by Lee Tincher, MS, RDN

CMS Finalizes Rule to Bolster Emergency Preparedness

The Centers for Medicare & Medicaid Services (CMS) has finally released the long-expected Final Rule for health care emergency preparedness. CMS wants to ensure that all healthcare providers and facilities have an emergency preparedness plan in place at all times. This new Rule has been in development from shortly after Hurricane Katrina in 2005. Recent disasters—from hurricanes in New York, New Jersey and Florida to flooding in North Carolina and Louisiana to wildfires in the west—have forced the evacuation of many hospitals and healthcare facilities. These disasters put the health and safety of Medicare and Medicaid beneficiaries, and the public at large, at risk.

"Situations like the recent flooding remind us in the event of an emergency, the first priority of healthcare providers and suppliers is to protect the health and safety of their patients," said CMS Deputy Director and Chief Medical Officer Patrick Conway, MD. "Preparation, planning, and one comprehensive approach for emergency preparedness is key. One life lost is one too many."

The new disaster Rule is in response to the Office of the Inspector General's 2006 post Hurricane Katrina report. The OIG review examined the experiences of selected nursing homes in five Gulf Coast states during 2005-06 hurricanes on the completeness of their emergency preparedness plans:

- 94 percent met Federal standards for emergency plans
- 80 percent had sufficient emergency training

PART ONE OF A TWO-PART ARTICLE ON THE NEW CMS DISASTER RULE

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However, despite having a plan and training, 100 percent of the sampled skilled nursing facilities experienced disaster problems, whether they evacuated or sheltered in place. Some of the issues from the OIG report: contracts were not honored, lengthy travel times, host facilities that were unavailable or inadequately prepared, inadequate staff, insufficient food and water, administrators and staff often did not follow their emergency plan, emergency plans often lacked provisions, and lack of collaboration between state and local emergency entities. CMS concluded that the current regulatory requirements were not comprehensive enough, so the new requirements will mandate certain preparedness standards. Further, emphasis is placed on preparedness planning (rather than response to a disaster), and one comprehensive approach across the continuum of healthcare providers to ensure coordination and communication.

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NEW CONDITION OF PARTICIPATION RULE

In 2013 CMS published the proposed emergency preparedness Rule for comment by stakeholders. The Final Rule was published on September 15, 2016 and addressed the thousands of comments CMS received on the proposed Rule. The Final Rule contains 651 pages and was reorganized for clarification and includes CMS responses and rationale for the Final Rule, but mostly closely followed the proposed Rule. This Rule applies to 17 levels of healthcare providers including acute hospitals, psychiatric hospitals, critical access hospitals, skilled nursing facilities, intermediate care facilities, hospice providers, outpatient surgery centers, and dialysis centers. Elements of the Rule that apply to all provider types include: require a comprehensive emergency plan, policies and procedures, communication plan, and training/testing the emergency plan by each provider.**

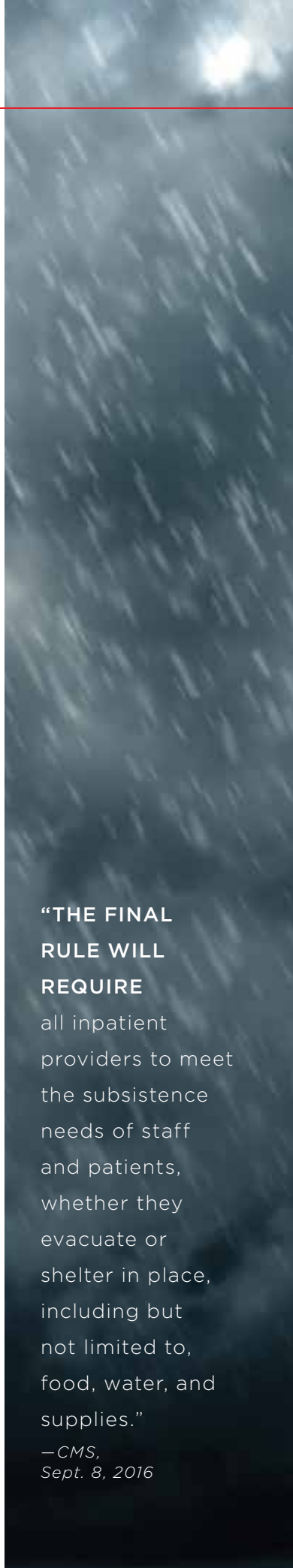
This new condition of participation for all provider-types is effective November 15, 2016 but will be implemented in two phases. Some requirements must be met immediately as these requirements were generally already part of the Conditions of Participation, such as having an emergency plan. Other requirements will be phased in and be required by November 15, 2017.

A critical element of the new Rule is the requirement for each healthcare entity to apply an all-hazards approach to assess their risk for a disaster or emergency, their patient population, their capabilities, and their capacity to care for their patients, staff, and visitors. This includes a plan to coordinate with federal, state, tribal, regional, and local emergency preparedness systems. Each healthcare facility or provider will therefore need a customized plan that addresses their locality, their hazards, their capabilities, and their preparedness plan. And the plan must include shelter-in-place as well as evacuations.

THE IMPORTANCE OF FOOD AND WATER PREPAREDNESS PLANS

In the CMS press release just prior to the Rule publication, CMS declared that "The Final Rule will require all inpatient providers to meet the subsistence needs of staff and patients, whether they evacuate or shelter in place, including, but not limited to, food, water, and supplies."[1] This is a more comprehensive approach than is commonly observed. The CDM, RDN, or foodservice director will be critically involved in a comprehensive emergency plan for provision of food and water for not only patients/residents, but also staff and visitors. Furthermore, this food and water plan must be functional for shelter-in-place as well as evacuations.

In the Rule, CMS also states that they expect inpatient providers to currently have food, water and supplies, alternate sources of energy to provide electrical power, and the maintenance of temperatures for the safe and sanitary storage of provisions as a routine measure and customary business practice. Furthermore, CMS expects that providers



"THE FINAL RULE WILL REQUIRE all inpatient providers to meet the subsistence needs of staff and patients, whether they evacuate or shelter in place, including but not limited to, food, water, and supplies."

—CMS, Sept. 8, 2016

have agreements with their vendors to receive additional supplies within 24-36 hours in the event of an emergency, as well as arrangements with a back-up supplier in case the disaster affects the primary supplier. Notably, the Rule stops short of imposing a requirement that providers must keep a larger quantity of food and water on hand in the event of a disaster. CMS believes that providers should have the flexibility to determine what is adequate based on their respective location and characteristics of the facility. CMS recognizes that a larger stockpile may exceed storage capacity in some facilities and pose an unnecessary economic impact on a provider. Some analysts have suggested that keeping this part of the Rule vague allowed CMS to state that there is no additional cost burden for compliance with the new Rule. Many states have regulations with more specific requirements for food, water and supplies, and the most restrictive regulation must be met in those states.

THE NEED FOR SELF SUFFICIENCY

The new CMS Rule clearly states their expectation that all healthcare communities and providers be self-sufficient for 48 hours. At the onset of a disaster, CMS believes that all providers will have on hand two to three days of supplies, and community resources can be accessed within that time frame. Notwithstanding this statement, the emergency preparedness plan for each healthcare facility or provider must include their specific all-hazard analysis risk for a disaster or emergency, their patient population and their capabilities and capacity to care for their patients, staff, and visitors. Therefore, the amount of food, water, and supplies required to be stockpiled may exceed the 48 hour period minimum cited by CMS.

THE CMS SURVEY

The annual survey process is guided by the Interpretive Guidelines for Surveyors, which are expected to be released in November 2016. These survey guidelines will be critical to understanding the expectations from surveyors, and how emergency preparedness will be evaluated. Part two of this article will examine these details. E

BEST PRACTICE STANDARDS

The new Rule requires Medicare and Medicaid participating providers and suppliers to meet the following four common and well-known industry best practice standards:

1. Emergency Plan

Based on a risk assessment, develop an emergency plan using an all-hazards approach focusing on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the location of a provider or supplier.

2. Policies and Procedures

Develop and implement policies and procedures based on the plan and risk assessment.

3. Communication Plan

Develop and maintain a communication plan that complies with both Federal and State law. Patient care must be well-coordinated within the facility, across healthcare providers, and with State and local public health departments and emergency systems.

4. Training and Testing Program

Develop and maintain training and testing programs, including initial and annual training, and conduct drills and exercises or participate in an actual incident that tests the plan.

REFERENCE

1. CMS Press Release, September 8, 2016 www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-09-08.html