CMS Emergency Preparedness Rule Implementation
To establish national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems

• Increases patient safety during emergencies
• Establishes consistent emergency preparedness requirements across all provider and supplier types
• Establishes a more coordinated response to natural and man-made disasters
• Intended to address system gaps, ensure consistency and encourage coordination
Requirements

- Requirements will apply to all 17 provider and supplier types
- Each provider and supplier will have its own set of Emergency Preparedness regulations incorporated into its set of conditions or requirements for certification
- Must be in compliance with Emergency Preparedness regulations to participate in the Medicare or Medicaid program.
Who is Affected - 17 Medicare and Medicaid Providers and Suppliers

- Hospitals
- Religious Nonmedical Health Care Institutions (RNHClIs)
- Ambulatory Surgical Centers (ASCs)
- Hospices
- Psychiatric Residential Treatment Facilities (PRTFs)
- All-Inclusive Care for the Elderly (PACE)
- Transplant Centers
- Long-Term Care (LTC) Facilities
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Home Health Agencies (HHAs)

- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Critical Access Hospitals (CAHs)
- Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services
- Community Mental Health Centers (CMHCs)
- Organ Procurement Organizations (OPOs)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- End-Stage Renal Disease (ESRD) Facilities
What is Required?

Providers and suppliers must comply with the following four common and well-known industry best practice standards:

- Emergency plan and risk assessment
- Policies and procedures
- Communication plan
- Training and testing program

Emergency power systems are required for hospitals and long-term care facilities.

Other requirements will vary by provider type.
Timeline

• Rules are effective November 15, 2016 and providers must be in compliance by November 15, 2017.

• Allowances bring made for transitions stages on some requirements
Four Core Elements of Emergency Preparedness

• Risk Assessment and Emergency Planning
• Communication Plan
• Policies and Procedures
• Training and Testing
Risk Assessment and Emergency Planning

- Hazards likely in geographic area
- Care-related emergencies
- Equipment and Power failures
- Interruption in Communications, including cyber attacks
- Loss of all/portion of facility
- Loss of all/portion of supplies

- HVA
- Facility and community based RA
- Patient population (at-risk)
- Plan is to be reviewed and updated at least annually
Communication Plan

• Complies with Federal and State laws
• System to contact staff, including patients’ physicians, other necessary persons
• Well-coordinated within the facility, across health care providers, and with state and local public health departments and emergency management agencies.

• Method for sharing information and medical documentation with other healthcare providers
• A means to release patient HIPAA information during an evacuation
• A means of providing information about the general condition and location of patients
• A means of providing information about the hospital’s occupancy, needs and ability to provide assistance
Policies and Procedures

• P and P’s based on the emergency plan, risk assessment and communication plan
• Plans coordinate with local, state, tribal, or federal partners to maintain an integrated response
• Complies with Federal and State laws
Specific Hospital Policies and Procedures

- Subsistence for staff and patients if evacuated or sheltering in place
- Alternate source of energy to maintain temperature, lighting, fire protection
- Provisions for sewage and waste disposal
- System to track location of staff and patients during emergencies
- Safe evacuation of facility
- A means to shelter in place
- System of medical documentation that preserves patient information
- Address use of volunteers
- Process for transferring and receiving patients
P and P for 1135 Waiver

- Temporarily waiver or modification of certain Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods.

- Policy and procedure to address the role of the hospital under a 1135 waiver for the provision of care and treatment at an (ACS) alternate care site identified by emergency management officials:
  - Preapproval requirements
  - Requirements health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State
  - Emergency Medical Treatment and Labor Act (EMTALA)
  - Performance deadlines and timetables may be adjusted (but not waived)
  - Limitations on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers
Training and Testing

- Program based on emergency plan, risk assessment and communication plan
- Complies with Federal and State laws
- Maintain and at a minimum update annually
- Provide training to all staff, registry, volunteers and maintain documentation
- Demonstrate staff knowledge of emergency plans
- Participate in a community drill or individual facility based exercise
- Full scale and tabletop
- Must analyze response and revise plan accordingly
Emergency and Standby Power

- Implement emergency and standby power systems
- Generator located in accordance with Heath Care Facilities Code and NFPA 110
- Implement emergency power system inspection, testing and maintenance (NFPA 99 102, 101 2012, 110 2010)
- Onsite fuel power source
EHR Incentive Programs

- provide incentive payments to eligible professionals and eligible hospitals as they demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology
- These incentive programs are designed to support providers in this period of Health IT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care
- Eligible Professional (EP) and hospital types
  - Doctors, MAO (Medicare Advantage Organization), Medicaid EP’s
  - Subsection (d) hospitals, Critical Access hospitals, MA - Affiliated Hospitals, Children’s Hospitals
Themes of Final Long Term Care Rule (CFR 483 Subpart B)

- Person-Centered Care
- Quality
- Facility Assessment, Competency-Based Approach
- Alignment with HHS priorities
- Comprehensive Review and Modernization
- Implementation of Legislation
Person-Centered Care

Residents and Representatives: Informed, Involved, and In Control

- Existing protections maintained
- Choices (diets, schedule and activities)
- Care & Discharge Planning
- Prohibition on Pre-dispute Arbitration Agreements, Requirements for Post-Dispute Arbitration Agreements
- Photo of resident only with their consent
- Right to privacy with email, internet
Quality of Care and Quality of Life—overarching principles for every service.

- Additional special care issues: restraints, pain management, bowel incontinence, dialysis services, and trauma-informed care
- Quality Assurance and Performance Improvement
- Resident treated in alignment with professional standards, person-centered care plan and individual choice
- Develop Infection and Control Program
Compliance and Ethics

• Develop a compliance ethics program – written policies and standards
• Assign specific individual responsibility to staff
• Designated compliance officer for 5 or more facilities
• Use due care to avoid delegating substantial discretion to individuals known to have the propensity to engage in violations
• Have a training program regarding compliance
Facility Assessment and Competency – Base Approach

Facilities need to know themselves, their staff, and their residents

• Two to a room with sink and commode for facilities
• Accounts for and allows for diversity in populations and facilities
• Focus on each resident achieving their highest practicable physical, mental, and psychosocial well-being
• Annual facility wide assessment (population type, staff competencies, resources, at-risk assessment)
Training and Testing

- Abuse, neglect and exploitation training for all employees
- Broader training for new staff, and contracted staff, volunteers
- Training needs based on facility assessment
Behavioral Health Services
(483.40)

- New requirement (incorporates highest practicable well-being, specialized rehabilitation, and medical social services)
- Sufficient, competent staff
- Resident with dementia has treatment and services needed to meet his/her needs
- Implementation on non-pharmacological intervention
- Safeguarding nursing home residents from the use of unnecessary psychototropic (antipsychotic) medication
Phased in Implementation
Schedule

• Phase 1: Existing requirements, those requirements relatively straightforward to implement, and require minor changes to survey process. (November 28, 2016)
• Phase 2: All Phase 1 requirements, and those that providers need more time to develop, foundational elements, new survey process can assess compliance. (November 28, 2017)
• Phase 3: All Phase 1 and 2, those requirements that need more time to implement (personnel hiring and training, implementation of systems approaches to quality). (November 28, 2019)
# Phased Implementation

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<td>• Resident Rights and Facility Responsibilities*</td>
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<td>• Infection Control – Program*</td>
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<td>• Physical Environment*</td>
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(*) this section is partially implemented in Phase 2 and/or 3)
### Phased Implementation

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<td>• Behavioral Health Services*</td>
<td>• Quality Assurance and Performance Improvement* - Implementation of QAPI</td>
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<td>• Quality Assurance and Performance Improvement* - QAPI Plan</td>
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<td>• Infection Control – Facility Assessment and Antibiotic Stewardship **</td>
<td>• Compliance and Ethics*</td>
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*This section is partially implemented in other phases*
Questions

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