2022 LTC Emergency Preparedness Updates

Understanding the Emergency Preparedness Final Rule

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Final Rule

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

Four Provisions for All Provider Types

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.**

HVA Tool

- AHCA/NCAL and Jensen Hughes have developed the AHCA/NCAL HVA Tool*. Built on a foundation of established risk probability and assessments, the tool is specifically designed for the nursing home and assisted living environment, and specifically addresses CMS requirements.

- https://www.ahcancal.org/Survey-Regulatory-Legal/Emergency-Preparedness/MemberOnlyDocs/AHCA%20HVA%20Worksheets.xlsx

**AHCA/NCAL login required, may need to create user account*

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.
  - 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.

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.

Interpretive Guidelines

- The Survey & Certification Group (SCG) developed Interpretive Guidelines (IGs) to assist in implementation of the EP regulation.

- The IGs are formatted into Appendix Z within the State Operations Manual (SOM) applicable to all 17 provider/supplier types.

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_z_emergprep.pdf

Compliance

- In the event facilities are non-compliant, the same general enforcement procedures will occur as is in place for any other conditions or requirements cited for non-compliance.
- Training resources are available on the CMS QSEP website.
  - EP: Basic Training
  - EP: Provider Readiness
  - https://qsep.cms.gov/ProvidersAndOthers/publictraining.aspx#e

The SGC 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.

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html

The SGC Website

Home › Medicare › Quality, Safety & Oversight Group - Emergency Preparedness

Quality, Safety & Oversight Group - Emergency Preparedness

- Nursing Homes
- State Survey Agency Guidance
- Health Care Provider Guidance
- Lessons Learned/Archives
- Emergency Preparedness Rule
- Core EP Rule Elements
- 1135 Waivers
- Earthquakes
- Hurricanes
- Severe Weather
- Flooding
- Wild Fires and Fires General
- Influenza and Viruses
- Homeland Security Threats
- Templates & Checklists

Quality, Safety & Oversight Group - Emergency Preparedness

Emergency Preparedness for Every Emergency

Mission

Enable Federal, State, Tribal, Regional, and local governmental agencies, and health care providers to respond to every emergency in a timely, collaborative, organized, and effective manner.

The Centers for Medicare & Medicaid Services (CMS) Survey and Certification Group (SCG) has developed this site to provide useful information to CMS Central and Regional Offices, State Survey Agencies (SAs), their State, Tribal, Regional, and local emergency management partners, and health care providers, for developing effective and robust emergency plans and responses. This Web site provides information and tools, utilizing an "all hazards" approach for disruptive events such as:

- Pandemic flu (e.g., H1N1 influenza virus)
- Hurricanes
- Tornados
- Fires
- Earthquakes
- Power outages
- Chemical spills
- Nuclear or biological terrorist attack
- Etc.

This Web site provides "one-stop shopping" to obtain both mandated and voluntary emergency preparedness information and tools. The Web site will be updated regularly to provide helpful guidance regarding issues such as:

- Clarifying the roles, responsibilities and actions of CMS Central and Regional Survey & Certification (S&C) Offices.
- Clarifying the roles, responsibilities, and actions of SAs.
- Effective emergency planning across all health care provider types to ensure the well-being of vulnerable populations – whether in long-term care, acute care, or community-based facilities -- during a disruptive event.

Collaboration with ASPR TRACIE

- SCG's primary focus is on the development of Interpretive Guidelines and Surveyor Training.
- SCG collaborates with the ASPR TRACIE.
- https://asprtracie.hhs.gov/cmsrule

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

Don’t Lose Sight of Fire Safety…Plan, Train and Test

- Fire safety remains a critical component of EP to ensure a safe home and workplace.
- Like many emergency situations, a fire can result in the implementation of multiple components of an organization’s EP plan.
- The importance of the three components of EP come to mind when considering any potential fire or disaster:
  - Planning;
  - Training; and
  - Testing.

Don’t Lose Sight of Fire Safety…Plan, Train and Test

- Sprinkler systems save lives. However, these systems require on-going testing, inspection and maintenance. If your facility has not re-engaged normal ITM tasks and frequencies, now is the time to contact your vendor(s) and schedule these services.
- ITM intervals can run from quarterly to every two years depending on the system component. Work with your vendor to review your most recent documentation and develop a schedule to get back on track.
- A reminder that CMS references the 2011 edition of NFPA 25 for sprinkler system ITM and the 2010 edition of NFPA 72 for fire alarm ITM even though more recent editions of both exist.

Don’t Lose Sight of Fire Safety…Plan, Train and Test

- While sprinkler systems often control the flames, a significant amount of smoke can develop even from a relatively small, controlled fire. Health care facilities are designed to contain fire and smoke to the room of origin. However, that requires the room door to be shut and to remain shut. Do your staff fire procedures focus on smoke containment? Procedures that highlight extinguishment or instruct staff to gather fire extinguishers may have the wrong focus. The most important focus for staff is to remove anyone from the fire room, close the door and keep it closed. Is this the focus of your fire procedures?

Don’t Lose Sight of Fire Safety…Plan, Train and Test

- Procedures may work on paper, but they are only as effective as the staff implementing them. Fire drills can be the most effective method of staff education. Do you just walk through the motions during a fire drill or do staff actively close doors, clear hallways, communicate and discuss the factors that may require further evacuation? Participating in hands-on, critiqued fire drills can lead directly to competent and confident staff actions during a true emergency.
- Healthcare providers were permitted to alter the process for conducting quarterly fire drills by providing a documented staff training program rather than facilitate traditional fire drills that could result in moving and massing residents together.
- The requirements of the Life Safety Code will again apply. Commencing in June, drills should occur quarterly on each shift, at varying times and under varied conditions.

Don’t Lose Sight of Fire Safety…Plan, Train and Test

- Find up-to-date fire safety tools and resources on the AHCA/NCAL fire safety and life safety webpage.

- https://www.ahcancal.org/Survey-Regulatory-Legal/Pages/Fire-Life-Safety.aspx

Temporary Walls and Partitions

- Healthcare providers were permitted to install temporary barriers to provide separation and minimize contact during the pandemic. These barriers were sometimes utilized in individual rooms or used to separate entire wings or units from the remainder of the building. The 1135 waiver allowed for the use of products and finishes that would otherwise not be permitted for use as a barrier. Plywood, plastic sheathing and even plexiglass were commonly used materials. However, the Life Safety Code® only permits Class A or Class B interior wall finishes. An evaluation of all barriers installed during the pandemic should be evaluated and where they remain today, the materials should be assessed for compliance. This could result in the need to remove barriers or replace them with alternate materials.

Temporary Walls and Partitions

- The use of plastic sheathing as a barrier should sunset along with the waivers. If a temporary barrier needs to remain in place, non-combustible materials such as drywall should be considered. Some organizations have adjusted their COVID units to be a dedicated wing or smoke compartment that is inherently separated by smoke barrier doors. This essentially utilizes the built-in barriers of the building to provide separation. Where these doors were previously held open, they now remain closed. Creating temporary barriers can often impact egress. If you can use the existing compartmentation of the building, you minimize the potential for unrelated compliance issues. The use of plexiglass has been common inside facilities during the pandemic. Plexiglass is a transparent solid thermoplastic that will burn. Under normal conditions, and without the application of the 1135 waiver, plexiglass would not be permitted as a barrier or wall finish by the Life Safety Code®. However, this does not limit the use of plexiglass as an accessory or furnishing. Appendix Section A.3.3.90.2 of the 2012 Edition of the Life Safety Code® indicates that “furnishings that, in some cases, might be secured in place for functional reasons should not be considered as interior finish.” This should allow applications such as a plexiglass barrier on a reception desk or nurse’s station to remain.

Sunsetting of 1135 Waivers

- You can find the full CMS memo on the sunsetting of the 1135 waivers at the following link:

- Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers (cms.gov)

- https://www.cms.gov/files/document/qso-22-15-nh-nltc-lsc.pdf?cm_ven=ExactTarget&cm_cat=COVID-19+Update+%23+283&cm_pla=Marks+Memos+2022+List&cm_ite=memo%E2%80%8B&cm_lm=1553546734&cm_ainfo=&&&&&

Ask Yourself

- What emergency response plans should be in place for known hazards?
- What infrastructure improvements, equipment purchases, training, or collaboration with partners can be done to mitigate hazards?
- What should the exercise / drill planning focus be for the year?

Action Steps

- Identify any disaster/emergency situations the facility faced over the last year with particular focus on any after action reports that may have been developed.
- Review your community's HVA or Hazard Mitigation Plan. They can often be accessed online or by placing a call to your Local Office of Emergency Preparedness.
- Make sure the HVA addresses hazards such as cyber attack, persons with a weapon, staffing shortages, supply shortages and emerging infections disease/pandemic. These will likely rank higher than in previous years.
- Include a variety of department heads in the HVA review process to ensure a comprehensive analysis of the ramifications of each hazard to your organization.

Action Steps

- The HVA is just one component of a comprehensive emergency preparedness plan. Don’t forget to review the entire plan annually with specific focus on names, numbers, agreements, supplies, etc. An updated plan will serve you better when it is needed and you in compliance during survey.

Thank You!

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