Centers for Medicare & Medicaid Services Emergency Preparedness Conditions of Participation:

RESOURCES FOR MISSOURI HEALTH CARE PROVIDERS

An Interactive Toolkit

In December 2013, the Centers for Medicare & Medicaid Services released a proposed rule for emergency preparedness Conditions of Participation. On Sept. 8, 2016, the rule was finalized with an effective date of Nov. 15, 2016, with a one-year implementation period for all applicable provider and suppliers.

17 PROVIDER AND SUPPLIER TYPES REFERENCED IN THE RULE

- Hospitals
- Critical Access Hospitals
- Rural Health Clinics and Federally Qualified Health Clinics
- Long-Term Care and Skilled Nursing Facilities
- Home Health Agencies
- Ambulatory Surgical Centers
- Hospice
- Inpatient Psychiatric Residential Treatment Facilities
- Programs of All-Inclusive Care for the Elderly
- Transplant Centers
- Religious Nonmedical Health Care Institutions
- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Clinics, Rehab. Agencies and Public Health Agencies as Providers of Outpatient Physical Therapy & Speech Language Pathology Services
- Comprehensive Outpatient Rehabilitation Facilities
- Community Mental Health Centers
- Organ Procurement Organizations
- End-Stage Renal Disease Facilities

MHA
MISSOURI HOSPITAL ASSOCIATION

As cited in the *Federal Register* on September 16, 2016, CMS recognized that despite the increased focus on health care preparedness and readiness following several national security incidents and natural disasters, established emergency preparedness requirements across all health care providers were "not comprehensive enough to address the complexities of the actual emergencies." The final rule defines an emergency or disaster as, "an event that can affect the facility internally as well as the overall target population or the community at large that precipitates the declaration of a state of emergency at a local, state, regional, or national level by an authorized public official." Therefore, it is the intent of the final rule to "issue emergency preparedness requirements that establish a comprehensive, consistent, flexible and dynamic regulatory approach to emergency preparedness and response that incorporates the lessons learned from the past, combined with the proven best practices of the present."
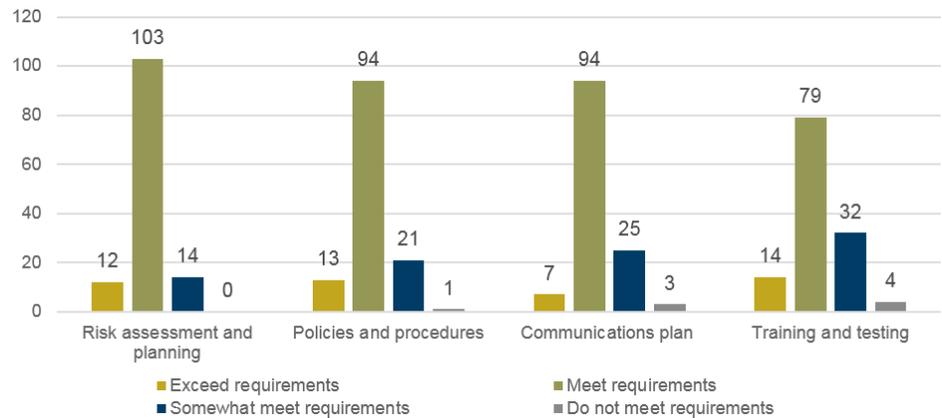
While the final rule applies to all 17 provider and supplier types eligible for Medicare and Medicaid, CMS drafted the CoPs with a focus on hospitals, modifying them by provider type as appropriate. Specifically, CMS highlights the critical role of hospitals during preparedness and response in the rule.
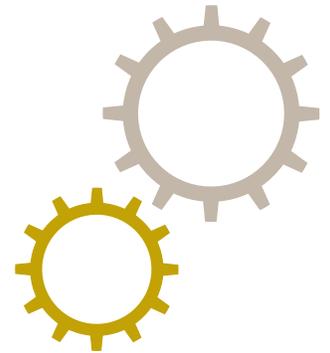
"Hospitals are often the focal points for health care in their respective communities; thus, it is essential that hospitals have the capacity to respond in a timely and appropriate manner in the event of a natural or man-made disaster. Additionally, since Medicare participating hospitals are required to evaluate and stabilize every patient seen in the emergency department and to evaluate every inpatient at discharge to determine his or her needs and to arrange for post-discharge care as needed, hospitals are in the best position to coordinate emergency preparedness planning with other providers and suppliers in their communities."

Missouri hospitals are well-positioned for implementation of the final rule. In December 2016, following the final release of the CoPs in the *Federal Register*, hospital emergency preparedness staff self-reported their interpretation of their level of readiness by each of the four categories. Of the 129 hospitals completing the 2017 Emergency Preparedness Capacity Assessment, the large majority of respondents reported meeting or exceeding the requirements of CoPs as finalized.

CMS Emergency Preparedness Requirements
MHA 2017 Statewide Capacity Assessment, n=129

	Risk assessment and planning	Policies and procedures	Communications plan	Training and testing
Exceed requirements	12	13	7	14
Meet requirements	103	94	94	79
Somewhat meet requirements	14	21	25	32
Do not meet requirements	0	1	3	4

This level of readiness can be attributed to the resources and efforts put forth by individual organizations throughout the last two decades, the high number of Missouri hospitals that meet accreditation organization preparedness requirements and the technical resources provided through the Assistant Secretary of Preparedness and Response Hospital Preparedness Program since 2002. Despite the efforts to date, continued program development and refinement by all providers is necessary to maintain current and applicable hospital emergency preparedness programs ensuring continuity of services during crisis. Therefore, this document provides technical implementation assistance to Missouri hospitals and health care organizations by compiling state and national planning resources and toolkits. It draws awareness to current, established systems of preparedness to facilitate alignment among providers rather than duplicate efforts. The document is most effectively viewed electronically; however, can be printed for reference. This is a living document that MHA will update as new resources/information become available.

The following resources are structured into two sections. First, several overarching technical resources for review and use are included for reference. Second, the four core elements of an effective and comprehensive emergency preparedness framework outlined by the final rule are detailed with specific resources to assist providers with implementation.

- risk assessment and planning
- policies and procedures
- communication plan
- training and testing
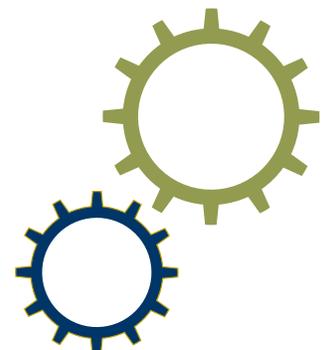
Overarching Technical Resources

MHA WEBINAR SERIES

Utilizing ASPR Hospital Preparedness Program funding, MHA has developed and released a webinar series to provide hospital emergency preparedness staff, health care facility partners and health care coalition members the knowledge to understand the rule and prepare for implementation. This includes, but is not limited to, how the rule interrelates with Missouri hospital licensing and regulations, codes and standards of the National Fire Protection Agency, and requirements of deemed accrediting agencies.

MHA SELF-ASSESSMENT CHECKLISTS

MHA has completed self-assessment checklists for acute and critical access hospitals for emergency preparedness. These checklists will walk you through the regulatory requirements found in the final rule.

OTHER RESOURCES

CMS has provided additional information on its website, which includes FAQs. CMS has issued survey and certification memos on the rule.

- October 28: Information on the Implementation Plans for the Emergency Preparedness Regulation
- March 24: Information to Assist Providers and Suppliers in Meeting the New Training and Testing Requirements of the Emergency Preparedness Requirements for Medicare & Medicaid Participating Providers and Suppliers Final Rule

Yale New Haven Cross Walk

HHS ASPR Hospital Preparedness Program Resources
- ASPR TRACIE (Technical Resources, Assistance Center and Information Exchange) has developed a webpage specifically for the rule.

Conditions of Participation

482.15 EMERGENCY PREPAREDNESS PLAN AND PROGRAM

482.15(A)(1) RISK ASSESSMENT

■ Hospital risk assessment is based on and includes a documented, facility-based and community-based risk assessment, using an all hazards approach.

Organizational Risk Assessment:

While CMS does not require the use of a specific facility-based risk assessment, many organizations use the Kaiser Permanente model or a similar, self-modified version.

The tool and instruction sheet are available for public use.

Community-based Risk Assessment:

Locally, jurisdictions complete a risk-assessment through their local emergency planning committee or emergency manager, dependent on county structure. Participation in this process by health care providers is encouraged, and information on the findings is available upon request. Health care providers should use this information to recognize external threats that could impact facility operations or result in incidents creating medical surge.

Regionally, health care coalitions and multidisciplinary emergency management planning bodies conduct similar assessments on a broader scale. These Threat and Hazard Identification and Risk Assessments are required to be reviewed and updated every three years.

482.15(A)(2) EMERGENCY PLAN

■ Emergency plan includes strategies for addressing emergency events identified by the risk assessment.

Facility emergency operation plans should reflect findings of the annual review of the risk assessment, while maintaining an all-hazards planning approach. Hospitals and health care providers looking to review, refine or restructure their emergency operation plan should review the Federal Emergency Management Agency's Comprehensive Preparedness Guide 101: Developing and Maintaining Emergency Operations Plans.

The Association for Professionals in Infection Control Mass Casualty Disaster Plan Checklist: A Template for Healthcare Facilities Checklist

482.15 (A)(3) PATIENT POPULATION AND AVAILABLE SERVICES

■ The hospital emergency plan must address its patient population, including, but not limited to, persons at-risk.

Hospitals should consider aligning their emergency preparedness efforts with their organization's community health needs assessment. MHA has made a variety of resources available to members on our website.

■ The hospital emergency plan must address the types of services that the hospital would be able to provide in an emergency.

■ All hospitals include delegations and succession planning in their emergency plan to ensure that the lines of authority during emergency are clear and the plan is implemented promptly and appropriately.

Hospital Incident Command System Job Action Sheets outline and provide resources to accurately delegate and transition leadership during an activation. For smaller organizations, including CAHs, modified versions are available.

482.15 (A) (4) THE HOSPITAL MUST HAVE A PROCESS FOR COOPERATION AND COLLABORATION WITH LOCAL, TRIBAL, REGIONAL, STATE OR FEDERAL EMERGENCY PREPAREDNESS OFFICIALS' EFFORTS TO MAINTAIN AN INTEGRATED RESPONSE DURING A DISASTER OR EMERGENCY SITUATION, INCLUDING DOCUMENTATION OF THE HOSPITAL'S EFFORTS TO CONTACT SUCH OFFICIALS AND, WHEN APPLICABLE, ITS PARTICIPATION IN COLLABORATIVE AND COOPERATIVE PLANNING EFFORTS.

Extensive work has occurred under the direction of the ASPR Hospital Preparedness Program to establish communication and coordination networks among health care providers and between the health care sector and other disciplines engaged in emergency management planning efforts.

Hospital Mutual Aid

Missouri hospitals may elect to participate in the MHA Hospital Mutual Aid Agreement which serves to facilitate the sharing of staff and/or resources in the event of a prolonged incident impacting the medical community.
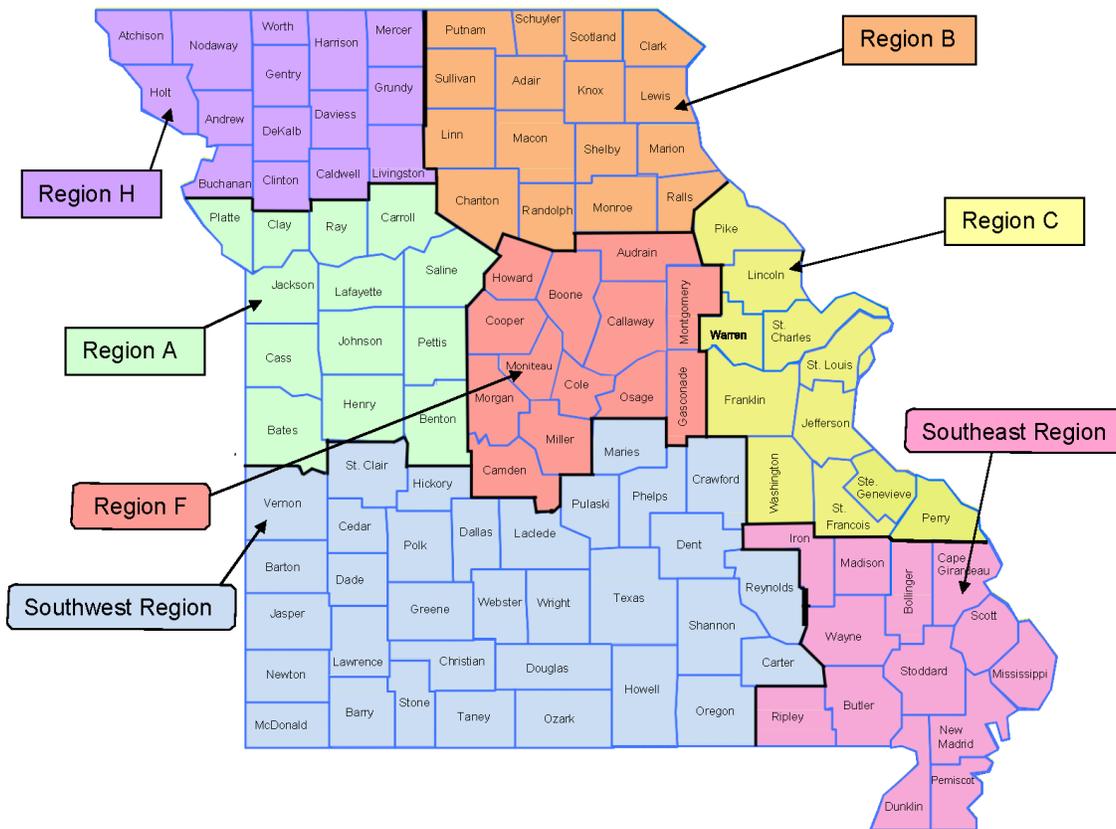
Local and Regional Collaboration

All health care providers, to include hospitals, are encouraged to actively participate in their local and regional emergency management planning processes. In Missouri, health care planning and response is structured geographically by health care coalition. While MHA serves as the planning and fiduciary agent for the nonurban health care coalitions, the Mid-America Regional

Council and St. Louis Area Regional Response System serve the Kansas City/Highway Patrol Region A and St. Louis/Highway Patrol Region C areas, respectively. The following map provides more detail.

More information on the MHA-led nonurban health care coalitions, to include a memorandum of understanding for participating members, is available on MHA's website.

MISSOURI HEALTHCARE COALITIONS

Regional Healthcare Coalition Contacts

Region A

Ian Saxton, Mid-America Regional Council
isaxton@marc.org
816-701-8396

Region B,F,H, Southeast & Southwest

Jackie Gatz, Missouri Hospital Association
jgatz@mhanet.com
573-893-3700

Region C

John Whitaker, St. Louis Area Regional Response System
John.Whitaker@ewgateway.org
314-421-4220

482.15 B) POLICIES AND PROCEDURES — HOSPITALS ARE REQUIRED TO DEVELOP AND IMPLEMENT EMERGENCY PREPAREDNESS POLICIES AND PROCEDURES BASED ON THE EMERGENCY PLAN, RISK ASSESSMENT PLAN AND COMMUNICATION PLAN, REVIEWED AND UPDATED ANNUALLY. POLICIES AND PROCEDURES MUST ADDRESS:

- 482.15 (b) (1) Subsistence needs (staff and patients)

  - 482.15 (b) (1) (i) Food, water, pharmaceuticals and medical supplies

  - 482.15 (b) (1) (ii) Provision of alternate sources of energy to maintain temperatures, lighting, fire detection, extinguishing and alarm systems

  - 482.15 (b) (1) (ii) (D) Sewage and waste disposal including solid waste, recyclables, chemical, biomedical waste and waste water.

While not required by CMS, many accredited health care organizations use a 96-hour resource planning document to better determine critical areas of needs during a resource shortage.

- 482.15 (b) (2) System to track the location of staff and patients during an emergency — if evacuated, document details of their relocation

With the adoption of electronic health records, many providers have the infrastructure in place to track their patients during an emergency. Planners should evaluate the organization's comfort with prolonged, no-notice downtime of the electronic systems to ensure staff and patients are accurately tracked throughout an incident.

Best practice: Nationally, hospitals have implemented the use of a specific DRG code to assign to incoming patients that are associated with a specific incident. This allows for better tracking, documentation and streamlined billing should state or federal disaster assistance be made available.

While Missouri does not currently maintain a statewide, electronic patient tracking system, work is in progress to evaluate and develop such platform.

- 482.15 (b) (3) Ensure safe evacuation, transportation and placement

There are several nationally recognized resources available at no charge to assist hospitals with planning for evacuation.

- The Agency for Healthcare Research and Quality Hospital Evacuation Decision Guide
- The Massachusetts Department of Public Health Hospital Evacuation Toolkit

- 482.15 (b) (4) A means to shelter in place for patients, staff and volunteers

- 482.15 (b) (5) Systems of medical documentation to preserve, secure and maintain availability of records

- 482.15 (b) (6) The use of volunteers during an emergency, other emergency staffing strategies and the process to use state and federal resources

In addition to the aforementioned hospital mutual aid agreement, Missouri health care providers also should have awareness and consider <u>Show Me Response</u> as a source for health care volunteers. This program falls under the federally funded emergency system for the advance registration of volunteer health professionals (<u>ESAR-VHP</u>).

- 482.15 (b) (7) Continuity of services — arrangements with other hospitals and providers to receive patients, because of limitations or temporary closure

- 482.15 (b) (8) The role of the hospital under a 1135 waiver, for the provision of care and treatment at an alternate care site

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482.15 (C) COMMUNICATIONS

- Hospital must develop, maintain and review annually an emergency preparedness communication plan that complies with federal, state and local law.

Extensive planning and equipment acquisition has taken place for redundant emergency communications among emergency management organizations, public health agencies and health care providers to improve communication among and between response agencies during an incident response.

In 2013, MHA facilitated the development of implementation guidance for the adoption of <u>standardized, plain language emergency codes</u> with the goal of all Missouri hospitals using this framework to facilitate improved patient and worker safety through consistent terminology. Missouri has adopted the Intermedix suite of products as the platform for health and medical emergency communications. EMResource and the electronic Incident Command System platform are the two primary platforms used by Missouri's health care providers. Intermedix also owns and operates the platforms for the Health Alert Network and WebEOC, used by public health and emergency management, respectively.

■ **482.15 (c) (1) Contact information for staff, entities providing services under arrangement, physicians, other hospitals and volunteers**

Missouri hospitals, health care providers and health care coalition members have access to the Intermedix eICS platform for electronic incident management document. This includes a staff listing feature to capture appropriate contact information and a call notification system. More information is available on MHA's website.

■ **482.15 (c) (2) Government agency contact information for federal, state, tribal and/or local**

While much of this information is available on public websites, this information should be included in the facility's emergency operations plan and also can be included under external contracts in the eICS platform referenced above.

■ **482.15 (c) (3) Establish Primary and alternate communication**

Based on the communication methods employed by the organization, staff should identify each of these communication methods and their order of priority in the emergency operations plan. It is important for providers to recognize several of the existing communication platforms available to health care organizations when evaluating and expanding their communication capabilities.

▶ All Missouri hospitals with emergency departments have VHF radio capability for communication with incoming emergency medical services.

▶ Many health care providers also have taken advantage of hospital preparedness and emergency management grants to secure amateur radio and trunked radio capability.

▶ In recent years, the Missouri Department of Public Safety has managed the development of a trunked radio network, referred to as MOSWIN, or the Missouri Statewide Interoperability Network, which provides a multidisciplinary platform for communication. While MOSWIN has been developed predominantly in the nonurban areas, work continues to bridge the digital platforms in the metropolitan areas to build a statewide system.

■ **482.15 (c) (4) Method for sharing information and medical documentation for patients with providers to maintain continuity of care**

■ **482.15 (c) (5) Means, in the event of evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii)**

■ **482.15 (c) (6) Means to provide information about the general condition and location of patients under the facility's care**

- 482.15 (c) (7) Means to provide information about occupancy, needs and ability to provide assistance

All Missouri health care providers have access to the Intermedix EMResource platform which serves to provide situational awareness and data collection capability of all providers participating and contributing to the electronic platform. Health care providers can find more information and request access to this platform on MHA's website.

- 482.15 (d) Training and Testing — Hospital develop and maintain an emergency preparedness training and testing program that includes initial training based on hospital emergency plan, risk assessment, policies and procedures, and communication plan.

  - 482.15 (d) (1) hospitals provide such training to all new and existing staff, volunteers, consistent with their expected roles and maintain documentation of such training. Training on emergency procedures occur at least annually and demonstrate staff knowledge.

While NIMS compliance is not a requirement of the CMS CoPs, FEMA's recommendation for ICS training may be considered when developing the organizational training program.
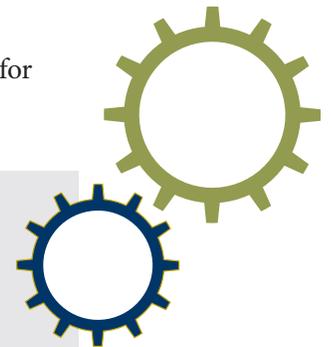
FEMA ICS Training

IS-700.a introduces the National Incident Management System.

Primary audience: Individuals with emergency management responsibilities, including any role in emergency preparedness, response, recovery and mitigation, should take the course.

Prerequisites: None

ICS-100.HC and the update IS-100.HCb introduces the Incident Command System and provides the foundation for higher-level ICS training.

Primary audience: ICS -100.HC and IS -100.HCb should be completed by hospital staff who would have a direct role in emergency preparedness, incident management and/or emergency response during an incident, including personnel designated to fulfill ICS roles. Additional participants may include the following staff members from hospital and health care systems: physicians, nursing, ancillary, materials/resource management, security/safety, laboratory, radiology, inter-facility transport.

Prerequisites: Completion of IS -700 is recommended.

IS-200 and the updated IS-200b are designed to enable staff to operate efficiently during an incident or event within the Incident Command System. ICS -200 provides training on and resources for staff who will likely assume a supervisory position within the ICS.

> **Primary audience:** Individuals involved with emergency planning, response or recovery efforts.
>
> **Prerequisites:** Completion of IS -100 and IS -700 is required.

IS-800.B introduces participants to the concepts and principles of the National Response Framework.

> **Primary audience:** This course is intended for government executives, private-sector and nongovernmental organization leaders, plus emergency management practitioners.
>
> **Prerequisite:** None

■ 482.15 (d) (2) drills and exercises to test emergency plans

**As referenced in the aforementioned March 28 survey and certification memo, note that CMS has directly stated, "Many providers and suppliers have asked whether they will be expected to have completed the "exercises" per the training and testing requirements in each standard (d) of the final rule, by the implementation date. Because the final rule has an implementation date of November 15, 2017, one year following the effective date, providers and suppliers are expected to meet the requirements of the training and testing program by the implementation date."

While no specific exercise program is referenced or required by CMS, the [Homeland Security Exercise and Evaluation Program](#) is a nationally recognized program that provides a set of guiding principles for exercise programs, as well as a common approach to exercise program management, design and development, conduct, evaluation, and improvement planning.

■ 482.15 (d) (2) (i) participate in a full-scale exercise annually

**While the industry is still awaiting the release of interpretative guidance by CMS, which may better inform the scope and definition of the exercise requirements, the April 27 MLN Connect call, 'Understanding the Emergency Preparedness Final Rule & Training and Testing Requirements', directed participants to use the following definitions.

A full scale exercise is a multi-agency, multi-jurisdictional, multi-discipline exercise involving functional (for example, joint field office, emergency operation centers, etc.) and/or "boots on the ground" response (for example, firefighters decontaminating mock victims).

■ 482.15 (d) (2) (ii) exemption if hospital experiences an actual incident

■ 482.15 (d) (2) (iii) conduct an annual exercise of hospitals choice for second requirement

Many providers are considering the use of a table-top exercise to meet the second requirement referenced above. As referenced on the April 27 MLN call, a table-top exercise is a group discussion led by a facilitator, using narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. It involves key personnel discussing simulated scenarios, including computer-simulated exercises, in an informal setting. TTXs can be used to assess plans, policies, and procedures.

For additional awareness, HSEEP identifies several types of exercises that contribute to a progressive exercise program. The most common types are outlined below.

Discussion-Based Exercises
  ‣ Seminars
  ‣ Workshops
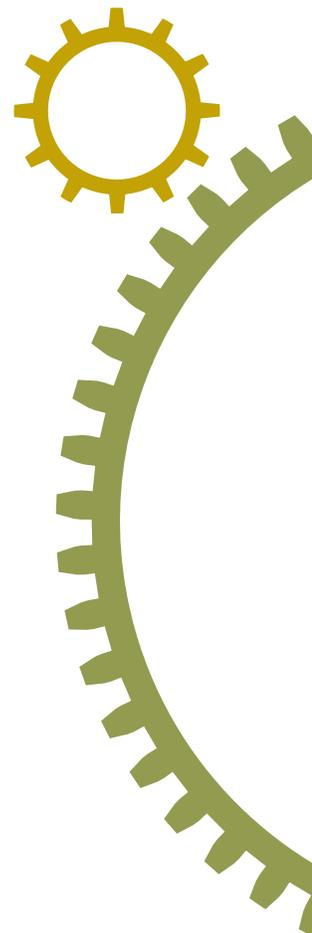 ‣ Tabletop Exercises
  ‣ Games

Operations-Based Exercises
  ‣ Drills
  ‣ Functional exercises
  ‣ Full-scale exercises

■ 482.15 (d) (2) (iv) hospitals analyze their response to, and maintain documentation on all drills, tabletop exercises and emergency events, and revise the hospital's emergency plan as needed.

The evaluation and improvement activities that result from the exercise program are a critical component to the emergency preparedness cycle. HSEEP provides fillable evaluation and improvement guides.

■ 482.15 (e) Emergency Fuel and Generator Testing

   − 482.15 (e) (1) (i) hospitals must meet the requirements of

      • NFPA 99, 2012 edition
      • NFPA 101, 2012 edition
      • NFPA 110, 2010 edition

Resources to assist health care providers with these requirements are available through the national fire protection agency.