EMERGENCY PREPAREDNESS
Are you Ready for Disaster?

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OBJECTIVES

- Discuss current regulatory requirements – New Condition of Participation

- Review briefly state hospice demographics and state regulations

- Define regional healthcare coalitions and their role in emergency preparedness with hospice
Continue to Check Your Resources

- Please note this information is current as of the date these slides were sent for the presentation (Jan 2017)

- Please continue to check the CMS Emergency Preparedness Website and other resources as Medicare policy changes frequently
Conditions of Participation

- Conditions of Participation (CoPs) are health and safety regulations which must be met by Medicare and Medicaid-participating providers and suppliers.

- Their purpose is to protect all individuals receiving services from those organizations.
New CoP 418.113

- From subpart D of CoPs

- IPU requirements have been moved from 488.110 to 418.113

- There are no standards – only the condition of participation. If your agency is cited, it will be a condition level citation
National Hospice Statistics

- 412 inpatient hospices
- 3,989 hospices that provide care to patients in their homes
- Federal Register, published 9/16/16, section on cost estimates for detailed information of expectations
Emergency Preparedness Condition of Participation

- Final Rule Published September 16, 2016
- Effective November 15, 2016
- Implementation Effective November 15, 2017
Emergency Preparedness Condition of Participation

- Surveyors will begin evaluating the new requirements after November 17, 2017
- Interpretive Guidelines for the CoP are being developed
- To be released sometime in the spring of 2017
- CMS currently developing self-paced, web-based surveyor training for evaluating this CoP
- May be available to providers as well
Purpose of New Emergency Preparedness CoP

- Increases patient safety during an emergency
- Establishes consistent emergency preparedness requirements across provider and supplier types
- Establishes a more coordinated response to natural and man-made disasters
- Applies to 17 Medicare and Medicaid providers and suppliers

(MLN Connects National Provider call October 5, 2016)
CoP Has Four Provisions for All Provider Types

1. Risk Assessment & Emergency Planning
2. Policies and Procedures
3. Communication Plan
4. Testing and training
1. Risk Assessment

Develop an emergency plan based on a risk assessment

Use “all hazards” approach – an integrated approach to emergency preparedness planning that focuses on capacities and capabilities;

Is specific to physical location and geographical area of provider

May include, but not limited to: care-related emergencies; equipment and power failures; interruptions in communications; loss of all or part of a facility, etc.
Facilities are required to develop and implement policies and procedures that support the successful execution of the emergency plan and risks identified during the risk assessment process.
Facilities are required to develop and maintain an emergency preparedness communication plan that complies with both federal and state law.
3. Communication Plan

Pt. care must be well-coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management agencies and systems to protect patient health and safety in the event of a disaster.
3. Communication Plan

During an emergency it is critical that all providers/suppliers have a system to contact appropriate staff, patients’ treating physicians, and other necessary persons in a timely manner to ensure continuation of patient care function, and ensure the functions are carried out in a safe and effective manner.
4. Training and Testing

- Facilities are required to develop and maintain an emergency preparedness training and testing program.

- Must be well-organized, effective initial training for new and existing staff in emergency preparedness policies and procedures; and annual refresher trainings.

- The facility must offer annual emergency preparedness training so that staff can demonstrate knowledge of emergency procedures.
4. Training and Testing

- The hospice is required to conduct drills and exercises to test the emergency plan to identify gaps and areas for improvement.

- Two drills are required: One should be a multi-disciplinary, boots on the ground, community-based full scale exercise. There may be an exemption if you experience an actual emergency.

- The second exercise may be at the discretion of the hospice agency.
Link to the Final Rule

View the Federal Registered published on 9/16/16 at:


Encourage someone from your agency to read the rule – the Hospital Rule, and then hospice-specific sections
Georgia Information
Georgia’s Patient Population

Diagnosis at time of death:
- Respiratory
- Cardiac
- Cancer

50% + on Oxygen

Short supply of medications (<2 weeks)

Frail, many bedbound

No caregiver requirement

No homebound requirement - many patients are mobile!
Georgia’s Hospice Landscape 2016

- 197 Licensed Hospice Providers in Georgia
- Approximately 42,000 patients served
  - Cobb, Fulton, DeKalb, Gwinnett, Chatham, Muscogee
- 96% of hospice care provided in the patient’s place of residence
  - Home  (private residence)
  - Skilled Nursing Facility
  - ALF / Personal Care Home
- 4% General In-Patient Care
  - Hospice in-patient unit
  - Hospital/Nursing Home Contractual Agreement
111-8-37-.11 Disaster Preparedness

- Every hospice must have a current disaster preparedness plan that addresses potential situations where services to patients may be disrupted and outlines appropriate courses of action in the event a local or widespread disaster occurs including communications with patients and their families and emergency management agencies.

- The plan must be reviewed and revised annually, as appropriate, including any related written agreements.
GA Regulations

The disaster preparedness plan must include at a minimum plans for the following emergency situations:

Local and widespread severe weather emergencies or natural disasters, such as floods, ice or snow storms, tornados, hurricanes, and earthquakes;

Interruption of service of utilities, including water, gas, or electricity, either within the facility or patients’ homes or within a local or widespread area; and

Coordination of continued care in the event of an emergency evacuation of the area.
If the hospice offers residential and/or inpatient services, in addition to the procedures specified, the plan must also include:

- Fire safety and evacuation procedures and procedures for the provision of emergency power, heat, air conditioning, food, and water
- Plans for the emergency transport or relocation of all or a portion of the hospice patients, should it be necessary, in vehicles appropriate to the patients’ conditions when possible, including written agreements with any facilities which have agreed to receive the hospice’s patients in such situations, and notification of the patients’ representatives.
- The hospice must have plans to ensure sufficient staffing and supplies to maintain safe patient care during the emergency situation.
Disaster preparedness plans for hospice care facilities must be rehearsed at least quarterly. Rehearsals must be documented to include staff and patient participants, a summary of any problems identified, and the effectiveness of the rehearsal. In the event an actual disaster occurs in any given quarter, the hospice may substitute the actual disaster’s response in place of that quarter’s rehearsal.

Hospices must include emergency management agencies in the development and maintenance of their disaster preparedness plans and also provide copies of such plans to those agencies as requested.

The Department may suspend any requirements of these rules and the enforcement of any rules where the Governor of the State of Georgia has declared that a state of emergency or disaster exists as a result of a public health emergency.
So..........What are our Resources?

Survey and Certification Group (SCG) – in process of developing interpretive guidelines

Emergency Preparedness Rule

Survey & Certification - Emergency Preparedness


On September 8, 2016 the Federal Register posted the final rule Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. The regulation goes into effect on November 16, 2016. Health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date, on November 16, 2017.

Purpose: 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. The following information will apply upon publication of the final rule:

- 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. The below downloadable sections will provide additional information, such as the background and overview of the final rule and related resources.

Additional information has been provided on the left side hyperlinks categorized by information from the EP Rule, such as the Emergency Preparedness Plan, Communication Plan, Policies and Procedures and Testing.
SURVEYOR TRAINING

Self-paced, web-based surveyor training

May be available to agencies/providers as well
CMS Hosted Medicare Learning Network

- MLN calls for providers

- Look up date October 5, 2016

- Click on that date to access audio recording and written transcript

## MLN National Provider Calls & Events

These conference call and webcast presentations by CMS subject matter experts cover changes to the Medicare program and include question and answer sessions. Events are free but registration is required.

Contact us with questions, comments, or suggestions for a future call. Find out about associations offering credit for MLN events.

Search for upcoming events or view materials from previous events, including slide presentations, transcripts, audio recordings, and videos.

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ASPR TRACIE

- Office of Assistant Secretary for Preparedness and Response (ASPR)
- Technical Assistance Center and Information Exchange (TRACIE)
- https://www.asprtracie.hhs.gov
Welcome to ASPR TRACIE

Brought to you by HHS ASPR, the Technical Resources, Assistance Center, and Information Exchange (TRACIE) was created to meet the information and technical assistance needs of regional ASPR staff, healthcare coalitions, healthcare entities, healthcare providers, emergency managers, public health officials, and other entities involved in planning for and responding to healthcare-related emergencies.
Updated! CMS Emergency Preparedness Rule: Resources at Your Fingertips

This document provides links to resources that can help providers and suppliers comply with the recently released CMS Emergency Preparedness Rule.

Scroll down right side of page and click on the CMS Emergency Preparedness Rule: Resources at Your Fingertips
HealthCare Coalitions (HCC)

- Part of Hospital Preparedness Program (HPP)

- HCCs-developed to incentivize diverse and competitive health care organizations with differing priorities and objectives to work together
What are Regional Healthcare Preparedness Coalitions?

The Georgia Healthcare Preparedness Coalitions have been formed to help bridge gaps and improve healthcare preparedness for disasters. County, community, or organizational plans alone may not be sufficient to take care of the health care needs during and after a disaster, therefore a regional approach is needed to improve the continuity of healthcare. Healthcare organizations planning together will create a more prepared and resilient healthcare system.

http://nwgapublichealth.org/regional-healthcare-preparedness-coalitions/
Recognizing that hospitals alone are not sufficient to take care of the health care needs after a disaster, Regional Healthcare Preparedness Coalitions include but are not limited to:

Hospitals
Hospices – 13% of coalition membership
Community Health Centers
Emergency Management Agencies (EMA)
Emergency Medical Services (EMS)
Nursing Homes
Public Health
Home Health
Mental/Behavioral Health Providers
Dialysis Centers
Pharmacies
Community Partnerships

Pharmacy – provide several days of medication in advance of storm so patients have enough in case they shelter in place for a length of time

DME Companies – provided additional oxygen tanks for use in the event of prolonged power outages

EMS – transport deceased patients when other vehicles are unable to get to patient; transport patients who needed to be evacuated

EMA – assistance with contacting power companies for patients on high oxygen flow equipment that cannot be used without electricity (bi-pap; trilogy vents)
Community Partnerships

Everbridge Communications for communicating with staff collectively and timely

Local hospitals for receiving patients who could not shelter in place at home due to high-skilled needs for either oxygen or nursing care

SNFs to receive patients to shelter patients who could not stay at home due to needs for electrical equipment or nursing care

WEB EOC – part of GHA911 to communicate during drills and disasters
Regional Disaster Drills Region C

- Annual Regional Drills
- Observed functioning of the Incident Command Center at Floyd Medical Center
- Facilitated communication between the Incident Command center and Heyman HospiceCare
- Mostly passive participation, and great learning experience for the hospice
CMS Recommendations

- Throughout federal register/final rule on emergency preparedness CMS recommends participation in regional health care coalitions

- Will assist with drills, networking, community partnerships, resources

- May provide assistant with development of policies and procedures
Healthcare Preparedness Program (HPP)

Federal grant to each of the 62 states, territories, & funded cities
Health & Human Services, Assistant Secretary for Preparedness & Response

Grant must come to the Department of Public Health
No state dollars involved
“Sister” grant is the Public Health Emergency Preparedness administered by CDC
Regional Coordinating Hospitals started around 2000

1 Specialty Coordinating Hospital (pediatric)

14 Coalitions “born” 2012

Annual Strategic Planning meetings
Home Rule
www.GHA911.org

Bed counts
Facility information
WEBEOC
Everbridge messaging
Infectious Disease Network

- **Identify and Isolate**
  - Hospitals identify EVD symptoms
  - Isolate patients if needed
  - EMS transport to hospitals for diagnosis

- **Diagnose**
  - Hospitals have capability to manage a suspect case of EVD
  - Specimen collection for diagnostic testing
  - EMS transport to hospitals for treatment if positive
  - Lab capacity complete for diagnosis

- **Treat**
  - Hospitals designated to treat EVD

- **Designated EMS Service**
  - 25 EMS zones
  - Increased PPE, protocols and training
  - Dedicated phone number for triage and EMS coordination 1-866-PUB-HEALTH

- **Walk in to the Emergency Department**
  - 911 Call
  - Monitor case that becomes symptomatic
Disproportionately Impacted

Whole Community approach to community Inclusion
Healthcare Preparedness
Example: Dialysis Winter

• Are you involved in your local coalition?

Transportation Partners
Verification of Services
Points of Contact
Guidance
CMS Emergency Preparedness

Effective date 16 Nov 2016
Implementation date 16 Nov 2017
Georgia developing assistance documents for various healthcare organizations
Opportunity!

The finalized CMS rules can be accessed here:
https://www.federalregister.gov/public-inspection

ASPR Tracie dedicated page
https://asprtracie.hhs.gov/cmsrule
Preparedness Plans Include:

- Communication Tree
- Mass Evacuation plan vs. Fire Escape plan
- A real connection with EMA
- No more silo plans
- Drills and Exercise
- Generator and Transfer Switch

Involved with local Health Care Preparedness Coalition

Comprehensive Plans
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