# 2022 *CMS Emergency Preparedness Rule Training*
## *March 17, 2022*

| Goals and Objectives |
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| • The purpose of today's education session is to understand better the Centers for Medicare Services Standards in relation to Emergency Preparedness/Management.<br><br>• These presentations and subsequent discussions will allow the Rhode Island Health Centers and its partners to understand the CMS requirements better, assess their programs' readiness, and institute corrective actions where needed.<br><br>• This is an open no-fault learning environment and your opportunity to ask/discuss any questions, issues, and/or concerns to CMS experts. |

| Speakers | | |
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| **Joseph Reppucci**<br>  <br>Lead Fire and Emergency Management Consultant<br><br>**Jensen Hughes** | **Caecilia Blondiaux**<br>  <br>Health Insurance Specialist/ Program Lead for Emergency Preparedness, Outpatient Physical Therapy Organizations, and Religious Non-Medical Healthcare Institutions.<br><br>**Centers for Medicare Services** | **Shonte Carter**<br>  <br>Analyst at the Centers for Medicare and Medicaid Services (CMS) Division of Continuing and Acute Care Providers within the Quality, Safety, and Oversight Group (QSOG)<br><br>**Centers for Medicare Services** |

| Agenda | | |
|---|---|---|
| **Time** | **Event** | **Presenter** |
| 9:00 am – 9:15 am | Welcome and Introductions | Mary Evans/Joe Reppucci |
| 9:15 am – 10:15 am | FQHC and RHCs CMS Emergency Preparedness Rule Training | Caecilia Blondiaux and Shonte Carte – Center for Medicare Services |
| 10:15 am – 10:30 am | Q&A Session | All |
| 10:30 am – 11:00 am | Review Tools and Information Sheets/Wrap-Up | Joe Reppucci |

# Biography

**Caecilia Blondiaux**

*Center for Medicare Services*
*Quality, Safety & Oversight Group*
*Health Insurance Specialist/ Program Lead for Emergency Preparedness, Outpatient Physical Therapy Organizations, and Religious Non-Medical Healthcare Institutions.*

Caecilia Blondiaux (Cece) joined the Division of Continuing and Acute Care Providers in the Quality, Safety & Oversight Group within CMS in May 2019 and serves as the current program lead for the Emergency Preparedness regulations for all 17 providers and suppliers. She also serves as the program lead for both the Outpatient Physical Therapy program and Religious Non-Medical Healthcare Institutions. Her role primarily consist of development of the interpretive guidelines, surveyor training and working with stakeholders to address concerns in the provider/supplier community. She also serves as a co-lead for oversight of Accrediting Organizations and deeming activities within CMS.

Prior to her position in the division, Cece served as the Special Assistant of the Quality, Safety & Oversight Group. In this role, she led the coordination of policy work products, communications, and regulations in support of the Director, Deputy Director and the Division of Nursing Homes, Division of Continuing Care Providers, Division of Acute Care Services, Division of Clinical Laboratory Improvement & Quality, and the Quality, Safety & Education Division. She also served primary contact for internal emergency preparedness, to include business continuity preparedness for the Center for Clinical Standards and Quality (CCSQ) and worked closely with the Regional and Central Office collaboration, and emergency crises such as the Ebola, Zika Virus, influenza, and others.

Prior to joining CMS, Cece worked three years at HRSA within the HIV/AIDS Program supporting the Director and Senior Policy Advisor for the international Global PEPFAR Program; Special Programs of National Significance and the Education and Training branch. Her background is in Emergency Management and Homeland Security through direct work with the United States Army. She has multiple deployments to include Iraq; worked with the Wounded Warriors as part of the Triad for Care for returning combat veterans; and spend four years working for the Joint Chief of Staff J2 and Defense Intelligence Agency as a Staff Sergeant.

# Biography

**Shonte Carter**

*Center for Medicare Services*
*Division of Continuing and Acute Care Providers within the Quality, Safety, and Oversight Group (QSOG)*

Shonte Carter is an analyst at the Centers for Medicare and Medicaid Services' (CMS) Division of Continuing and Acute Care Providers within the Quality, Safety, and Oversight Group (QSOG). Mrs. Carter is responsible for developing and managing the regulatory interpretive guidelines and survey procedures and collaborating with the CMS locations to monitor the implementation of program policy and procedures for the Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and Organ Procurement Organization programs. She has been with CMS for over 30 years and has over 20 years of experience with the FQHC and RHC survey and certification process.

# Biography

**Joseph Reppucci,**
MSEM, CEM, EMT-AC

*Jensen Hughes*
*Lead Fire and Emergency Management Consultant*

Joe joined Jensen Hughes in January 2020. Prior to joining, he was the Hospital Preparedness Program Coordinator (HPP) and Healthcare Emergency Management Director for the Rhode Island Department of Health, and the Co-Chair for the Healthcare Coalition of Rhode Island. In these roles, he led the efforts to improve the interactions between RI's healthcare system, the Department of Health, and other state, local, tribal and federal entities to streamline healthcare emergency management. Prior to working for the RIDOH, he was the initial Emergency Preparedness Coordinator for Kent Hospital and a Correctional Officer in RI's maximum-security prison.

Joe has extensive experience in all phases of Emergency Management, EMS Operations, Firefighting, and Coalition Building. As a consultant to the State of Rhode Island, most recently, Joe led the State efforts with a Rhode Island National Guard Team to design and build the States Alternate Care Sites for COVID-19 and is currently working with the City of New Bedford Police Department to help develop a new Community Policing Strategy.

He has dual degrees from Northeastern University in Criminal Justice (BS) and Environmental Studies (BA) and a Master's Degree in Emergency Management (MSEM) from Massachusetts Maritime Academy. In addition, Joe is a Certified Emergency Manager for the International Association of Emergency Managers (IAEM); he has his Rhode Island Advanced Emergency Manager Certification and has completed the National Emergency Management Advanced Academy through the Federal Emergency Management Agency's Emergency Management Institute.

CENTERS FOR MEDICARE & MEDICAID SERVICES

**Federally Qualified Health Centers (FQHCs) & Emergency Preparedness Requirements**
**Brown Bag - Webinar Emergency Preparedness Information Session**

# Overview of FQHCs and What's New based on the *Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction* Final Rule

**Shonte Carter & Caecilia Blondiaux**
*Division of Continuing & Acute Care Providers*
*Quality, Safety & Oversight Group*
*Centers for Medicare & Medicaid Services*
*QSOG_EmergencyPrep@cms.hhs.gov*

# Overview & Agenda

- Overview of the Federally Qualified Health Centers (FQHCs) program
- Provide an overview of the recent regulatory changes as they relate to the Emergency Preparedness Medicare Condition.
- Review each of the core elements of the Emergency Preparedness Program
- Additional clarifications made over the last few months

# FQHC Overview

- FQHCs must remain in substantial compliance with all of the FQHC regulatory requirements specified in 42 CFR Part 405, Subpart X, and in 42 CFR Part 491, with the exception of Section 491.3.

- Unlike RHCs, FQHCs do not undergo initial/recertification surveys. Instead, they are subject to a filing procedure. Under this procedure, the FQHC self-attest that it is in substantial compliance and will remain in substantial compliance with all applicable Medicare regulations.

- Facilities are expected to be in compliance with the revised EP requirements effective 11/29/2019.

# FQHC Conditions for Coverage

Title 42 - CFR Part 491

§491.1 - Purpose and scope
§491.2 - Definitions
§491.3 - Certification procedures **(not applicable for FQHCs)**
§491.4 - Compliance with Federal, State and local laws
§491.5 - Location of clinic
§491.6 - Physical plant and environment
§491.7 - Organizational structure
§491.8 - Staffing and staff responsibilities
§491.9 - Provision of services.
§491.10 - Patient health records.
§491.11 - Program evaluation.
§491.12 - Emergency preparedness

# State Agency Survey

- If CMS receives a credible allegation(s) of noncompliance with the Medicare requirements and health and safety standards found at 42 CFR 405 and 42 CFR 491, the State Survey Agency (SA) will conduct a unannounced complaint survey investigation on behalf of CMS.

- To determine whether the FQHC is in substantial compliance with the Medicare requirements, SAs (or CMS regional offices, in the case of tribal FQHCs) follow the general complaint survey process located in Chapter 5 of our State Operations Manual (SOM), particularly §§5200 – 5240 and Appendix G. (See Chapter 5: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c05pdf.pdf and Appendix G: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf

# Complaint Investigation – Compendious Review

- In general, a complaint investigation is a focused survey conducted on the specific regulatory requirement(s) related to the allegation, but the SA can expand the scope of review as necessary to determine compliance or noncompliance.

- If deficiencies are cited, the SA documents the deficiencies on the Form CMS-2567 and obtains an acceptable Plan of Correction (PoC).

- The Form CMS-2567 is the official document that communicates the determination of compliance or noncompliance with Federal requirements.  Also, it is the form that the FQHC would use to submit a plan to achieve compliance, i.e., the PoC.

# COVID-19 Flexibilities

- *CMS is committed* to taking critical steps to ensure America's healthcare facilities can respond to the threat of COVID-19.

- All healthcare facilities are encouraged to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities).

# RHC and FQHC Flexibilities in Response to Coronavirus Disease 2019 (COVID-19)

To assist RHCs and FQHCs in furnishing services during the COVID-19 PHE, CMS has temporarily waived regulatory requirements applicable to the following:

- 50% mid-level staffing requirement for RHCs;
- Physician supervision requirement for nurse practitioners (NPs), (*to the extent permitted by State law),* and
- Location requirements for existing RHCs and FQHC to allow additions of temporary service locations.

# Details for Flexibilities

- The flexibilities are retroactively effective beginning March 1, 2020
- Expires at the end of the emergency declaration and CMS issues an end of outbreak notification.
- Only apply to existing RHCs and FQHCs

# Physician Supervision of NPs

- During the PHE, NPs may function to the fullest extent possible without physician supervision, and to the extent of applicable state law.

- Physician continues to be responsible for providing the overall medical direction for the RHC/FQHC's health care activities, consultation for, and medical supervision of all other health care staff, either in person or through telehealth and other remote communications.

# Temporary Locations

- During the COVID-19 PHE, CMS is allowing currently approved RHCs/FQHCs to provide patient care services in temporary expansion to help address the urgent need for supplementary care.
- The temporary site may include a parking lot.
- Temporary sites are not restricted to the rural/shortage area location requirements.
- Each location is obligated to meet the same RHC/FQHC regulations as the main site, to the extent not waived.

# Temporary Locations (cont'd)

- The RHC/FQHC is expected to be operating in a manner not inconsistent with its state's emergency preparedness plan.

- FQHCs must also have an updated Health Resource and Service Administration (HRSA) Notice of Award, expanding the scope of service to include the temporary location(s) to support response to the COVID-19 PHE.

- Providing all requirements are met, services provided at a temporary site may be provided under the permanent location's CMS Certification Number (CCN)

# Temporary Locations (cont'd)
# Patient's Vehicle

- During the COVID-19 PHE, to help minimize transmission, an RHC/FQHC visit can take place if:
  - the patient is in a vehicle on the premises of the RHC/FQHC and all requirements for a billable visit are met (e.g. medically-necessary, face-to-face visits with an RHC/FQHC practitioner).
  - All services provided are held to all RHC/FQHC regulations, unless otherwise waived. This includes, but is not limited to, the provisions of services as per 42 CFR 491.9(c).

# Temporary Locations (cont'd)
# Patient's Vehicle

  - RHCs/FQHCs must consider the clinical appropriateness of services before conducting a visit and/or treating a patient in their vehicle.

- The RHC/FQHC would provide the services using its existing CCN.

# Temporary Location (cont'd)
# State's Emergency Preparedness Plan.

- An RHC/FQHC seeking approval of its temporary location is not inconsistent with its state's emergency preparedness plan.
- Retain any communications with the State emergency preparedness representatives to demonstrate that its temporary location(s) are not inconsistent with the state emergency preparedness and pandemic plan for the COVID-19 PHE.
- Once the state has approved the addition of temporary location(s), there are no additional CMS enrollment or reporting requirements. The RHC/FQHC may begin utilizing the temporary expansion location throughout the duration of the COVID-19 PHE.

# Temporary Location (Cont'd)
# COVID-19 PHE Ends

- All waived CoPs, CfCs, requirements, and most temporarily revised regulations will terminate at the end of the PHE.

- If the RHC/FQHC wishes to continue services at the temporary expansion location after the PHE has ended, the facility must submit form 855A to begin the process of enrollment and initial certification as a RHC/FQHC under the regular process and meet all applicable requirements, including 42 CFR 491.5.

# FQHC Resources

- Appendix G – Guidance for Surveyors: Rural Health Clinics
- Appendix Z – Guidance: Emergency Preparedness for All Provider and Certified Supplier Types

QSOG_EmergencyPrep@cms.hhs.gov

QSOG_RHC-FQHC@cms.hhs.gov

# Additional FQHC Resources

- Medicare FFS Billing FAQ document available at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf.
- CMS MLN Article - FQHCs furnishing telehealth services during the PHE, https://www.cms.gov/files/document/se20016.pdf
- COVID-19 FAQs Non-Long Term Care facilities: https://www.cms.gov/files/document/covid-faqs-non-long-term-care-facilities-and-intermediate-care-facilities-individuals-intellectual.pdf
- Additional waiver information: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

# FQHC Emergency Preparedness

Emergency Preparedness Rules

# Final Rules

- Original Emergency Preparedness Final Rule: *Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* (2016)

- Revisions to Emergency Preparedness Requirements: *Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction* (2019)

# Important Reminders

- The Final Rule for Emergency Preparedness published in 2016 and provisions were updated with the Burden Reduction Final Rule *published 2019*.

- Emergency Preparedness still applies to all 17 provider and supplier types

- Compliance required for participation in Medicare

- Emergency Preparedness is ONE CoP/CfC of many already required

# Primary Changes as of 2019's Burden Rule

- **Review & Updates**:
  - Plans, policies and procedures, communication plan **reduced to at least every 2 years** (annually for LTC). Review/updates should still occur as needed with changes.

- **Training/Testing**
  - For outpatient providers, revised the requirement such that only one testing exercise is required annually, which may be either one community-based full-scale exercise, if available, or an individual facility-based functional exercise, every other year and in the opposite years, these providers may choose the testing exercise of their choice.

# What's New- Appendix Z Updates

- On March 26, 2021, CMS has made several updates to Appendix Z of the State Operations Manual (SOM). Revisions include:
  - Recommendations during PHE's for facilities to monitor Centers for Disease Control and Prevention (CDC) and other public health agencies, which may issue event-specific guidance and recommendations to healthcare workers.
  - Added additional guidance on risk assessment considerations, to include EIDs
  - Added additional guidance/considerations for emerging infectious diseases (EID) planning to include personal protective equipment (PPE).
  - Expanded guidance on the identification and use of best practices related to reporting of facility needs, the facility's ability to provide assistance and occupancy reporting.
  - Expanded guidance for surge planning due to natural disasters and EIDs.
  - Included planning considerations for potential patient surges and staffing needs.
  - Added additional planning considerations for hospices during EIDs outbreaks.

# What's New- Appendix Z Updates *(Cont.)*

- Expanded guidance and added clarifications related to alternate care sites and 1135 Waivers.
- Added new definitions based on the Omnibus Burden Reduction Final Rule expansion of acceptable testing exercises.
- Revised guidance related to training and testing program as the Burden Reduction Rule extensively changed these requirements, especially for outpatient providers.
- Provided clarifications related to testing exercise exemptions when a provider/supplier experiences an actual emergency event.
- Clarified expectations surrounding documentation of the emergency program.
- Expanded surveyor guidance to ensure Life Safety Code and health surveyors communicate/collaborate surrounding potential deficiencies for alternate source energy.
- Clarified existing guidance

# 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.
- Facilities must still have a process for cooperation and collaboration with local, tribal (as applicable), regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.
- Update emergency plan at **least every 2 years** (annually for LTC)

# All-Hazards Approach:

- An all-hazards approach is an integrated approach to emergency preparedness that focuses on identifying hazards and developing emergency preparedness capacities and capabilities that can address those as well as a wide spectrum of emergencies or disasters.

- This approach includes preparedness for natural, man-made, and or facility emergencies that may include but is 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; and emerging infectious disease (EID) threats.

# Additional Guidance for EID Planning

- CMS does not specifically define infectious disease or which types to include in the risk assessment/plan.

- Some examples of EID's may include, but are not limited to:
  - Potentially infectious Bio-Hazardous Waste
  - Bioterrorism
  - Pandemic Flu
  - Highly Communicable Diseases (such as Ebola, Zika Virus, SARS, or novel COVID-19 or SARS-CoV-2)

# Additional Guidance for EID Planning

- EID's should be identified within a facility's risk assessment.
- EID's may be localized to a certain community or be widespread (as seen with the COVID-19 PHE) and therefore plans for coordination with local, state, and federal officials are essential.
- Consider having infection prevention personnel involved in the planning, development and revisions to the EP program, as these individuals would likely be coordinating activities within the facility during a potential surge of patients.

# Policies and Procedures

- Develop and implement policies and procedures based on the emergency plan and risk assessment, and the communication plan.

- 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 every 2 years** (annually for LTC).

# P&P Additional Clarifications/Guidance

- Appendix Z provides additional guidance related to incorporating EID's into the facility's policies and procedures. This included overarching themes of:
  - Surge Planning Considerations
  - Reporting of Facility Needs and Ability to Provide Assistance
  - Contingency of Services and Operations
- For example, facilities must have policies which address their ability to respond to a surge in patients requiring care. As required, these policies and procedures must be aligned with a facility's risk assessment, and should include planning for EIDs.

# Reminders and Important Notes

- When developing transfer agreements, facilities must take into account the patient population and the ability for the receiving facility to provide continuity of services.

- If a facility has a transfer arrangement with another facility and this facility could not accommodate all patients, then the facility should plan accordingly to provide continuity of services with another facility who could receive the remaining residents.

# Reminders and Important Notes

***Continued***

- Facilities should also take into account the availability of contracted resources during an emergency event. For instance, a facility has a written arrangement with a transportation company, yet during an emergency the transportation company is unable to reach the facility due to flooding and/or having other arrangements with the community.

- The facility is responsible to ensure these areas are discussed and managed within their policy and procedure to ensure availability of resources during an emergency event.

- It would be appropriate for the facility to have discussions with transportation vendors about their competing contracts during an emergency and the vendor's continuity of business plans in the event of an emergency.

# 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 at **least every 2 years** (annually for LTC).
- Updated Appendix Z also provides additional considerations for facility's on reporting occupancy and sharing information with emergency management systems.

# Training and Testing Program

- Develop and maintain a training and testing program including initial training in policies and procedures, based on the emergency plan, risk assessment, policies & procedures and the communication plan.

- Review and update the training and testing program at **least every 2 years.**

# Training Requirements

- Conduct initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers
- After initial training, provide emergency preparedness training **every 2 years** (Annually for LTC)
- Demonstrate staff knowledge of emergency procedures.
- Maintain documentation of all emergency preparedness training.
- If the emergency preparedness policies and procedures are significantly updated, conduct training on the updated policies and procedures.

# Additional Guidance for Training Program

- Training refers to a facility's responsibility to provide education and instruction to staff, contractors, and facility volunteers to ensure all individuals are aware of the emergency preparedness program.

- For training requirements, the facility must have a process outlined within its emergency preparedness program which encompasses staff and volunteer training complementing the risk assessment.

- The training for staff should at a minimum include training related to the facility's policies and procedures.

# New Definitions for Testing

- **Functional Exercise (FE):** "FEs are designed to validate and evaluate capabilities, multiple functions and/or sub-functions, or interdependent groups of functions. FEs are typically focused on exercising plans, policies, procedures, and staff members involved in management, direction, command, and control functions" as defined by HSEEP. We have attempted to align our definitions with those guidelines.

- For additional details, please visit HSEEP guidelines located at https://preptoolkit.fema.gov/documents/1269813/1269861/HSEEP_Revision_Apr13_Final.pdf/65bc7843-1d10-47b7-bc0d-45118a4d21da

# New Definitions for Testing

- ***Mock Disaster* Drill:** A drill is a coordinated, supervised activity usually employed to validate a specific function or capability in a single agency or organization. Drills are commonly used to provide training on new equipment, validate procedures, or practice and maintain current skills.

- For example, drills may be appropriate for establishing a community-designated disaster receiving center or shelter. Drills can also be used to determine if plans can be executed as designed, to assess whether more training is required, or to reinforce best practices.

# New Definitions for Testing

- ***Workshop:*** A workshop, for the purposes of this guidance, is a planning meeting/workshop which establishes the strategy and structure for an exercise program**,** as defined by HSEEP. We have attempted to align our definitions with those guidelines.

For additional details, please visit HSEEP guidelines.

# Testing Changes with Burden Reduction

- **For outpatient providers:** Facilities are required to only conduct one testing exercise on an annual basis, which may be either one community-based full-scale exercise, if available, or an individual facility-based functional exercise, every other year and in the opposite years, these providers may choose the testing exercise of their choice.

- These outpatient providers are required to conduct one full-scale or individual facility based exercise every two years, and in the opposite years, the providers can conduct testing exercise of choice, which can include either a full-scale, individual facility-based, drill, tabletop exercise/workshop which includes a facilitator.

# Testing Exercises- Reminder

- CMS is not specifying a minimum number of staff which must attend these exercises, however facility leadership and department heads should participate in each exercise.

- A sufficient number of staff should participate in the exercise to test the scenario and thoroughly assess the risk, policy, procedure, or plan being tested

- If an exercise is conducted at the individual facility-based level and is testing a particular clinical area, the expectation is that staff who work in this clinical area participate in the exercise for a clear understanding of their roles and responsibilities.

# Testing Exercises- Reminder

- Additionally, facilities can review which members of staff participated in the previous exercise, and include those who did not participate in the subsequent exercises to ensure all staff members have an opportunity to participate and gain insight and knowledge.

- CMS added additional clarification to Appendix Z related to testing exercises and defined “community partners” in relation to facility exercises.

- Community partners are considered any emergency management officials (fire, police, emergency medical services, etc.) for full-scale and community-based exercises, however can also mean community partners that assist in an emergency, such as surrounding providers and suppliers.

# Testing Exercise- Exemption

- If a facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.

- Exemption only applies to the NEXT REQUIRED full-scale exercise.

- Facilities must demonstrate activation of the emergency plan.

- Also see https://www.cms.gov/files/document/qso-20-41-all-revised-06212021.pdf

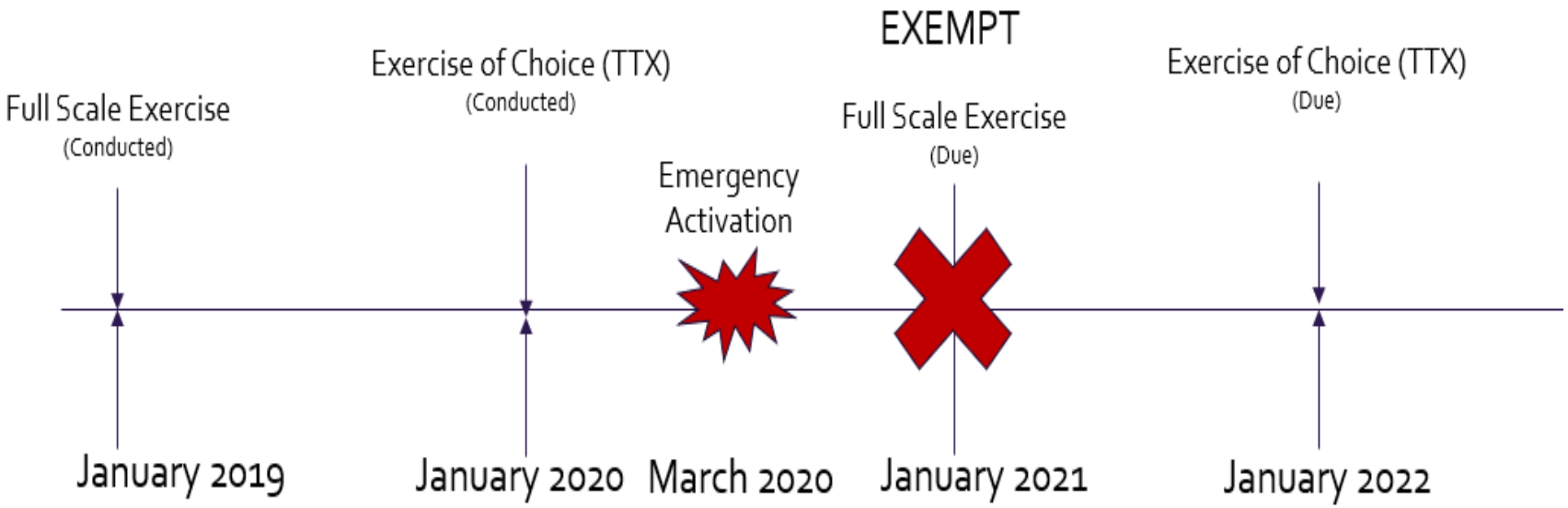
# Outpatient Provider Scenarios

- **<u>Scenario #1</u>.** Facility X conducted a full-scale exercise in January 2019 and a table-top exercise as their exercise of choice for January 2020 (opposite year). In March 2020, Facility X activates its emergency preparedness program due to the COVID-19 Public Health Emergency (PHE).

**Question #1:** When must the facility conduct its next required full-scale exercise? What is the exemption based on the requirements?

# Outpatient Provider Scenarios

**Answer #1**: The facility is exempt from the January 2021 full-scale exercise for that "annual year" and is required to complete an exercise of choice by January 2022.



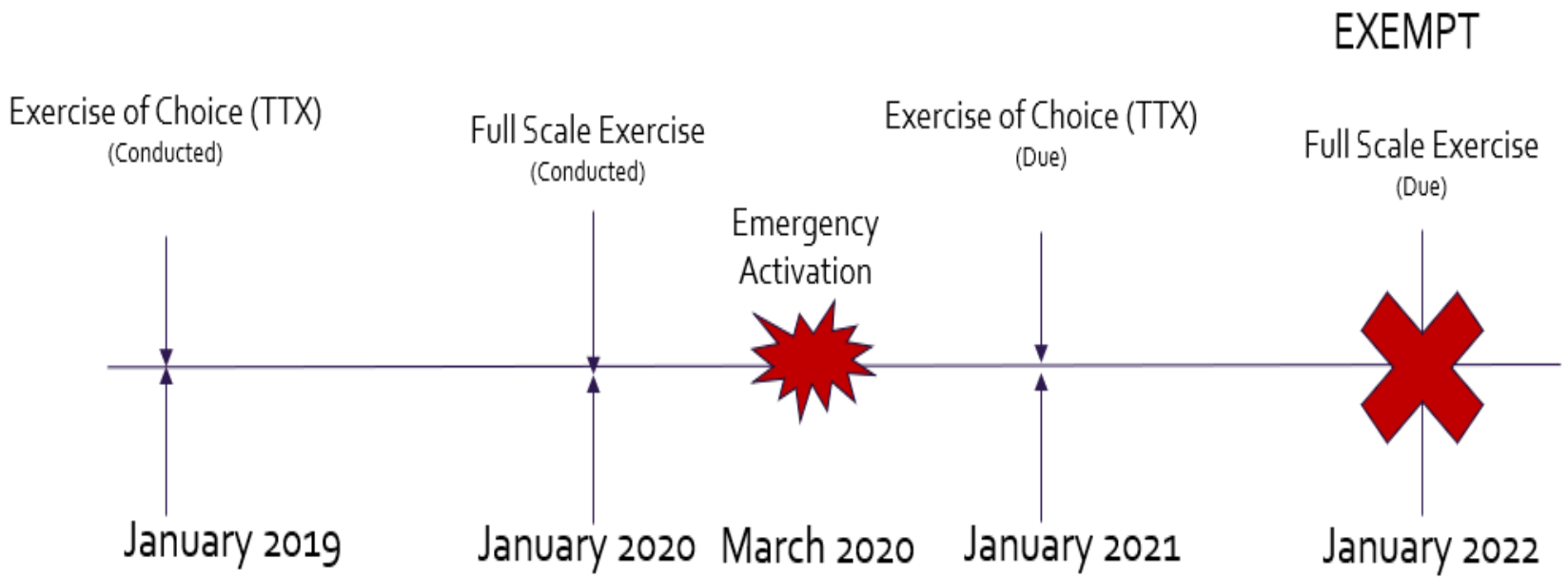
# Outpatient Provider Scenarios

- **Scenario #2.** Facility Y conducted a table top exercise in January 2019 as the exercise of choice and conducted a full-scale exercise in January 2020. In March 2020, Facility Y activates its emergency preparedness program due to the COVID-19 PHE.

**Question #2:** When must the facility conduct its next required full-scale exercise? What is the exemption based on the requirements?

# Outpatient Provider Scenarios

**Answer #2**: The facility is exempt from the January 2022 full-scale exercise for that "annual year". However, the facility must conduct its exercise of choice by January 2021, and again in January 2023



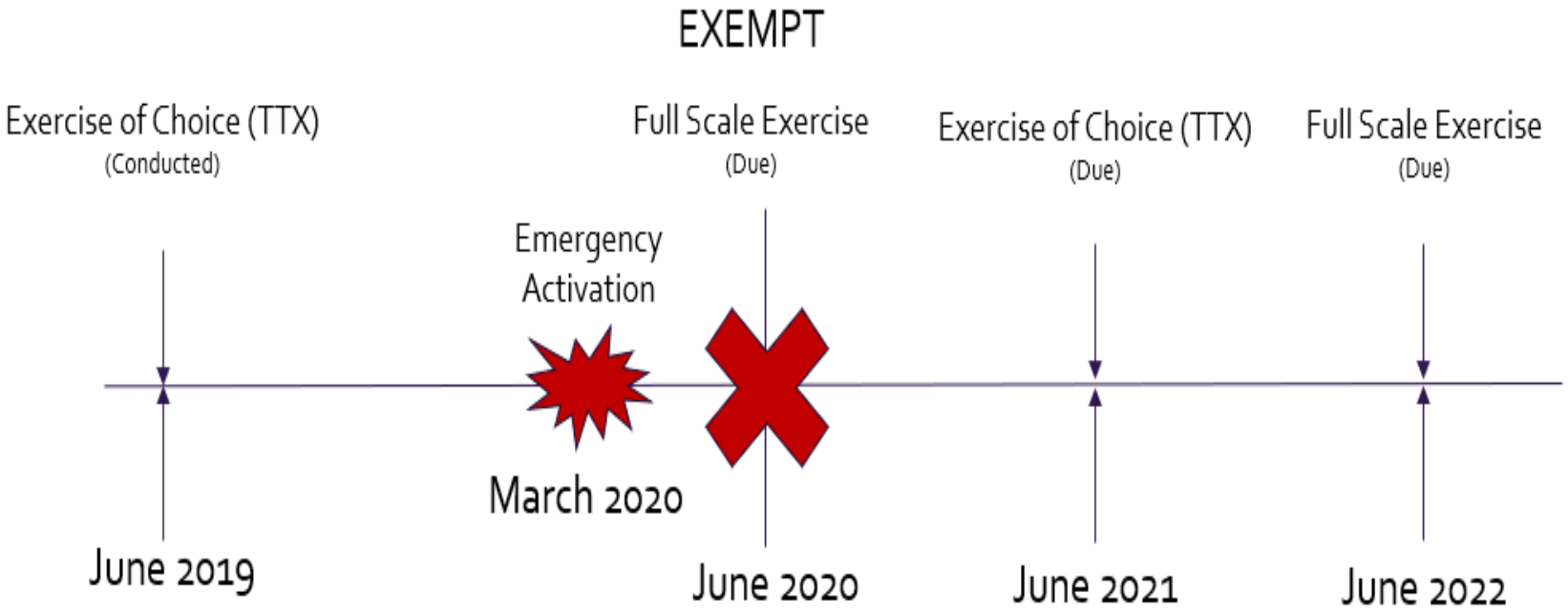
# Outpatient Provider Scenarios

- **Scenario #3.** Facility Z conducted a table top exercise in June 2019 (based on its annual cycle). It is scheduled to conduct a full-scale exercise in June 2020. In March 2020, Facility Z activates its emergency preparedness program due to the COVID-19 PHE.

**Question #3:** When must the facility conduct its next required full-scale exercise? What is the exemption based on the requirements?

# Outpatient Provider Scenarios

**Answer #3**: The facility is exempt from the June 2020 scheduled full-scale exercise for that "annual year" and is required to complete an exercise of choice in June 2021, and a following full-scale exercise in June 2022. It is exempt from its **next required** full-scale or individual facility-based exercise which would have been in June 2020.



# Documentation Requirements

- Facilities must be able to demonstrate, through written documentation, that they activated their program due to the emergency.

- During natural disasters, facilities generally show activation by providing notice of imminent weather to staff; showing documentation of evacuations; closures etc.

- There is no need to submit any documentation.

# Reminders and Important Notes

- While we encourage the use of healthcare coalitions, we recognize this is not always feasible for all providers and suppliers.

- For facilities participating in coalitions, we are not specifying the "level" of participation. However, if facilities use healthcare coalitions to conduct exercises or assist in their efforts for compliance, we ask this would be documented and in writing.

# State & Accrediting Organization Requirements

- The Emergency Preparedness Rule does not specify quantities within any provisions. The rule is broad and overarching.

- Facilities should check with their State Survey Agencies and Accrediting Organizations (as applicable) for any additional requirements which may exceed the CMS requirements.

- During public health emergencies such as pandemics, the Centers for Disease Control and Prevention (CDC) and other public health agencies may issue event-specific guidance and recommendations.  Facilities are recommended to have a process to ensure monitoring of event-specific guidance.

# Where are we now?

- Changes are effective upon implementation of the Burden Reduction Final Rule - November 29, 2019, no grace period.
- Our Surveyor Training (available publically) https://qsep.cms.gov/pubs/CourseMenu.aspx?cid=0CMSEmPrep_ONL
- We would recommend facilities use the checklists developed by ASPR to help guide them to their specific requirements. Review the checklists under Facility-Specific Requirement Overviews at https://asprtracie.hhs.gov/cmsrule.
- Consider annotating on the checklist, the location of each of your elements of the plan to assist surveyors reviewing on-site

# The QSOG EP 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. We will be working on revisions to FAQs and other resources for the next several months to reflect the new changes

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

# Thank you!

# FACT SHEET

## CMS Releases Updated Emergency Preparedness Guidance

### Overview

Today, March 26, 2021, the Centers for Medicare & Medicaid Services (CMS) is releasing revised guidance to surveyors related to the emergency preparedness Medicare-condition. The Burden Reduction rule (84 FR 51732) released on September 30, 2019, in part, made revisions to the emergency preparedness requirements to reduce the frequency of certain required activities and, where appropriate, revised timelines for certain requirements for providers and suppliers.

In general, the regulatory requirement revisions are as follows:

- *Emergency program:* Decreasing the requirements for facilities to conduct an annual review of their emergency program to a biennial review. However, based on industry feedback, long term care (LTC) facilities will continue to review their emergency program annually.
- *Emergency plan:* Eliminating the requirement that the emergency plan include documentation of efforts to contact local, tribal, regional, state, and federal emergency preparedness officials and a facility's participation in collaborative and cooperative planning efforts.
- *Training:* Decreasing the training requirement from annually to every two years. Nursing homes will still be required to provide annual training.
- *Testing (for **inpatient** providers/suppliers):* Increasing the flexibility for the testing requirement so that one of the two annually-required testing exercises may be an exercise of the facility's choice; and
- *Testing (for **outpatient** providers/suppliers):* Decreasing the requirement for facilities to conduct two testing exercises to one testing exercise annually.

Additionally, since CMS had revised Appendix Z in February 2019 to add "emerging infectious diseases" (EIDs) to the definition of all-hazards approach, we are taking the opportunity to further expand upon the interpretive guidelines where applicable to include best practices and planning considerations for preventing and managing EIDs in light of lessons learned during the onset of the COVID-19 public health emergency (PHE). Several of the expanded guidance surrounding EIDs is considered recommendations and best practices, not requirements, and includes the below:

- Clarified expectations surrounding documentation of the emergency program.
- Added additional guidance/considerations for EID planning to include personal protective equipment (PPE).
- Added additional guidance on risk assessment considerations, to include EIDs.
- Included planning considerations for potential patient surges and staffing needs.
- Expanded guidance for surge planning due to natural disasters and EIDs.

- Included recommendations during PHE's for facilities to monitor Centers for Disease Control and Prevention (CDC) and other public health agencies, which may issue event-specific guidance and recommendations to healthcare workers.
- Added additional planning considerations for hospices during EIDs outbreaks.
- Expanded guidance and added clarifications related to alternate care sites and 1135 Waivers.
- Expanded guidance on the identification and use of best practices related to reporting of facility needs, the facility's ability to provide assistance and occupancy reporting.
- Revised guidance related to training and testing program as the Burden Reduction Rule extensively changed these requirements, especially for outpatient providers.
- Provided clarifications related to testing exercise exemptions when a provider/supplier experiences an actual emergency event.

**Training Resources:**
CMS is working on revisions to the current Emergency Preparedness Online Basic Surveyor Training Course which can be accessed 24/7 by the public, free of charge on the CMS Quality, Safety and Education Portal.

Additionally in 2017, CMS released training for surveyors and health care professionals related to infection prevention. This free course also contains a module relevant to EIDs. You may access the *Universal Infection Prevention Training* course here: https://qsep.cms.gov/pubs/CourseMenu.aspx?cid=0CMSUIPC_ONL. While the course does not incorporate COVID-19 specific information, it does speak to infections with high mortality rates (Ebola, Flu, C-diff and MRSA), which can be found under module 2.

CMS also refers all provider types to the Assistant Secretary for Preparedness and Response's (ASPR's) Technical Resources Assistance Center & Information Exchange (TRACIE) for additional resources, how-to guides and tools. ASPR TRACIE is a public resource for all healthcare preparedness and contains current tools and resources relevant for infectious diseases. See: https://asprtracie.hhs.gov/infectious-disease.

**The revised guidance (Appendix Z) is available at:** https://www.cms.gov/files/document/qso-21-15-all.pdf

# Rhode Island Health Center Association Sponsored Exercise Schedule 2019 - 2027

Note: 2019 Post-Burden Reduction Act timeframe

| Year | CMS Requirement Type | Type Needed | Date | Exercise Conducted | Notes / Exemption |
|---|---|---|---|---|---|
| 2019 | Functional/Full-Scale Exercise | Functional Exercise | 2019 | Active Shooter Exercise (FSE) | Dates are in 2019 due to onsite exercise and facility schedules. |
| 2020 | Facilitated TTX | Facilitated TTX | Tuesday, October 20, 2020 | COVID-19 (TTX) | |
| | EOP/Command Activation | Activation | Wednesday, July 12, 1905 | Activation | Exempt from FE/FSE due to COVID AAR |
| 2021 | Functional/Full-Scale Exercise | Functional Exercise (EXEMPT) | Tuesday, September 28, 2021 | Operation Comfort Zone (TTX) | Conducted a TTX (Operation Comfort Zone - COOP Exercise) |
| 2022 | Facilitated TTX | Facilitated TTX | Expected September 2022 | | |
| 2023 | Functional/Full-Scale Exercise | Functional Exercise | Expected September 2023 | | |
| 2024 | Facilitated TTX | Facilitated TTX | Expected September 2024 | | |
| 2025 | Functional/Full-Scale Exercise | Functional Exercise | Expected September 2025 | | |
| 2026 | Facilitated TTX | Facilitated TTX | Expected September 2026 | | |
| 2027 | Functional/Full-Scale Exercise | Functional Exercise | Expected September 2027 | | |

Note: The facility must have documented After Action Reports and Improvement Plans to prove that the exercise was conducted.

# [Facility] Spons

Note: 20

| Year | CMS Requirement Type | Type conducted | Date |
|---|---|---|---|
| 2019 | Functional/Full-Scale Exercise | | |
| 2020 | Facilitated TTX | | |
| 2021 | Functional/Full-Scale Exercise | | |
| 2022 | Facilitated TTX | | |
| 2023 | Functional/Full-Scale Exercise | | |
| 2024 | Facilitated TTX | | |
| 2025 | Functional/Full-Scale Exercise | | |
| 2026 | Facilitated TTX | | |
| 2027 | Functional/Full-Scale Exercise | | |

# ;ored Exercise Schedule 2019 - 2027

)19 Post-Burden Reduction Act timeframe

| Exercise Conducted | Real Word Event |
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| Notes / Exemption |
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| EMERGENCY PREPAREDNESS CHECKLIST<br>RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING | | | |
|---|---|---|---|
| Not Started | In Progress | Completed | **Tasks** |
| | | | **Conduct a Hazard Vulnerability Analysis (HVA)**: A facility-based and community-based risk assessment should be conducted utilizing an all-hazards approach. The HVA should guide your planning and exercise efforts for the year.<br>• Include community partners (local Emergency Mgt, healthcare coalition, etc.) in the assessment and have it reviewed by them to ensure alignment with local community risks and plans.<br>• Develop and include mitigation strategies for the identified events (suggested for top 10 minimum).<br>• The assessment should be documented and reviewed/renewed **annually** to address any preparedness and/or mitigation changes done by the facility or community. |
| | | | **Emergency Plans Development:** Gather all available relevant information for developing the emergency plan. This information includes, but is not limited to:<br>• Copies of any state and local emergency planning regulations or requirements.<br>• Updated Emergency Contact Information - INTERNAL Resources: this includes Executive, Staff, Patients, and Volunteers.<br>• Updated Emergency Contact Information - EXTERNAL Resources: this includes local & state emergency managers, Emergency Response Agencies, Utilities, local & state regulatory agencies, & vendors providing emergency assistance.<br>• A means to identify and define a chain-of-command with staff roles<br>• Building construction and Life Safety systems information.<br>• Specific information about the characteristics and needs of the population/individuals for whom care is provided. |
| | | | **Analyze the specific vulnerabilities of the facility:** Determine the following actions for each identified hazard:<br>• Specific actions to be taken for the hazard<br>• Identified key staff responsible for executing the plan<br>• Address patient needs and those of persons at risk<br>• Staffing requirements and defined staff responsibilities<br>• Based on the facility's assessment of the hazard vulnerabilities, the identification, and maintenance of sufficient supplies and equipment to sustain operations and deliver care and services for 4+ days (96-hours). This recommendation can be achieved bymaintaining 4+ days of supplies on hand and holding agreements with suppliers for the remaining days.<br>• Communication procedures to receive emergency warning/alerts, and for communication with staff, families, individuals receiving care, before, during, and after the emergency<br>• Designate critical staff, providing for other staff and volunteer coverage and meeting staff needs, including transportation and sheltering, if needed.<br>• Include delegations of authority and succession plans for when primary staff is unavailable. |



**Note**: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
***** Task may not be applicable to all facility types, consult CMS and state and local requirements
**Revised March 2022**

| EMERGENCY PREPAREDNESS CHECKLIST<br>RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING | | | |
|---|---|---|---|
| Not Started | In Progress | Completed | **Tasks** |
| | | | **Address the resident population**:<br>• The Emergency Operations Plan should specify the population served within the facility and their unique vulnerabilities in the event of an emergency or disaster.<br>• The type of services the facility has the ability to provide in an emergency.<br>• Identify Populations at-risk |
| | | | **Develop all-hazards, and specific hazards type plans:** Healthcare facilities should appropriately develop emergency plans and tailor them to their specific needs and geographical locations.<br>• Define how the Emergency Operations Plan (EOP) is identified<br>• Provide an executive summary that defines the purpose, scope, and applicability of the plan<br>• Include decision-making criteria for activation of emergency operations and process for coordinating with local authorities<br>• Includes language defining the legal authorities and references<br>• Develop all-hazards plans. These plans could be used to address issues across multiple emergency types (e.g., building lockdown, shelter-in-place, emergency credentialing)<br>• Develop hazard-specific plans (e.g., hurricanes, floods, tornadoes, fire, bioterrorism, etc.) that could potentially affect the facility directly and/or indirectly within the particular area or location. (Indirect hazards could affect the community but not the facility and, as a result, interrupt necessary utility, supplies, or staffing.)<br>• Include strategies for addressing emergency events identified by the HVA. |
| | | | **Emerging Infectious Diseases (EIDs) Planning**: Examples include Ebola, Zika Virus, SARS, or novel COVID-19 or SARS-CoV-2) and others.<br>• As emerging infectious disease outbreaks may affect any facility in any location across the country, a comprehensive emergency preparedness program should include emerging infectious diseases and pandemics during a public health emergency (PHE). The comprehensive emergency preparedness program emerging infectious disease planning should encompass how facilities plan, coordinate, and respond to a localized and widespread pandemic, similar to the 2019 Novel Coronavirus (COVID-19) PHE.<br>• Facilities should ensure their emergency preparedness plans are aligned with their State and local emergency plans/pandemic plans.<br>• EIDs may require modifications to facility protocols to ensure health and safety requirements, such as isolation and personal protective equipment (PPE) measures. |



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**Revised March 2022**

| EMERGENCY PREPAREDNESS CHECKLIST<br>RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING | | | |
|---|---|---|---|
| Not Started | In Progress | Completed | **Tasks** |
| | | | **Develop a Communications Plan** that outlines how the facility will communicate with patients, families, local, state, and federal authorities during an emergency. This plan should also establish contingencies for the facility's communication infrastructure in the event of telephone failures (e.g.,walkie-talkies, ham radios, text messaging systems, etc.). The communication plan should include all of the following:<br>○ Names and contact information for the following:<br>○ Staff.<br>○ Entities providing services under arrangement.<br>○ Patients' physicians.<br>○ Other facilities.<br>○ Volunteers.<br>○ Contact information for the following:<br>○ Federal, state, tribal, regional, or local emergency preparedness staff.<br>○ The State Licensing and Certification Agency.<br>○ The Office of the State Long-Term Care Ombudsman.<br>○ Other sources of assistance.<br>○ Primary and alternate means for communicating with the following:<br>○ The facility's staff.<br>○ Federal, state, tribal, regional, or local emergency management agencies.<br>○ A system to re-call staff during emergencies: Call / Phone Tree, Computer Automated Systems, etc.<br>○ A method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health care providers to maintain the continuity of care.<br>○ A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).<br>○ A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).<br>○ A method for sharing information from the emergency plan that the facility has determined is appropriate with patients and their families or representatives. |
| | | E- | **Continuity of Operations & Succession planning:**<br>• Continuity of Operations, including:<br>○ Delegations of Authority - there should be a qualified person who "is authorized in writing to act in the absence of the administrator or person legally responsible for the operations of the facility." This typically outlines the roles and responsibilities of the different individuals (e.g., incident commander, public information officer, patient liaison, etc.) and refers to those individuals by their titles.<br>• Succession plans – These should outline the specific individuals and alternate/successors who can activate the facility's emergency plans to ensure patient safety is protected, and patients will receive care at the facility or, if transferred, under what circumstances transfers will occur. |



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**Revised March 2022**

| EMERGENCY PREPAREDNESS CHECKLIST<br>RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING | | | |
|---|---|---|---|
| Not Started | In Progress | Completed | **Tasks** |
| | | | **Collaboration with Local Emergency Management Agencies and Healthcare Coalitions:**<br>○ Establish a collaboration with other FQHC/RHC's.<br>○ Establish a collaboration with different types of healthcare providers (e.g., hospitals, nursing homes, hospices, home care, dialysis centers, etc.) at the State and local level to integrate plans and activities of healthcare systems into state and local response plans to increase medical response capabilities. *<br>○ Include and document in the facility plans a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation |
| | | | • **Develop Evacuation Plan:** Develop an effective plan for evacuation by ensuring Safe evacuation from the RHC/FQHC, which includes:<br>• Appropriate placement of exit signs.<br>• Staff responsibilities<br>• Needs of the patients, visitors, and staff. |
| | | | **Develop policies and procedures for use and incorporation of Volunteers (**Medical and Non-Medical):<br>● Policies should guide the use of volunteers in an emergency and/or emergency staffing strategies, including the process and role for integrating State and Federally designated health care professionals to address surge needs during an emergency.<br>● If facilities use volunteers as part of their emergency staffing strategy, policies and procedures should clearly outline what type of volunteers would be accepted during an emergency and what role these volunteers might play.<br>● In order for volunteering healthcare professionals to be able to perform services within their scope of practice and training, facilities must include any necessary privileging and credentialing processes into the facility's emergency preparedness plan policies and procedures.<br>● Non-medical volunteers would perform non-medical tasks but should still have a vetting/clearing process defined.<br>**Note**: Facilities are also encouraged to collaborate with state-established volunteer registries(RI Medical Reserve Corps) and, where possible, State-based Emergency System for Advanced Registration of Volunteer Health Professionals (RI -ESAR-VHP). |
| | | | **1135 Waivers:** Define the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. |



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**Revised March 2022**

| EMERGENCY PREPAREDNESS CHECKLIST<br>RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING | | | |
|---|---|---|---|
| Not Started | In Progress | Completed | **Tasks** |
| | | | **Training and testing:** The facility must develop and maintain an emergency preparedness training and testing program that is based on the risk assessment and emergency plans. The training and testing program should be specific to the facility and its Emergency Preparedness Program and must be reviewed and updated at least annually. The program should address:<br>• Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.<br>• Provide emergency preparedness training at least annually.<br>• Maintain documentation of all emergency preparedness training.<br>• Demonstrate staff knowledge of emergency procedures |
| | | | **Exercises & Drills**: FQHC/RHC's are required to conduct one testing exercise annually (that at least every two years, their exercise must be a full-scale exercise). Facilities are required to only conduct one testing exercise on an annual basis, which may be either:<br>• one community-based full-scale exercise, if available, or<br>• an individual facility-based functional exercise.<br>The opposite years (every other year opposite of the full-scale exercises), these providers may choose the testing exercise of their choice, which can include either another full-scale, individual facility-based, a mock disaster drill (using mock patients), tabletop exercise or workshop which includes a facilitator |
| | | | **Review Emergency Plan:** Complete an internal review and update of the emergency plan **annually** to ensure the plan reflects the most accurate and up-to-date information. Updates may be warranted under the following conditions:<br>• Regulatory change<br>• New hazards are identified, or existing hazards change<br>• After tests, drills, or exercises when problems have been identified<br>• After actual disasters/emergency responses<br>• Infrastructure changes<br>• Funding or budget-level changes |



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**Revised March 2022**