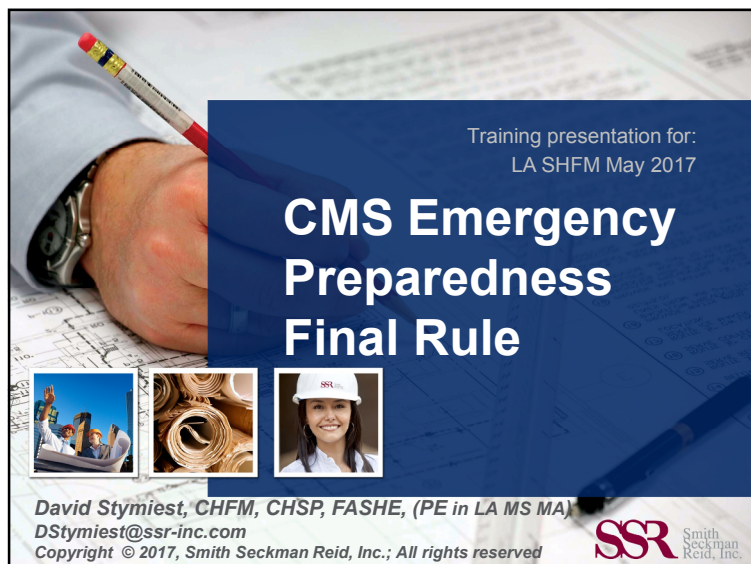




Training presentation for:
LA SHFM May 2017

CMS Emergency Preparedness Final Rule

David Stymiest, CHFM, CHSP, FASHE, (PE in LA MS MA)
DStymiest@ssr-inc.com
Copyright © 2017, Smith Seckman Reid, Inc.; All rights reserved

Content Disclaimer

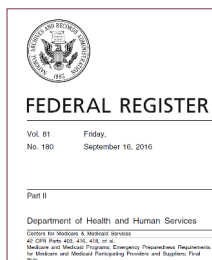


- **Content Disclaimer:** These slides are only meant to be cue points, which were expounded upon verbally by the original presenter and are not meant to be comprehensive statements of requirements or best practices, nor represent all the content of the presentation. Thus, care should be exercised in interpreting content based solely on the content of these slides.
- Refer to the CMS Final Rule, the NFPA Reference Tool, and the ASHE Analysis for full information.

Important dates



- **FR Page 63860:**
- Final Rule published 9-16-2016
- In effect 11-15-2016
- Implementation complete 11-15-2017
– Includes training & testing
- 180+ pages
- **ALL** provider types



CMS 3178F SEPT 2016 Reference Tool



FEDERAL REGISTER

Vol. 81 Friday,
No. 180 September 16, 2016

Part II

Department of Health and Human Services
Centers for Medicare & Medicaid Services
42 CFR Parts 403, 416, 418, et al.
Medicare and Medicaid Programs; Emergency Preparedness Requirements
for Medicare and Medicaid Participating Providers and Suppliers; Final
Rule

- **NFPA's Free Tool** (matrix) to help those impacted gain familiarity with CMS expectations and requirements.

<http://www.nfpa.org/~media/files/codes-and-standards/cms/cms-3178f-sept-2016-reference-tool.pdf?la=en>

Covered by the Final Rule: Sept 2016 CMS 3178F

- ASC Ambulatory Surgical Center
- CAH Critical Access Hospital
- CMHC Community Mental Health Center
- CORF Comprehensive Outpatient Rehabilitation Facilities
- ESRD End-Stage Renal Disease
- FQHC Federally Qualified Health Center
- HHS Home Health Services / HHA Home Health Agencies
- Hospice
- Hospital & Transplant
- ICFs/IID Intermediate Care Facilities for Individuals with Intellectual Disabilities
- **IHS Integrated Health Systems**
- LTC Long Term Care
- OPO Organ Procurement Organization
- OPT Outpatient Physical Therapy
- PACE Program for the All-Inclusive Care for the Elderly
- PRTF Psychiatric Residential Treatment Facilities
- RNHCs Religious Nonmedical Health Care Institutions
- RHC Rural Health Clinic
- SLP Speech Language Pathology

CMS 3178F SEPT 2016 Reference Tool**BASIC PROVISIONS**

PART PROVIDER	EMERGENCY PLAN	POLICY PROCEDURE	COMMUNICATION	TRAINING/TESTING	IHS PROVISION ¹	EMERGENCY STANDBY POWER ²
42 CFR						
403.748 RNHC	YES	YES	YES	YES	NO	NO
416-ASC	YES	YES	YES	YES	YES	NO
418-HOSPICE	YES	YES	YES	YES	YES	NO
441-PRTF	YES	YES	YES	YES	YES	NO
460-PACE	YES	YES	YES	YES	YES	NO
482-HOSPITAL (INCLUDES TRANSPLANT CENTERS)	YES	YES	YES	YES	YES	YES
483-LONG TERM CARE	YES	YES	YES	YES	YES	YES
483.475-ICF IID	YES	YES	YES	YES	YES	NO
484-HHS	YES	YES	YES	YES	YES	NO
485-CORF	YES	YES	YES	YES	YES	NO
485.635 CAH	YES	YES	YES	YES	YES	YES
485.727-OPT SLP	YES	YES	YES	YES	YES	NO
485.930 CMHC	YES	YES	YES	YES	YES	NO
486-OPO	YES	YES	YES	YES	YES	NO
491-RHC FQHC	YES	YES	YES	YES	YES	NO
494-ESRD	YES	YES	YES	YES	YES	NO

To navigate back to this table after clicking a link, click Alt + left arrow on your keyboard.

¹ Addresses items related to an all hazards disaster or emergency situation based upon a risk assessment.

² Includes elements identified in the plan such as provisions for food, water and supplies; alternative energy sources for fundamental operation; location and tracking; evacuation protocols; alternative sites to receive patients/residents.

³ Includes a registry or equivalent for staff so as to provide update or direction during an emergency.

⁴ Requires a training program to familiarize staff with their roles and responsibilities identified in emergency plan. Also requires periodic testing of the plan which varies by type of provider. May include tabletop, full-scale or paper-based exercise.

⁵ Allows the facility to participate in an integrated health care systems plan that is coordinated amongst the systems providers.

⁶ Mandate specific compliance with NFPA 99, NFPA 101 and NFPA 110 for generator design, location, installation and ongoing ITM.

⁷ Generator capacity and fuel supplies should be evaluated as part of the risk assessment with particular attention being paid to the policy/procedure section that considers the sources of energy and related provisions that require consideration of building temperature, emergency lighting, fire protection systems and sewage and waste disposal.

ALL HYPERLINKED TABLE © 2016 National Fire Protection Association

Basic Categories of CMS Requirements**Part 482 (CoPs for Hospitals)**

FR page 64028 (reference tool PDF page 173)

§ 482.15 CoP: Emergency preparedness.

- Emergency plan
- Policies & procedures
- Communication plan
- Training & testing
- Emergency and standby power systems
- Integrated healthcare systems

> **OTHER CoPs FOR OTHER PROVIDER TYPES** <

HOSPITAL: Emergency Plan

- Develop a plan based on a risk assessment using an “all hazards” approach, which is an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies and disasters. The plan must be updated annually.

HOSPITAL: Policies & Procedures



- Develop and implement policies and procedures based on the emergency plan, risk assessment, and communication plan which must be reviewed and updated at least annually.
- System to track on-duty staff & sheltered patients during the emergency.
- *Includes provisions for food, water and supplies; alternative energy sources; location and tracking; evacuation protocols*

HOSPITAL: Communication Plan



- Develop and maintain an emergency preparedness communication plan that complies with both federal and state laws. Patient care must be well-coordinated within the facility, across health care providers and with state and local public health departments and emergency systems. The plan must include contact information for other hospitals and CAHs; method for sharing information and medical documentation for patients.

HOSPITAL: Training & Testing



- Develop and maintain training and testing programs, including initial training in policies and procedures and demonstrate knowledge of emergency procedures and provide training at least annually.
- Also annually participate in:
 - A full-scale exercise that is community- or facility-based;
 - An additional exercise of the facility's choice.

HOSPITAL: Emergency & Standby Power Systems



- Implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.

ASHE Resource: Implications of the CMS EP rule



- Some subsequent slides are based upon the PDF: **ASHE resource: Implications of the CMS emergency preparedness rule.**
- ASHE's 29 page table shows each requirement of the CMS rule and whether hospitals complying with Joint Commission or NFPA 99 standards will need to change their emergency preparedness programs to comply with the requirement. (September 20, 2016)" – That document is Copyright © ASHE 2016
- AVAILABLE AT:**
<http://www.ashe.org/resources/member/pdfs/ashecmsruleinterpretation.pdf>
- Refer to original ASHE file for detailed information**



Sample page from ASHE Analysis Tool



ASHE Resource: Implications of the CMS emergency preparedness rule		
CMS EMERGENCY PREPAREDNESS RULE TEXT	CMS INTENTION (excerpted from CMS final rule)	IMPLICATIONS FOR HEALTH CARE FACILITIES (ASHE interpretation)
§ 482.15 Condition of participation: Emergency preparedness. The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. § 485.625 Condition of participation: Emergency preparedness. The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. § 482.15 Condition of participation: Emergency preparedness. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. § 485.625 Condition of participation: Emergency preparedness. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach.	While we agree that the responsibility for ensuring a community-wide coordinated disaster preparedness response is under the state and local emergency authorities, healthcare facilities will still be required to perform a risk assessment, develop an emergency plan, policies and procedures, communication plan, and train and test all staff to comply with the requirements in this final rule. These new requirements will require a coordinated and collaborative relationship with state and local governments during a disaster. An all hazards planning approach is considered "a more efficient and effective way to prepare for emergencies. Rather than managing planning initiatives for a multitude of threat scenarios, all hazards planning focuses on developing capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters." Thus, all-hazards planning does not specifically address every possible threat but ensures that hospitals and all other providers will have the capacity to address a broad range of related emergencies. The providers and suppliers discussed in this regulation should utilize an all-hazards approach to perform a "hazard vulnerability risk assessment." This final rule will require each of the Medicare- and Medicaid-participating providers and suppliers to perform a risk analysis; establish an emergency preparedness plan, emergency preparedness policies and procedures, and an emergency preparedness communication plan; train staff in emergency preparedness, and test the emergency plan.	Organizations that are compliant with either the 2012 edition of NFPA 99 or current Joint Commission emergency management requirements will have addressed community involvement within their emergency operations plan, but will need to evaluate the detail to which this cooperative effort is documented and ensure that it indicates how a collaborative relationship with state and local governments is to be coordinated. Organizations that are compliant with either the 2012 edition of NFPA 99 or current Joint Commission emergency management requirements will have completed a detailed hazard vulnerability assessment (HVA), but will need to evaluate the HVA process to ensure that this documentation includes an all hazards approach.

September 28, 2016 | Copyright © ASHE 2016

Page 1

NFPA 99 & TJC EM should already comply



- 482.15(a) Emer Prep Plan, annual review
- 482.15(a)(2) strategies address HVA risks
- 482.15(b) P&Ps annual review
- 482.15(b)(2) system to track staff / patients
- 482.15(b)(4) means to shelter in place
- 482.15(b)(5) medical documentation reqmts
- 482.15(d)(2) testing (annual exercises)
- 482.15(d)(2)(iii) analyze responses; update plan
- 482.15(e)(1) EPSS; EPS location
- 482.15(e)(2) emergency generator ITM
- 482.15(e)(3) emergency generator fuel
- 482.15(g) transplant centers involved
- 482.15(h) invokes 99-2012, 101-2012, 110-2010
- Refer to original ASHE file for detailed information**



§ 482.15 CoP: Emergency Preparedness



- "...comply with all applicable Federal, State, and local emergency preparedness requirements."
 - "perform a risk assessment, develop an emergency plan, policies and procedures, communication plan, and train and test all staff to comply with the requirements in this final rule."
 - "require a coordinated and collaborative relationship with state and local governments during a disaster."
- 99-2012 or TJC EOPs address community involvement
- Evaluate how well documented
- Indicate how collaborative relationship is coordinated
- Refer to original ASHE file for detailed information**



§ 482.15 CoP: Emergency Preparedness

- “...develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.”
 - *all hazards planning approach considered ‘more efficient and effective way to prepare for emergencies*
 - *does not specifically address every possible threat; but ensures capacity to address broad range of emergencies*
 - *use all hazards approach in HVA risks*
 - *HVA, plan, policies, procedures, train, test*
- 99-2012 or TJC have HVA
- Evaluate HVA to ensure or add “all-hazards approach”
- **Refer to original ASHE file for detailed information**

**§ 482.15(a)(1): Emergency Plan**

- “...based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.”
 - *Must consider: (1) essential business functions*
 - *(2) all risks or emergencies*
 - *(3) all contingencies*
 - *(4) all locations: care, services, business*
 - *(5) extent they may cause svc to cease/limit*
 - *(6) arrgts. needed w/other entities to provide services*
- 99-2012 or TJC EOP should already comply
- Most HVAs may not address item (6)
- **Refer to original ASHE file for detailed information**

**§ 482.15(a)(3): Emergency Plan**

- “...Address patient population, including, but not limited to, persons at-risk; the type of services the hospital has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.”
 - *At-risk individuals: “children, pregnant women, citizens, individuals with disabilities, those from religious, racial and ethnically diverse backgrounds; and people with limited English proficiency and other individuals who have special needs in the event of a public health emergency”*
- 99-2012 or TJC EOP should already comply for general patient populations
- Ensure all listed “at-risk” populations are addressed.
- **Refer to original ASHE file for detailed information**

**§ 482.15(a)(4): Emergency Plan**

- “...Include a process for cooperation and collaboration with local, tribal, regional, State, and 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.”
 - *ensuring cooperation and collaboration ... with officials ... ensure an integrated response*
 - *documentation of the hospital's efforts to contact such officials*
 - *documentation of participation in collaborative and cooperative planning efforts*
- May need more EOP detail on community involvement
- Review / document efforts to include community partners within EM program
- **Refer to original ASHE file for detailed information**



Subsistence needs: evacuate OR shelter in place



- 482.15(b)(1)(i) Food, water, medical, pharmaceutical
 - *Facilities have flexibility on quantities (risk assessments) based on level of impact*
 - *Receiving facility after evacuation*
 - *Applies to staff & patients*

- Verify details

• **Refer to original ASHE file for detailed information**

Subsistence needs: alternate sources of energy



- 482.15(b)(1)(ii) Alternate sources of energy
 - (A) Temperatures (to protect patient health & safety; safe sanitary storage or provisions);
 - (B) Emergency lighting; *“such as battery-operated lights”*
 - (C) Fire detection, extinguishing, and alarm systems;
 - (D) Sewage and waste disposal. *“We are not requiring onsite treatment of sewage but that facilities make provisions for maintaining necessary services.”*

- Evaluate your current plans; changes

• **Refer to original ASHE file for detailed information**

§ 482.15(b)(3) CoP: Policies & Procedures



- “... Safe evacuation from the hospital, which includes consideration of care and treatment needs of evacuees; **staff responsibilities**; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.. ”
 - *“... we do not believe [TJC’s] requirements will ensure compliance with the requirement that the hospital establish policies and procedures for staff responsibilities”*



- TJC: evaluate P/Ps for staff responsibilities
- 99: Verify compliance with all specifics

Refer to original ASHE file for detailed information

§ 482.15(b)(6) CoP: Policies & Procedures



- “... use of volunteers in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.”
 - *“The intent of this requirement is to **address any volunteers**. We believe that in an emergency a facility or community would need to accept volunteer support from individuals with varying levels of skills and training and that policies and procedures should be in place to **facilitate** this support. Health care volunteers would be allowed to perform services within their scope of practice and training and **nonmedical volunteers would perform non-medical tasks**. As such, we disagree with limiting this requirement to just medical volunteers.”*



- TJC: evaluate P/Ps for non-medical volunteers
- 99: Should already comply

• **Refer to original ASHE file for detailed information**

§ 482.15(c) CoP: Communication Plan

- "... develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. "
 - "a system to contact appropriate staff, patients' treating physicians, and other necessary persons in a timely manner to ensure continuation of patient care functions throughout the hospital and to ensure that these functions are carried out in a safe and effective manner."
 - "contact information for federal, state, tribal, regional, or local emergency preparedness staff and other sources of assistance."
 - Review current communication plans, compare with emer prep plans; revise as necessary
- 99-2012 or TJC: evaluate current plans
- Verify compliance with all CMS-listed requirements
- Create a separate Communications Plan



• **Refer to original ASHE file for detailed information**

Need to move to Communications Plan

- 482.15(c)(1) info: listed types of groups; & review
- 482.15(c)(2) info: govt & other assistance
- 482.15(c)(3) primary & alternate means
- 482.15(c)(4) method to share pt info with other providers; & procedures
- 482.15(c)(5) means to release pt info
- 482.15(c)(6) info on pt general condition + location; & review
- 482.15(c)(6) means to provide info: occupancy, needs, abilities



- Other existing Communications content

• **Refer to original ASHE file for detailed information**

§ 482.15(d) CoP: Training & Testing: REVIEW

- § 482.15 (d)(1) Training program **[D]**
 - Initial & annual: ALL; demonstrate competency
 - Including volunteers
- § 482.15 (d)(2) Testing (Annual) **[D]**
- § 482.15 (d)(2)(ii) Testing (2nd Annual) **[D]**
 - Could be tabletop (not presently allowed by TJC)
- § 482.15 (d)(2)(iii) Analyze AARs



• **Refer to original ASHE file for detailed information**

CMS issues info on emergency prep

- "The Centers for Medicare & Medicaid Services (CMS) is providing information to assist providers and suppliers in meeting the Training and Testing requirements of the new Emergency Preparedness Final Rule that was published on Sept. 16, 2016 (81 FR 63860), and became effective on Nov. 15, 2016.
- While providers and suppliers are encouraged to partner with local and state emergency agencies and health care coalitions to conduct full-scale community exercises, not all agencies and coalitions will have the ability or resources to engage with all providers and suppliers. In such cases, **CMS expects those who have been unable to complete a full-scale exercise by Nov. 15, 2017, to complete an individual facility-based exercise and document the circumstances as to why a full-scale, community-based exercise was not completed."**

- **SOURCE: CMS 3-24-17 memo S&C 17-21-ALL**

§ 482.15(f) CoP: Integrated HC systems



- Hospital may participate in IHS emergency program
 - Certify each facility participated in development
 - Takes facility uniqueness into account
 - Facility capable & compliant
 - IHS plan meets (a)(2), (a)(3), (a)(4); and ...
 - community-based all-hazards risks
 - documented all-hazards risks for each HCF
 - IHS plan meets (b); (c); (d) requirements

Some other areas requiring review



- 482.15(b)(7) receiving patients from others
- 482.15(b)(8) alternate care site 1135 waiver

NFPA 99 & TJC EM should already comply



- 482.15(a) Emer Prep Plan, annual review
 - 482.15(a)(2) strategies address HVA risks
 - 482.15(b) P&Ps annual review
 - 482.15(b)(2) system to track staff / patients
 - 482.15(b)(4) means to shelter in place
 - 482.15(b)(5) medical documentation reqmts
 - 482.15(d)(2) testing (annual exercises)
 - 482.15(d)(2)(iii) analyze responses; update plan
 - 482.15(e)(1) EPSS; EPS location
 - 482.15(e)(2) emergency generator ITM
 - 482.15(e)(3) emergency generator fuel
 - 482.15(g) transplant centers involved
 - 482.15(h) invokes 99-2012, 101-2012, 110-2010
- **Refer to original ASHE file for detailed information**



If you haven't done anything yet ...



TABLE 126: TOTAL BURDEN HOUR ESTIMATES FOR ALL PROVIDERS AND SUPPLIERS TO COMPLY WITH THE ICRs CONTAINED IN THIS FINAL RULE: EMERGENCY PREPAREDNESS

PROVIDER TYPE	2012 Burden Hours	2013 Burden Hours	2014 Burden Hours	2015 Burden Hours	2016 Burden Hours	2017 Burden Hours	2018 Burden Hours	2019 Burden Hours	2020 Burden Hours	2021 Burden Hours	2022 Burden Hours	2023 Burden Hours	2024 Burden Hours	2025 Burden Hours	2026 Burden Hours	2027 Burden Hours	2028 Burden Hours	2029 Burden Hours	2030 Burden Hours
Acute Care Hospital	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Long-Term Care Facility	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000
Outpatient Clinic	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000
Emergency Department	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000
Physician Office	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000
Other Health Care Provider	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000
Total	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000

NOTE: These burden hour estimates are based on the number of providers and suppliers who are required to comply with the ICRs. The estimates are based on the number of providers and suppliers who are required to comply with the ICRs. The estimates are based on the number of providers and suppliers who are required to comply with the ICRs.

- From FR page 64007

HOSPITALS: From CMS Final Rule			
Federal Register / Vol. 81, No. 180 / Friday, September 16, 2016 / Rules and Regulations 63957 TABLE 43—TOTAL COST ESTIMATE FOR A TJC-ACCREDITED HOSPITAL TO DEVELOP POLICIES AND PROCEDURES— Continued			
Position	Hourly wage	Burden hours	Cost estimate
Chief of Surgery	231	1	231
Director of Nursing	104	2	208
Pharmacy Director	142	1	142
Facilities Director	104	1	104
Health Information Services Director	104	1	104
Security Manager	104	1	104
Community Relations Manager	107	1	107
Food Services Manager	70	1	70
Medical Secretary	32	1	32
Total		17	2,061

TABLE 46—TOTAL COST ESTIMATE FOR A NON TJC-ACCREDITED HOSPITAL TO DEVELOP A COMMUNICATION PLAN			
Position	Hourly wage	Burden hours	Cost estimate
Administrator	\$172	1	\$172
Risk Management Director	104	4	416
Director of Nursing	104	1	104
Facilities Director	104	1	104
Health Information Services Director	104	1	104
Security Manager	104	1	104
Community Relations Manager	107	1	107
Total		10	1,111

Thank You!

David Stymiest, P.E., CHFM, CHSP, FASHE
(P.E. in LA, MS, MA)

Senior Consultant
Smith Seckman Reid, Inc.
DStymiest@ssr-inc.com
www.ssr-inc.com



Compliance News archives and sign-up are available at:
<http://www.ssr-inc.com/blog/>