Disaster Planning for California Hospitals
September 2017
Emergency Preparedness Final Rule

Prepared by the Centers for Medicare & Medicaid Services (CMS), Western Division of Survey & Certification Group

Final Rule

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

• An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies and a man-made emergency (or both) or natural disaster. This approach is specific to the location of the provider or supplier and considers the particular type of hazards most likely to occur in their areas. These may include, but are not limited to, care-related emergencies, equipment and power failures, interruptions in communications, including cyber-attacks, loss of a portion or all of a facility, and interruptions in the normal supply of essentials such as water and food.

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.
### Training and Testing Requirements

- Facilities are expected to meet all Training and Testing Requirements by the implementation date (Nov. 15, 2017).
  - Participation in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based exercise.

- Conduct an additional exercise that may include, but is not limited to the following:
  - A second full-scale exercise that is individual, facility-based.
  - A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

### Training and Testing Program Definitions

- **Facility-Based**: When discussing the terms “all-hazards approach” and facility-based risk assessments, we consider the term “facility-based” to mean that the emergency preparedness program is specific to the facility. Facility-based includes, but is not limited to, hazards specific to a facility based on the geographic location; patient/resident/client population; facility type and potential surrounding community assets (i.e., rural area versus a large metropolitan area).

- **Full-Scale Exercise**: A full-scale exercise is a multi-agency, multijurisdictional, multi-discipline exercise involving functional (for example: joint field office, emergency operation centers, etc.) and “boots on the ground” response (for example: firefighters decontaminating mock victims).
Training and Testing Program Definitions (cont.)

• **Tabletop Exercise (TTX):** A tabletop 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.

Training Exercises and “Annual” Requirement

• **Question:** If a state or local emergency response agency conducts its annual emergency preparedness exercise the 3rd week of November 2017 (past the CMS implementation date of Nov. 15, 2017), will a facility be out of compliance if it does not participate in a full-scale community based exercise by Nov. 15, 2017, but instead participates in the state/local exercise during the third week of November 2017?
Training Exercises and “Annual” Requirement (cont.)

- **Answer**: Facilities would be out of compliance.

- Surveyors will likely cite the non-compliance as standard-level non-compliance (Level C for Long Term Care facilities) in this first year as modified enforcement. As with any other non-compliance, the facility would submit an acceptable plan of correction which would include plans to participate in the required training exercises. Facilities will be expected to demonstrate to surveyors that it has completed 2 of the required training exercises within the previous 12 months, or between Nov. 15 and Nov. 15 of the following year.

Final Rule — There are Requirements Which 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.
Temperature Controls and Emergency and Standby Power Systems

- Under the Policies and Procedures, Standard (b) there are requirements for subsistence needs and temperature controls.

- Additional requirements for hospitals, critical access hospitals, and long-term care facilities are located within the Final Rule under Standard (e) for Emergency Power and Stand-by Systems.

Where Are We Now?

- On Sept. 1, 2017, the surveyor training for emergency preparedness requirements was launched.

- The same training was made accessible to providers and suppliers through the Integrated Surveyor Training Website.

- Facilities will begin to be surveyed after Nov. 15, 2017 in conjunction with scheduled surveys and survey cycles based on their provider types.
Where Are We Now? (cont.)

• The Surveyor Systems
  – The new EP Tags will be in ASPEN and the systems beginning Nov. 15, 2017.
  – Survey reports for compliance for emergency preparedness will be a separate CMS Form 2567 Statement of Deficiencies BUT be conducted in conjunction with either a LSC or Health Inspection survey.

Compliance

• Facilities are expected to be in compliance with the requirements by Nov. 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.
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.

CCN Numbers and Integrated Health Systems

**Question:** What are the requirements for facilities with multiple locations versus a separately certified facility that is part of an integrated health system that elects to have a unified and integrated emergency preparedness program?

**Answer:** Each facility that has a separate CCN number must comply with the Emergency Preparedness regulations and demonstrate compliance, whether the facility is part of an integrated health system or not.
**CCN Numbers and Integrated Health Systems (cont.)**

**Answer (cont.):** A separately certified facility can have multiple locations all operating under one CCN. All locations of a facility operating under the same CCN must be included in the facility’s emergency preparedness program and be in compliance with all of the emergency preparedness requirements.

**CCN Numbers and Integrated Health Systems (cont.)**

**Answer (cont.):** An integrated health system is different in that it contains multiple separately certified facilities all operating under different CCNs. The health system is not certified by CMS and is not assessed for compliance. It is up to each provider/supplier to demonstrate compliance with the requirements upon survey. See examples below.
CCN Numbers and Integrated Health Systems (cont.)

**Example 1:** Hospital Z has one outpatient clinic located outside of the hospital and operates under Hospital Z’s CCN. The outpatient clinic is considered part of Hospital Z and must be in compliance with the emergency preparedness regulations. The outpatient location of hospital Z must be part of hospital Z’s emergency preparedness program. Emergency policies and procedures for the outpatient clinic must be part of Hospital Z’s emergency program as the clinic is part of the certified hospital.

CCN Numbers and Integrated Health Systems (cont.)

**Example 2:** Hospital Z has a SNF located in a separate building on Hospital Z’s campus. Hospital Z and the SNF have separate CCN numbers. Therefore they are separately certified providers and each must meet the emergency preparedness requirements independently. However, both Hospital Z and the SNF could be part of an integrated health system that elects to have a unified and integrated system emergency preparedness program. In that case Hospital Z and the SNF may participate in the integrated system program to meet the requirements. However, Hospital Z and the SNF are still individually responsible for being in compliance.
Example 3: An ESRD facility, a LTC facility and a hospital are all separately certified provider/supplier types operating under different CCNs. They are all part of the same healthcare system that has elected to have a unified and integrated system emergency preparedness program and are not co-located. Therefore, these facilities, while separately certified and not co-located, can choose to participate in the system’s unified and integrated emergency preparedness program.

Example 4: Hospital B has a co-located hospital unit (from Hospital C) within the same building. Both hospitals have separate CCN numbers and are not part of the same healthcare system. Because Hospital B and Hospital C are separately certified facilities with separate CCNs, they must demonstrate compliance with emergency preparedness as separate entities. Hospital B and Hospital C would not be able to participate in the same unified and integrated emergency preparedness program because they are not part of the same healthcare system. However, it is recommended, (not required) that both Hospital B and Hospital C (being co-located in the same building) understand each other’s needs, plans for evacuation and potentially coordinate with each other for exercises to be able to assist each other during emergencies as appropriate.
Questions?

Do Not Lose Sight of the Intent!

- The intent behind the emergency preparedness final rule is to collaborate and coordinate with emergency officials to improve patient access to care and continuing care during disasters.

- Use one another, healthcare coalitions, public health departments, emergency preparedness experts to gain compliance, share lessons learned and best practices.

- Don’t recreate the wheel!
Thank You!

SCGEmergencyPrep@cms.hhs.gov

---

WDSC Region IX – Point of Contact
Emergency Disaster Team

Sandra Pace
Associate Consortium Administrator,
Consortium for Quality Improvement and Survey & Certification Operations
Sandra.Pace@cms.hhs.gov

Steven Chickering
Associate Regional Administrator, Western Division of Survey & Certification
Steven.Chickering@cms.hhs.gov

Karen Fuller
State Oversight Branch Manager, Western Division of Survey & Certification,
San Francisco Regional Office
Karen.Fuller@cms.hhs.gov

CDR David Lum
State Oversight Branch, Western Division of Survey & Certification, San Francisco Regional Office
David.Lum@cms.hhs.gov