- Homeland Security Threats
- Templates & Checklists

Emergency Preparedness Rule

Survey & Certification- Emergency Preparedness Regulation Guidance

Guidance for Surveyors, Providers and Suppliers Regarding the New Emergency Preparedness (EP) Rule

On September 8, 2016 the Federal Register posted the final rule *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers.* The regulation goes into effect on November 16, 2016. Health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date, on November 16, 2017.

Purpose: To establish national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems. The following information will apply upon publication of the final rule:

- Requirements will apply to all 17 provider and supplier types.
- Each provider and supplier will have its own set of Emergency Preparedness regulations incorporated into its set of conditions or requirements for certification.
- Must be in compliance with Emergency Preparedness regulations to participate in the Medicare or Medicaid program. The below downloadable sections will provide additional information, such as the background and overview of the final rule and related resources.

Additional information has been provided on the left side hyperlinks categorized by information from the EP Rule, such as the Emergency Preparedness Plan, Communication Plan, Policies and Procedures and Testing.

The below downloadable sections will provide additional information, such as the background and overview of the final rule and related resources.

Downloads

By Name By State Healthcare Coalitions [PDF, 256KB]
Facility Transfer Agreement - Example [PDF, 56KB]
17 Facility- Provider Supplier Types Impacted [PDF, 89KB]
EP Rule - Table Requirements by Provider Type [PDF, 126KB]

Related Links

ASPR TRACIE
NCDMPH

FAQs

- Frequently Asked Questions (FAQs) have been developed and are posted on the CMS Emergency Preparedness Website https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html

- We will continue to edit and post new FAQs as inquiries are received.

Collaboration with ASPR TRACIE

- SCG has been collaborating for several months with the ASPR TRACIE
- SCG's primary focus is on the development of Interpretive Guidelines and Surveyor Training
- Currently working to provide additional recommendations through ASPR TRACIE for stakeholders who are interested in developing training for providers

Training Considerations
Don’t Lose Sight of the Intent!

- Providers/Suppliers and Emergency Preparedness officials should consider aiming training on overall Emergency Preparedness, with integration of the four core elements.

- Work toward assisting emergency preparedness officials and facility leadership on “how-to” guides – i.e. how do you complete a hazard vulnerability assessment/ risk assessment? How do you draft a communication plan?

Thank you!

SCGEmergencyPrep@cms.hhs.gov

TRACIE

HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

ASPR Technical Resources, Assistance Center, Information Exchange (TRACIE)

ASPR

ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE

Why ASPR TRACIE?

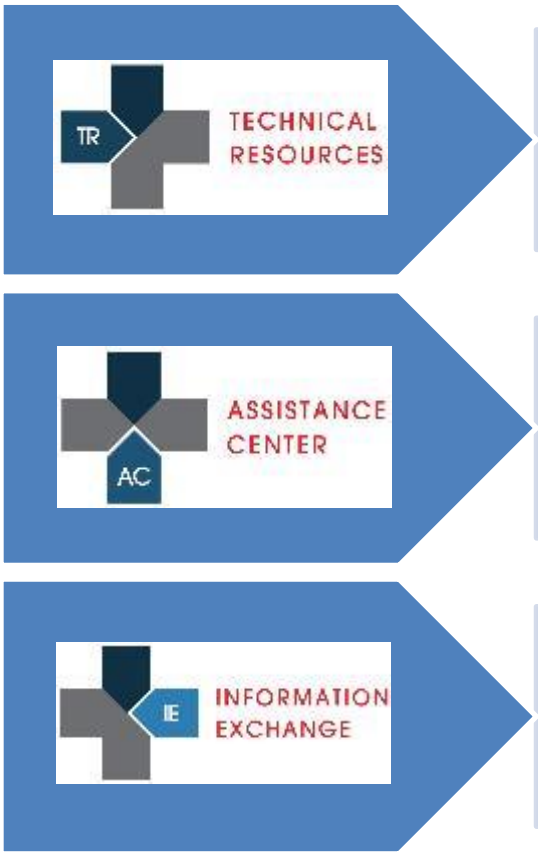
ASPR TRACIE was developed as a healthcare emergency preparedness information gateway to address the need for:

- Enhanced technical assistance
- Comprehensive, one-stop, national knowledge center for healthcare system preparedness
- Multiple ways to efficiently share and receive (push-pull) information between various entities, including peer-to-peer
- Leveraging and better integrating support (force multiplier)

ASPR ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE

TRACIE HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

ASPR TRACIE: Three Domains



- Self-service collection of audience-tailored materials
- Subject-specific, SME-reviewed "Topic Collections"
- Unpublished and SME peer-reviewed materials highlighting real-life tools and experiences

- Personalized support and responses to requests for information and technical assistance
- Accessible by toll-free number (1844-5-TRACIE), email (askasprtracie@hhs.gov), or web form (ASPRtracie.hhs.gov)

- Area for password-protected discussion among vetted users in near real-time
- Ability to support chats and the peer-to-peer exchange of user-developed templates, plans, and other materials

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TRACIE HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

Support for the CMS Emergency Preparedness Rule

- **ASPRtracie.hhs.gov/CMSrule**
- CMS Emergency Preparedness (EP) Rule Resources at Your Fingertips Document
  - Description of each of the 17 supplier and provider types affected by rule
- ASPR TRACIE's Topic Collections and provider- and supplier-specific resources can help organizations involved in implementing the CMS requirements with resources tailored to their specific needs
- Resources for hazard vulnerability assessments, emergency plans, policies and procedures, communications plans, trainings, and testing
- Assistance Center support

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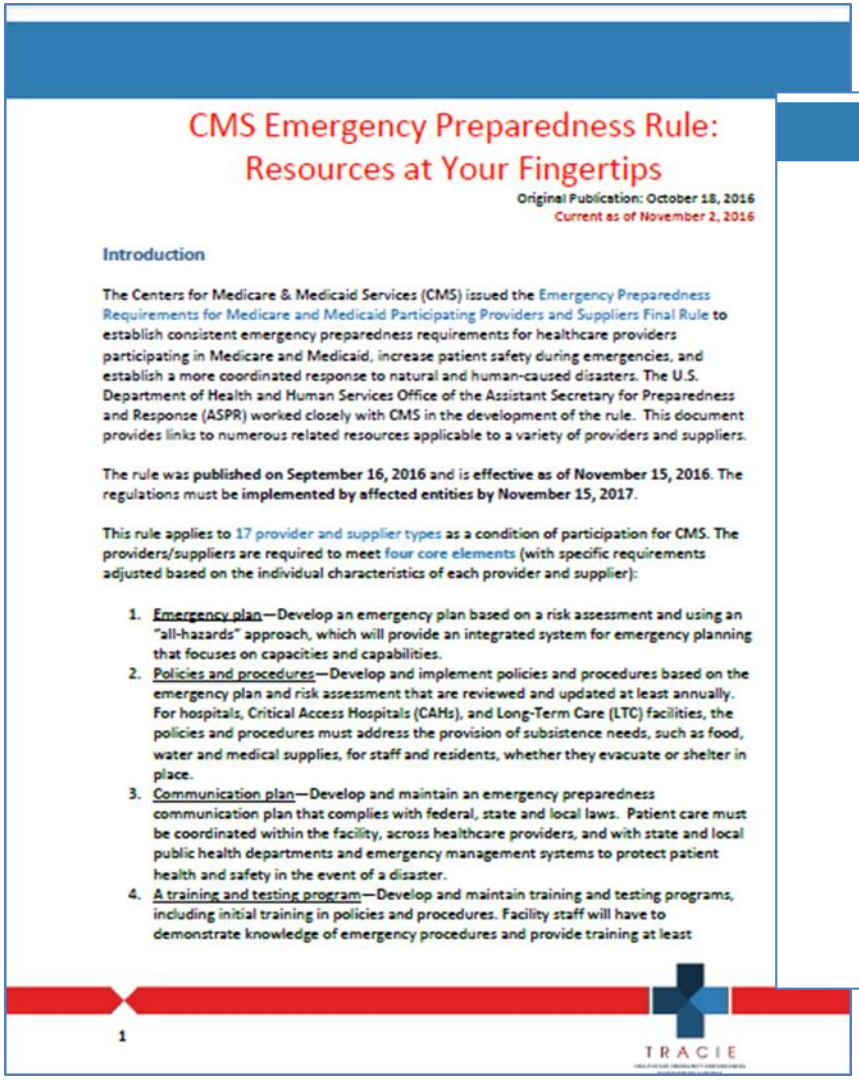
TRACIE HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

TRACIE Developed Resources



CMS Emergency Preparedness Rule: Resources at Your Fingertips

Original Publication: October 18, 2016
Current as of November 2, 2016

Introduction

The Centers for Medicare & Medicaid Services (CMS) issued the Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule to establish consistent emergency preparedness requirements for healthcare providers participating in Medicare and Medicaid, increase patient safety during emergencies, and establish a more coordinated response to natural and human-caused disasters. The U.S. Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (ASPR) worked closely with CMS in the development of the rule. This document provides links to numerous related resources applicable to a variety of providers and suppliers.

The rule was **published on September 16, 2016** and is **effective as of November 15, 2016**. The regulations must be **implemented by affected entities by November 15, 2017**.

This rule applies to 17 provider and supplier types as a condition of participation for CMS. The providers/suppliers are required to meet four core elements (with specific requirements adjusted based on the individual characteristics of each provider and supplier):

1. Emergency plan—Develop an emergency plan based on a risk assessment and using an "all-hazards" approach, which will provide an integrated system for emergency planning that focuses on capacities and capabilities.
2. Policies and procedures—Develop and implement policies and procedures based on the emergency plan and risk assessment that are reviewed and updated at least annually. For hospitals, Critical Access Hospitals (CAHs), and Long-Term Care (LTC) facilities, the policies and procedures must address the provision of subsistence needs, such as food, water and medical supplies, for staff and residents, whether they evacuate or shelter in place.
3. Communication plan—Develop and maintain an emergency preparedness communication plan that complies with federal, state and local laws. Patient care must be coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management systems to protect patient health and safety in the event of a disaster.
4. A training and testing program—Develop and maintain training and testing programs, including initial training in policies and procedures. Facility staff will have to demonstrate knowledge of emergency procedures and provide training at least

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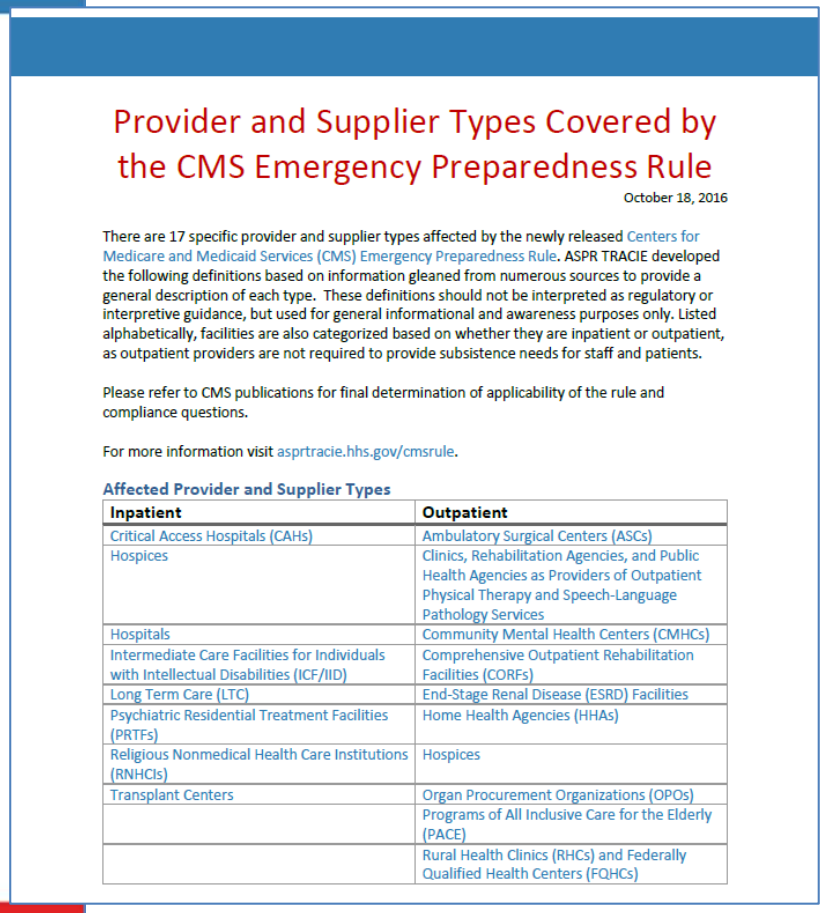

Provider and Supplier Types Covered by the CMS Emergency Preparedness Rule

October 18, 2016

There are 17 specific provider and supplier types affected by the newly released Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Rule. ASPR TRACIE developed the following definitions based on information gleaned from numerous sources to provide a general description of each type. These definitions should not be interpreted as regulatory or interpretive guidance, but used for general informational and awareness purposes only. Listed alphabetically, facilities are also categorized based on whether they are inpatient or outpatient, as outpatient providers are not required to provide subsistence needs for staff and patients.

Please refer to CMS publications for final determination of applicability of the rule and compliance questions.

For more information visit asprtracie.hhs.gov/cmsrule.

Affected Provider and Supplier Types

Inpatient	Outpatient
Critical Access Hospitals (CAHs)	Ambulatory Surgical Centers (ASCs)
Hospices	Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services
Hospitals	Community Mental Health Centers (CMHCs)
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	Comprehensive Outpatient Rehabilitation Facilities (CORFs)
Long Term Care (LTC)	End-Stage Renal Disease (ESRD) Facilities
Psychiatric Residential Treatment Facilities (PRTFs)	Home Health Agencies (HHAs)
Religious Nonmedical Health Care Institutions (RNHCIs)	Hospices
Transplant Centers	Organ Procurement Organizations (OPOs)
	Programs of All Inclusive Care for the Elderly (PACE)
	Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

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NVHA
Northern Virginia Hospital Alliance

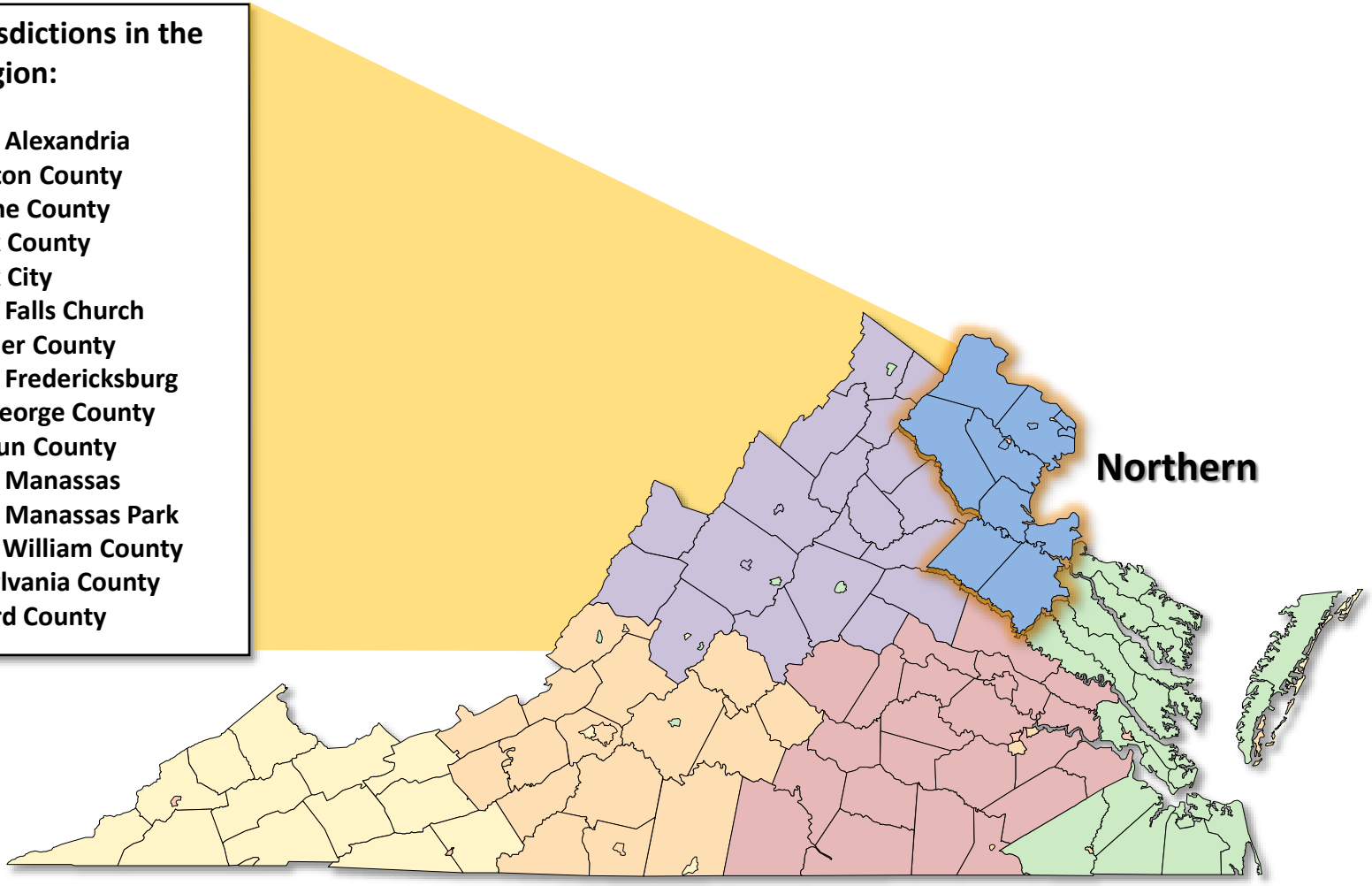
At a glance…

- Formed in 2002 as A 501(c)6 non-profit coalition
- Governed by Board of Directors
- 16 Hospital Members, 8 Free Standing Emergency Departments
- Received over $45M in funding to date from grant sources:
  - Urban Area Security Initiative (UASI)
  - Hospital Preparedness Program (ASPR)
  - Infectious Disease Grant (CDC)
- Members pay Equity Stake and Annual Dues

NoVA Hospital Preparedness Region

Local Jurisdictions in the NoVA Region:

- City of Alexandria
- Arlington County
- Caroline County
- Fairfax County
- Fairfax City
- City of Falls Church
- Fauquier County
- City of Fredericksburg
- King George County
- Loudoun County
- City of Manassas
- City of Manassas Park
- Prince William County
- Spotsylvania County
- Stafford County



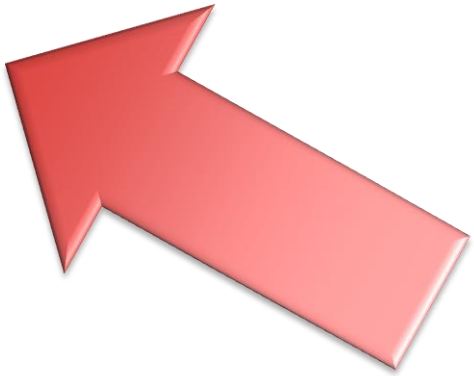
Members:

Hospitals

1. Fort Belvoir Hospital
2. Fauquier Hospital
3. INOVA Alexandria Hospital
4. INOVA Fair Oaks Hospital
5. INOVA Fairfax Hospital (Level I Trauma/Tertiary Care Center and Childrens Hospital)
6. INOVA Loudoun Hospital (Pediatric Emergency Department)
7. INOVA Mount Vernon Hospital
8. Mary Washington Hospital (Level II Trauma Center)
9. Novant Health UVA Health System Haymarket Medical Center
10. Novant Health UVA Health System Prince William Medical Center (Pediatric ED)
11. Reston Hospital Center (Level II Trauma)
12. Sentara Northern Virginia Medical Center
13. Spotsylvania Regional Medical Center
14. Stafford Hospital
15. StoneSprings Hospital Center
16. Virginia Hospital Center

Free Standing Emergency Departments

- INOVA Emergency Care Center- Cornwall
- INOVA Emergency Care Center- Fairfax
- INOVA Emergency Care Center- Reston
- INOVA Healthplex- Ashburn
- INOVA Healthplex- Lorton
- INOVA Healthplex- Springfield
- Mary Washington Healthcare FSED
- Sentara Lakeridge



Board of Directors: Hospital C-Suite Executives

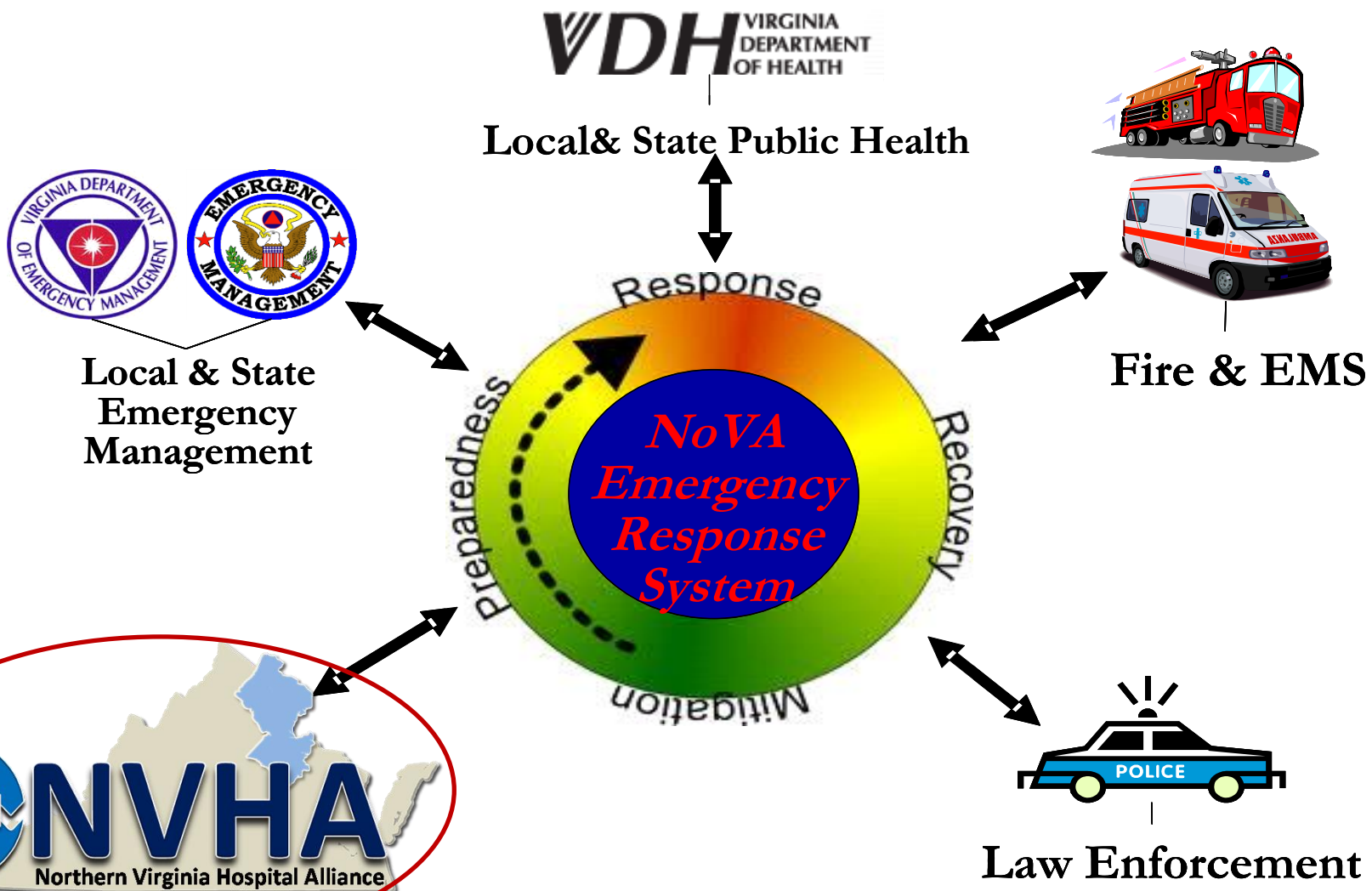
Executive Director

Finance Support

Director Hospital Preparedness Program	*Develop Regional Emergency Response Plans & Policies*	*Manage Regional Equipment, Supply & Rx Caches*	*Provide a Regional Hospital Coordination Center (RHCC)*
HPP Grant Development/ Implementation	Emergency Planner	Regional Pharmacy Coordinator	RHCC Manager
Training and Education		Warehouse Manager	

Work Groups- Department Directors/Managers

NVHA is a Coalition within a Coalition



Real Life Activations

- Presidential Inaugurations
- National Scout Jamboree 2005 / 2010
- Influenza "A" (H1N1) Outbreak
- "Snowmageddon"
- 3 bus crashes with 60+ patients
- 2 hurricanes
- Earthquake
- June 29th 2012 Derecho
- Ebola
- Concert of Valor
- Papal Visit

Emergency Preparedness Final Rule Considerations

NVHA Activities

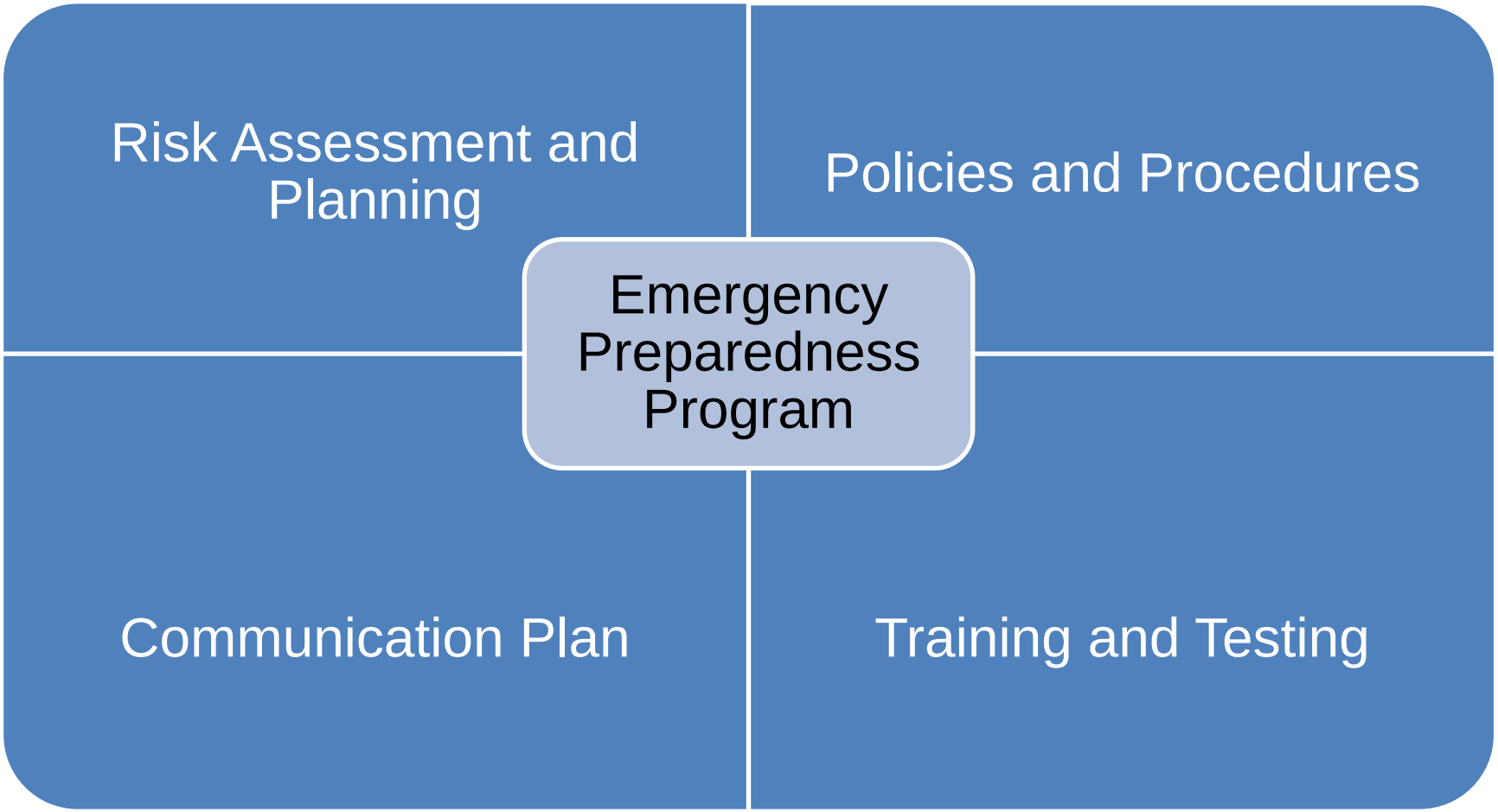
- Panic
- Rule & HCPRC Review
  - Comparison to TJC
  - Impact analysis
  - Project Mapping
  - Outreach with other HCCs
- Conversation with State Grantors (VDH, VHHA)
  - Other HCCs also concerned
  - Working with Grantors on interpretation of Rule and HCPRC requirements
- Board presentation
  - Impact of Rule and HCPRC to NVHA Member Facilities
  - Potential impact of Rule and HCPRC to NVHA structure
    - Consider change to membership model
    - Consider expanding projects
- ASPR and CMS Joint Collaboration Messaging; Reassuring

ASPR NHPP's Role for HCC's

"Although healthcare coalitions (HCCs) themselves are not included in the 17 provider and supplier types covered under the Emergency Preparedness Rule, the rule offers HCCs and newly engaged providers:

- The opportunity to achieve greater organizational and community effectiveness and financial sustainability.
- HCCs will continue to function as an accessible source of preparedness and response best practices as newly engaged provider types adapt to the new requirements."

Four Provisions of CMS EP Rule



NVHA, like many HCC's, has experience in these 4 areas

Planning and Surge Capabilities

Vulnerable Population Planning

- MAPs for 42 LTC in NoVA
- Partnership with NVERS
  - Branding
  - Vulnerable Population Coordinator
  - PH, EM included in workgroup
- MedComm II Radio System
- Expansion
  - Power Outage Planning for Dialysis
  - Long-term Sheltering

Surge Capacities and Capabilities

NVHA Members have plans to collectively manage for up to 96 hours

- 1,175 general medical/surgical patients
- 140 adult critical care patients
- 120 burn patients
- 40 pediatric critical care patients
- 100 general pediatric patients
- 1,000+ patients requiring negative pressure air isolation

These numbers are supported by...

40 "Crash" carts

100 + IV Pumps

130 air scrubbers

250+ suction units

$1.5M in hospital based drug stockpiles

1,200+ temporary beds

196 Disaster Ventilators

$3M+ of hospital based medical supplies

Operational Capabilities

Decontamination and Detection Capabilities

Radiological Detection Portals – 2 at each facility

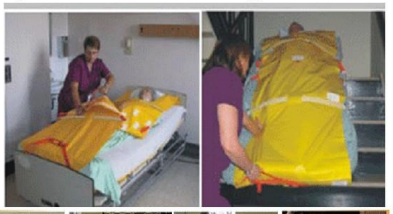
16 nerve agent CHEMPACK stockpiles in the member hospitals

Decon Showers & PPE in place at each hospital. Standardized equipment.

Regional Hospital Evacuation Support

Evacuation "Stair" Chairs
Portable chairs designed to assist in evacuating patients down stairs. Goal is to cover 5% of staffed beds with chairs. Target is low because every EMS vehicle in Virginia has a Stair Chair.

Evacusleds
Under the mattress sleds Initial goal was to cover 25 % of critical care beds among NVHA members.



Supersleds
Portable evacuation sleds to be stored in strategic locations around the hospital and brought to the specific patients requiring evacuation. Come in regular and bariatric sizes. Goal was 1 Supersled for every 3 staffed bed (excluding critical, ED and peds/NICU).

Ebola Preparedness

- Provide baseline standard of PPE for clinical staff
- Patient isolation capability
- Fixed, and mobile decontamination for hospitals, LE, EMS
- Regional (EMS, HD, hospital) planning and coordination around incoming travelers
- Response Coordination for PUIs

83% of Ebola-monitored travelers in Virginia were in Northern Virginia

System of Systems Approach to Communications

Telemedicine Support Network for Peds and Trauma

Regional telemedicine system allowing for centralized management and support for trauma and pediatric critical care during crisis

Deployed Voice / Data Satellite Terminals in every hospital command center

NoVA Regional Healthcare Coordinating Center (RHCC)

- A function, not just a place
- Multi-faceted responsibilities
- 24/7/365
- 2 RHCC facilities maintained
- Full radio Interoperability with NoVA Fire/EMS

MedComm Radio System

- 800 MHz, County PS System
- Hospital ED, Command Center, on-scene EMS, RHCC
- LTC System

Training and Testing Program

Exercises and Training

- Conducted 15,000+ hours of emergency preparedness and disaster training with staff in member hospitals
  - Incident Command
  - Communications
  - Active shooter incidents
  - And many more…
- Conducted 40+ large, multi-hospital and multi agency exercises

Improved Resiliency for Critical Power and Water Systems

Water

- Over $1M spent
- Installed emergency water pumping and storage systems per member hospital
- Maintains essential operations requiring water in event of critical water loss from public grid

Power

- Over $1M spent
- Installing emergency generator transfer panels at each member hospital
- Allows for connection to emergency generator in under 1 hour
- Without this quick transfer switch, process for hookup to a portable generator would take between 8-14 hours

Four Provisions for Hospitals

Risk Assessment & Planning

HVA: All hazards to include community and Facility Specifics

Focus on capabilities and capacities

Cooperation with partners

Update EOP annually

Policies & Procedures

Policies & Procedures based on emergency plan and risk assessment: to include evacuation, sheltering in place, tracking patients and staff during emergency

Review and update annually

Communication Plan

Complies with Federal & State laws

Coordinate patient care within facility, across healthcare providers and with VDH (local and state) and emergency management systems

Review and update annually

Training & Testing Program

Develop & maintain training: initial training for all new and existing staff

Annually:

One FSE (include Partners)participate in or a real event will be sufficient

One TTX Facility based

Emergency & Standby Power Systems

Where are we?

- No longer panic; we can handle this
- Decision: The Rule and HCPRC are positive steps
  - 2 sides of the same coin: HCC and Healthcare Preparedness
  - Address them as a single effort
- On-going analysis
- We do not have all of the answers
  - We don't need to at this point
- Accepted that change is coming and we can handle it
  - NVHA will continue to exist and serve our Region
- Preliminary conversation with Board
  - Consider all options
  - Measured approach
  - Realign priorities and use of funds

Bottom Line

- Change is coming
- NVHA Hospital Members will meet Rule
  - NVHA Projects, support of individual facilities
- NVHA will need to adjust to serving the other Providers
  - May require additional staff
  - May generate membership or “fee-for-service” model discussion
  - Working with Grantor to determine requirements
  - NVHA Board will determine our approach
- NVHA/NVERS already support LTC and are expanding to Dialysis
  - Opportunity to expand this effort
- NVHA will work with HHS, Grantor, CMS to ensure we retain our status as the Regional HCC

Contact Information

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Questions