

OPEN DOOR FORUM

Friday, March 14, 2007

Homeland Security Presidential Directive (HSPD) 21: Paragraph 40 Implementation Private Sector Health Care Facility Preparedness (Emphasis on Mass Casualty Events)

CMS EMERGENCY PREPAREDNESS INITIATIVE OVERVIEW

The Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) and the Office of the Assistant Secretary for Preparedness and Response (ASPR) has scheduled this Special Open Door Forum (ODF) to discuss your ideas and suggestions for implementing Paragraph 40 from Homeland Security Presidential Directive 21 (HSPD-21), Public Health and Medical Preparedness: “. . .to create financial incentives to enhance private sector health care facility preparedness. . .” Paragraph 40 has been developed as part of the mass casualty planning efforts and describes the criteria for implementing such a plan (e.g., rely on current grant funding programs, private payer incentives, market forces, CMS requirements, and other identified cost-effective methods).

National experts have stressed that effective emergency planning must be implemented in a coordinated and collaborative process that involves health care providers and local, State, Regional, Tribal and Federal agencies. The difficult lessons learned from Hurricane Katrina require us to successfully partner to ensure the protection of all vulnerable persons in every health care setting -- acute care, long-term care , and community-based facilities – to achieve a prepared and responsive national health care system.

It also makes prudent, cost-effective business sense for facilities to be proactive in their emergency planning efforts. Effective emergency planning not only helps facilities to achieve compliance with regulatory requirements of Federal, State and local agencies, it may also help the business to recover from financial losses, loss of market share, damages to equipment, or business interruption. Effective emergency planning can also help to reduce exposure to civil or criminal liability during a disaster, enhance a facility's image and credibility with employees, customers, suppliers and the community, and reduce insurance premiums.

CMS EMERGENCY PREPAREDNESS INITIATIVE

In Spring 2006, one component of CMS, the Survey and Certification Group, launched an emergency preparedness initiative to assist in the overall CMS emergency preparedness efforts. The purpose of the Survey and Certification (S&C) Emergency Preparedness Initiative is to create a robust, effective, and coordinated health care emergency planning and response system that ensures continuity of the S&C essential business functions, effective communication, improved data capability, ability to track providers affected by the disaster, and an effective response that protects the health and safety of patients and residents in the face of any potential disruptive event.

The first step of the initiative was to establish several internal CMS workgroups (with experienced representatives from both the Central and Regional Offices), to analyze and develop recommendations for improvements to the current health care facility survey and certification (S&C) policies and protocols. The S&C Emergency Preparedness Initiative utilizes an “all hazards” approach (e.g., hurricane, tornado, earthquake, flood, fire, chemical spill, nuclear or biological attack, pandemic flu, etc.), as a means of preparing for any disruptive event. [NOTE: mass casualty planning was not a specific focus.] Existing S&C policies and procedures were analyzed and assessed, and enhanced policy recommendations were developed regarding:

- Interagency Roles and Responsibilities
- Information technology (IT) Infrastructure
- Communication and Outreach
- Monitoring and Enforcement
- Education and Training

In Fall 2006, CMS invited approximately 50 stakeholders to participate in the S&C Emergency Preparedness Communication Forum for the purpose of disseminating information, gathering input and recommendations, and extracting lessons learned for overall emergency preparedness improvement. The stakeholders include a variety of perspectives: State Survey Agencies (SAs), accrediting organizations, provider associations, patient and resident advocates, quality and safety organizations, and other HHS operating divisions. CMS hosts regular teleconferences with these stakeholders to dialogue on emergency preparedness issues and concerns.

The recommendations regarding the current health care provider emergency preparedness regulations and the potential for improvements, as well as provider monitoring and enforcement policies are especially pertinent to HSPD-21 mission.

PROVIDER EMERGENCY PREPAREDNESS REGULATIONS AND GUIDANCE

The CMS workgroup analyzed the health care provider standards, policy and guidance, including a review of the current emergency preparedness regulatory requirements. Recommendations for improvements to future emergency preparedness regulations were also developed.

The analysis of the current health care provider emergency preparedness standards indicates that while several provider types have regulatory language related to emergency preparedness, the language is not thorough or consistent, and some provider types have little or no emergency preparedness regulations. A brief overview of the current emergency preparedness regulations by provider type is listed below:

- **Long Term Care (nursing facility/skilled nursing facility)**
 - 483.75(m) – Disaster and Emergency Preparedness
 - The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.
- **Intermediate Care Facility for the Mentally Retarded (ICF/MR)**
 - 483.470(h) – Emergency Plan and Procedures
 - The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.
 - The facility must hold evacuation drills at least quarterly for each shift under varied conditions.
- **End Stage Renal Disease (ESRD)**
 - 405.2140(d) – Standard: emergency preparedness
 - There is an established written plan for dealing with fires and other emergencies, which, when necessary, is developed in cooperation with fire and other expert personnel. Specific emergency preparedness procedures exist for different kinds of emergencies.

- All personnel receive regular training, including periodic drills, as part of their employment orientation, in all aspects of preparedness for any emergency or disaster.
- **Home Health Agency**
 - 484.36(a)(1)(vii) Content and Duration of Training
 - Home health aide must be trained to recognize emergencies and knowledge of emergency procedures.
- **Critical Access Hospital (CAH)**
 - 485.623 (c) - Emergency procedures
 - The CAH assures the safety of patients in non-medical emergencies by –
 - Training staff in handling emergencies, including prompt reporting of fires, extinguishing fires, protection and, when necessary, evacuation of patients, personnel, and guests, and cooperation with fire fighting and disaster authorities;
 - The CAH must meet the applicable provisions of the 2000 edition Life Safety Code of the National Fire Protection Association.
 - Taking other appropriate measures that are consistent with the particular conditions of the area in which the CAH is located.
- **Hospital**
 - 482.55(b)(2) – Condition of Participation, Emergency Services
 - The governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies and needs anticipated by the facility.
 - Develop and implement appropriate emergency plans to ensure the safety and wellbeing during emergency situations.
 - The hospital must meet applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association.
- **Hospice**
 - 418.100(b) – Disaster Preparedness
 - The hospice has an acceptable written plan, periodically rehearsed with staff, with procedures to be followed in the event of an internal or external disaster and for the care of casualties (patients and personnel) arising from such disasters.
- **Rural Health Clinic (RHC)**
 - 491.6(c) – Emergency procedures
 - The clinic or center assures the safety of patients in case of non-medical emergency by:
 - Training staff in handling emergencies;
 - Taking other appropriate measures that are consistent with the particular conditions of the area in which the clinic or center is located.

The workgroup also recommended that several practices, gleaned from the review of multiple documents, be disseminated for immediate use as a voluntary tool to encourage improved emergency planning efforts. As a result of the positive feedback of the stakeholders, CMS developed an all-hazards health care provider emergency planning checklist, entitled, *Emergency Preparedness Checklist: Recommended Tool for Effective Health Care Facility Planning*, located at: <http://www.cms.hhs.gov/SurveyCertEmergPrep/>

PROPOSED OMNIBUS EMERGENCY PREPAREDNESS REGULATIONS

In response to recommendations from the Office of the Inspector General, and various stakeholders, a proposed omnibus emergency preparedness regulation is currently under development by the CMS Office of Clinical Standards and Quality (OCSQ). The intent of the proposed regulations is to provide a framework that:

- Applies to participating Medicare and Medicaid certified health care facilities and agencies.
- Ensures comprehensive, coordinated and consistent emergency planning and response requirements that are cost-effective, while ensuring the health and safety of patients and residents.

The omnibus emergency preparedness regulation Notice of Proposed Rulemaking (NPRM) is targeted for issuance in Summer 2008.

PROVIDER MONITORING AND ENFORCEMENT

The CMS workgroup also identified and established recommendations for various CMS monitoring and enforcement actions during either a declared public health emergency or during a more localized disruptive event. CMS has within its authority to manage Medicare, Medicaid and the SCHIP programs a number of statutory, regulatory and other policy flexibilities to help ensure protection of health and safety of patients and residents in the face of potential disruptive events (see Attachment A). These range from some degree of flexibility under existing statutory or regulatory authorities, including but not limited to discretion on directing use of its resources and ability to invoke its demonstration authority, up to the additional flexibilities offered under Section 1135(b) of the Social Security Act, which allows certain requirements to be waived or varied during the time of a Public Health Emergency declared by the Secretary under section 319 of the Public Health Service Act.

For more information regarding 1135 waivers during a Public Health Emergency, see section 1135 of the Social Security Act at: http://www.ssa.gov/OP_Home/ssact/title11/1135.htm.

UPDATED S&C EMERGENCY PREPAREDNESS ALL-HAZARDS FAQs

As part of the initiative, CMS also reviewed and updated the *Survey and Certification Hurricane Katrina Frequently Asked Questions (FAQs)* to provide guidance and information to health care providers for permitted actions during a declared public health emergency, utilizing an all hazards approach. The S&C Emergency Preparedness Stakeholder Communication Forum members reviewed the draft FAQs and provided their input and comments. The updated *Survey and Certification Frequently Asked Questions – Declared Public Health Emergencies – All Hazards* was issued under S&C Letter 08-01, on October 24, 2007.

CMS S&C EMERGENCY PREPAREDNESS WEBSITE

CMS also implemented the S&C Emergency Preparedness Website to provide SAs, health care providers and other partners with helpful tools and resources, such as the emergency preparedness checklists, the FAQs, as well as links to other relevant Federal emergency preparedness Websites. Updates, new documents and resource links will be posted on a regular basis. The S&C Emergency Preparedness Website can be accessed at: <http://www.cms.hhs.gov/SurveyCertEmergPrep/>