Navigating the CMS Emergency Preparedness Rule

A Step-by-Step Guide

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

INTRODUCTION

On September 16, 2016, the Centers for Medicaid and Medicare (CMS) published a final rule on emergency preparedness for healthcare providers. The rule established emergency preparedness requirements for 17 different provider types participating in Medicare and Medicaid, including Federally Qualified Health Centers (FQHCs). Furthermore, CMS later revised these requirements in the Omnibus Burden Reduction Final Rule, which became effective on November 29, 2019.[1] This guide serves to help health centers navigate CMS' requirements.

OVERVIEW OF CMS RULE REQUIREMENTS

- Emergency Planning and Risk Assessment, Policies and Procedures (P&Ps), Communications Plan, Training and Testing Program, optional Integrated Health System[2]
- Note that the CMS Rule memorializes the role of health centers in emergencies and provides a framework for preparedness tailored to health centers

TASKS TO COMPLETE

1. Review CMS rule (64041) - Part 491 - Certification of Certain Health Facilities
2. Review Interpretive Guidelines
3. Review Omnibus Burden Reduction (Conditions of Participation) Final Rule CMS-3346-F

1 Although CMS requirements have been relaxed, health centers must still meet all relevant state and local requirements that may be more stringent than the CMS rule (e.g., New York state requires two exercises per year for health centers).

2 Although optional, this element carries specific requirements if you choose to utilize it. Please refer to 42 CFR §491.12(e) for more details.

TIMELINE FOR IMPLEMENTATION

CREATE TEAM

Time Required: 1-2 weeks to assemble and schedule initial meeting

The Emergency Management Program lead invites a multi-disciplinary team of staff to serve on the emergency management committee (EMC), including but not limited to staff representing the safety committee, infection control committee, and environment of care committee.

- The CMS rule states that a diverse team of staff is necessary to provide input into the creation of the emergency management program.
- Clinical input from a medical director, physician assistant, or nurse practitioner is recommended in developing the emergency plan as well as policies and procedures.
- Schedule EMC meetings and ensure staff commitment. The first meeting sets expectations, creates objectives, sets timelines, establishes the EMC lead/chair and creates clearly identified and assigned responsibilities.
- Best practice: Senior management should participate and give the authority to lead to the EM Program, including but not limited to CEO/Executive Director, COO, CFO, Human Resources, and Practice Managers.

TASKS TO COMPLETE

1. Determine Emergency Management Committee (EMC) Membership / Integrate into existing structure, e.g. QI or Safety Committee (if applicable)
2. Establish a set frequency / duration of meetings
3. Establish program goals, objectives and timeline
4. Create a standard EMC Meeting Agenda for subsequent meetings

TIMELINE FOR IMPLEMENTATION

KNOW YOUR RISKS

Time Required: 2-4 weeks, 2 meetings to assess/update and review

EMC reviews existing assessments and after action reports/debriefings from exercises and actual emergencies.

- CMS states that the all hazards risk assessments must be two-fold: facility-/site- and community-based; take into account patient populations and services provided before/during/after an emergency.

- Best practice: reach out to regional healthcare coalition (HCC/HMCC) for emergency preparedness or the local emergency planning committee (LEPC) to request their regional/community risk assessment to incorporate community risks into your health center assessment. Also consider other sources, like the local health department or county/state office of emergency management.

TASKS TO COMPLETE

1. Determine organizational facility risk assessment process / tools (HVA, safety assessments, etc.)
   - Identify Hazard Vulnerability Analysis Team
   - Gather Information
   - Conduct the HVA

2. Assess specific needs for the patient population(s) served

3. Determine organizational community risk assessment process / strategy

4. Establish organizational planning priority areas / hazards (usually around 5) based on all collected HVA information

TIMELINE FOR IMPLEMENTATION

CREATE THE PLANS

Time Required: 2 months, 3-4 meetings of review

EMC creates/updates the Emergency Operations Plan (EOP) and a written emergency communications plan (which can be part of the EOP).

- CMS requires both an emergency plan and a communication plan
  i. Both plans must be based on the risks identified in the risk assessment, reference the P&Ps (next section), and each plan respectively.
  ii. EOP must address patient population and services provided during an emergency, including delegations of authority and succession plans. Also include a process for collaboration and communications with local, state, and federal officials.
  iii. Communications plan must include internal and external communications; method for sharing medical documentation with other healthcare providers for continuity of care; ability to request and provide assistance; and, include primary and alternate means of communication.

- Best practice: create a comprehensive Emergency Operations Plan. Staff get the most out of the PROCESS of creating the plan rather than from the plan itself.

TASKS TO COMPLETE

1. Review existing organizational plans, protocols, procedures

2. Develop a protocol for reviewing Emergency Operations Plan (EOP) and associated policies on a biennial basis (please note that annual review remains best practice). This may include:
   - Plan maintenance section of EOP and Communications Plan
   - Integration of health center policy review protocols
   - Document as required by CMS

3. Update / Develop EOP (including hazard specific annexes)

4. Assess notification and communication needs / available technology

5. Update / Develop Communication Plan

6. Develop required contact lists

7. Develop required contact maintenance protocol

8. Identify primary / back-up methods for communication

TIMELINE FOR IMPLEMENTATION

DEVELOP/UPDATE POLICIES AND PROCEDURES

Time Required: 1 month, 2-3 meetings

CMS rule states that the P&Ps must reference the EOP, hazards, patients and services, expected staff roles, and communications plan.

- Include plan activation and deactivation procedures
- If possible, include clinical input into the EM Program and P&Ps.
- At minimum, your policies must address: 1) safe evacuation from the facility, including placement of exit signs; 2) a means to shelter in place for patients, staff, and volunteers who remain in the facility; 3) a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records; and 4) the use of volunteers in an emergency or other emergency staffing strategies.

TASKS TO COMPLETE

1. Review existing organizational plans, protocols, and procedures
2. Develop a protocol for reviewing emergency preparedness P&Ps on a biennial basis
3. Update / Develop required and supporting P&Ps

TRAINING STAFF

Time Required: 3-6 months, varies per health center

All staff (new and existing) must be trained on all elements of the plans, policies, and procedures.

- CMS requires training of staff on the risks identified in the assessment, EOP and Communications Plan, and P&Ps; provide initial training to all new/existing staff, contracted services, and volunteers; must include documentation and demonstrated knowledge of staff training and education. Training must be consistent with expected staff roles.

TASKS TO COMPLETE

4. Develop EM training program, including protocols for biennial program updates (please note that annual updates is still best practice)
5. Review job descriptions and staffing contracts, and incorporate emergency roles as appropriate to position and qualifications
6. Conduct training

TIMELINE FOR IMPLEMENTATION

EXERCISES

Time Required: 2-6 months, varies per exercise; overlaps with training period

Plans (or elements of the plans) are to be tested a minimum of once per year.

- CMS will accept the following types of exercises:
  i. Every 2 years: full-scale or functional exercise (6-12 months)
  ii. Every 2 years (opposite the year the full-scale or functional exercise is conducted): tabletop exercise (6 weeks - 3 months), mock disaster drill (approximately a month), or workshop (2 weeks)

- The post exercise reports must include 5 elements at a minimum and should determine 1) what was supposed to happen; 2) what occurred; 3) what went well; 4) what the facility can do differently or improve upon; and 5) a plan with timelines for incorporating necessary improvement.

TASKS TO COMPLETE

1. Review The Homeland Security Exercise and Evaluation Program (HSEEP) principles (recommended).

2. Develop EM testing program (multi-year approach recommended), including protocols for biennial program updates

3. Identify opportunities for and participate in a full-scale community-based exercise (if unavailable, develop and conduct a functional facility-based exercise)

4. Develop and conduct a tabletop exercise, a mock disaster drill, or a workshop

TIMELINE FOR IMPLEMENTATION

DOCUMENTATION

Time Required: 1 month, overlaps with all previous steps, 1 final meeting to review with team and set schedule for ongoing biennial maintenance (annual maintenance is best practice)

Every step of the development and improvement of an emergency program must be documented to satisfy a CMS audit.

- CMS Interpretive Guidelines state that documentation of exercises and real emergencies must be kept for a minimum of 3 years.
- Documentation includes plans, P&Ps, training materials and staff training logs, exercise and incident reports, and composition of the multidisciplinary Emergency Management team.
- Best practice: although not required, the Homeland Security Exercise and Evaluation Program (HSEEP) is recommended by CMS. Using the HSEEP toolkit, or other products of similar design, creates a recognized format that is acceptable by CMS surveyors.

TASKS TO COMPLETE

1. Develop a system of documentation of staff trainings including demonstration of knowledge.
2. Develop a system of evaluation and quality improvement (QI) for all exercises conducted
3. Develop a system of documentation, evaluation, and quality improvement following any real-world emergency events

SUMMARY

In total, this sample timeline for a full implementation would consist of 6-12 months depending on the starting point and existing capabilities and capacities of the health center. A health center with an existing EP program can follow this timeline and implement updates as described within six months, whereas a health center without an EP program can create one and test it within 12 months.

After the initial implementation, an ongoing maintenance plan plan of the emergency preparedness program should be implemented. At minimum, ensure that the review includes biennial review/update of risk assessment, plans, P&Ps, biennial training of staff and at least one exercise annually (annual review of the program and two annual exercises remain best practice).

FINAL CHECKLIST

- ☐ Emergency plans
- ☐ Policies and procedures
- ☐ Communications
- ☐ Training and exercises
- ☐ Integrated Healthcare System (optional element)

CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State

Alexander Lipovtsev, Director, Emergency Management Program
alipovtsev@chcanys.org

Massachusetts League
of Community Health Centers

Tina Wright, Director, Emergency Management
twright@massleague.org

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number and title for grant amount (under grant number U30CS09736, a National Training and Technical Assistance Cooperative Agreement (NCA) for $1,350,000, and is 100% financed by this grant). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.