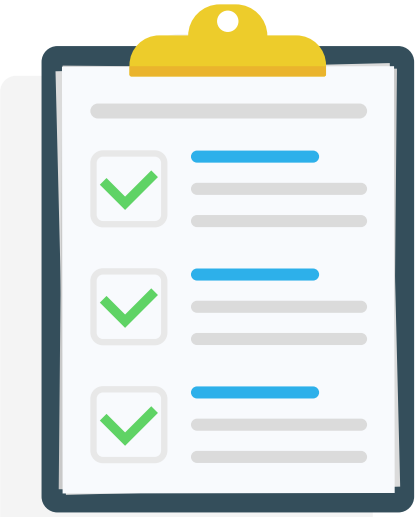
Navigating the CMS Emergency Preparedness Rule

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). 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[1]
- Note that the CMS Rule memorializes the role of health centers in emergencies, 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

1 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, environment of care committee

- The CMS rule states a diverse team of staff are necessary to provide input into the creation of the emergency management program.
- Specifically with the development of the emergency plan as well as policies and procedures, the rule requires clinical input from a medical director, physician assistant or nurse practitioner.
- Schedule EMC meetings and ensure staff commitment. First meeting sets expectations, creates objectives, sets timeline, establishes the EMC lead/chair and create 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 2-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 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, include delegations of authority and succession plans; and, include collaborations 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 an annual basis. 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
- Ensure 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, procedures
2. Develop a protocol for reviewing emergency preparedness P&Ps on an annual 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, P&Ps.

- 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 annual program updates
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 exercises; overlaps with training period

Plans (or elements of the plans) are to be tested a minimum of two (2) times per year.

- CMS states that qualifying exercises include tabletop and full scale, functional acceptable if full scale not available.
  i. Tabletop exercise (6 weeks - 3 months)
  ii. Full scale exercise (6-12 months)

- 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 annual program updates

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

4. Develop and conduct a tabletop exercise

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 annual maintenance

Every step of the development and improvements of an emergency program must be documented to satisfy a CMS audit or Joint Commission survey.

- 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: the Homeland Security Exercise and Evaluation Program (HSEEP) is highly recognized by the Joint Commission. Using the HSEEP toolkit, or other products of similar design, creates a recognized format that is acceptable by the Joint Commission and therefore 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 documenting, 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 CHC. A CHC with an existing EP program can follow this timeline and implement updates as described within six months, whereas a CHC without an EP program can create one and test it within 12 months.

After the initial implementation, a modified maintenance and annual renewal timeline can be truncated. The condensed timeline must continue to include annual updating of risk assessment, plans, P&Ps, ongoing annual training of staff, and two annual exercises.

FINAL CHECKLIST

- ☐ Emergency plans
- ☐ Policies and procedures
- ☐ Communications
- ☐ Training and exercises
- ☐ Integrated Healthcare System

CONTACT US

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

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 under grant number U30CS09736, a National Training and Technical Assistance Cooperative Agreement (NCA) for $1,350,000, and is 0% financed by nongovernmental sources. 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.