

AAHHS / HFAP



Emergency Management for Acute-Care Hospitals

Chapter 9

2018 Edition

Presented by:

Brad Keyes, CHSP

Jamie Crouch, BSBM, MHA



ACCREDITATION ASSOCIATION FOR
HOSPITALS / HEALTH SYSTEMS



Welcome . . .

Today's webinar will focus on the new requirements for Emergency Management, as identified in the 2018 edition of the Acute-Care Hospital Chapter 9 of the AAHHS Handbook and Chapter 9 in the HFAP manual.

Welcome . . .

We will not be identifying everything that is required per each standard.

The expectation is someone from your organization will have read the standards and explanation column, in order to determine compliance with the requirements.



CMS Final Rule

On September 16, 2016, CMS issued their Final Rule and published new standards on Emergency Management for all healthcare facilities receiving Medicare or Medicaid reimbursements.

The final rule set the date of November 15, 2016 when it becomes effective, however they also stated that healthcare providers have until November 15, 2017 to be in full compliance.

CMS Final Rule

CMS expects organizations to be in compliance with the published final rule by November 15, 2017, and AAHHS/HFAP standards are based on the published final rule.

Previous to issuing the final rule, the CMS CoPs had little to say about emergency management.

CMS Final Rule

With the recent natural disasters, such as Hurricane Sandy and other floods, CMS decided it was time that all healthcare providers and suppliers have the same set of standards on emergency management.

That is why CMS decided to create a brand-new set of standards and assign it a separate CoP number in each of the 17 different providers and suppliers standards.

[Actually... not a bad idea...]

CMS Final Rule

CMS says there are three key essential requirements for maintaining healthcare services during an emergency:

1. Safeguarding human resources
2. Maintaining business operations
3. Protecting physical resources

They have established their EM standards around these three essential requirements.

CMS Final Rule

You will notice that CMS does not subscribe to the four phases of Emergency Management that HFAP, AAHHS, and other AOs do:

1. **Mitigation**
2. Preparedness
3. Response
4. **Recovery**

While CMS does have aspects of Preparedness and Response in the EM standards, they do not include Mitigation or Recovery.

CMS Final Rule

CMS uses different terminology but it all means the same thing:

- Emergency Management = Emergency Preparedness
- Emergency Plan = Emergency Operations Plan, Emergency Management Plan, The Plan, Disaster Plan
- Risk Assessment = Hazard Vulnerability Analysis
- Emergency = Disaster
- Staff = Employees, Volunteers, Students, Physicians, Chaplains, individuals providing services under contract

Noticeable Changes

The following changes will be made in the 2018 EM standards:

- Where previously there were 16 standards in the EM chapter, now there are 33 standards
- **Safety** – A review of the Safety requirements in the 2017 manual reveals they are mostly Security related. So the ‘Safety’ name of the standard was dropped.
- **Triage** – There is no CMS requirement for Triage, and ERs will triage patients as they determine best for their organization, so this requirement has been removed.

Noticeable Changes

- **Business Continuity** – CMS is not interested in business continuity, so therefore, this requirement was removed
- **Personal Protective Equipment** – the requirements for PPE are combined with the standard for Supplies
- **NIMS Training** – Since CMS does not require NIMS training, neither will HFAP and AAHHS. NIMS training is required where Homeland Security funds are distributed and will be enforced by ‘others’.



New EM Standards

So... after that introduction, let's look at the new HFAP and AAHHS standards...

Planning

09.00.01 – Condition of Participation

The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this chapter, utilizing an all-hazards approach. (§482.15)

As you can tell, this is a CoP. CMS separated the Emergency Management portion out of the old §482.41 CoP (Physical Environment).



Planning

09.00.01 – Condition of Participation

The phrase “all-hazards” means the Emergency Management program must apply to any hazard that may occur (hence the term ‘all-hazards’), and is no longer limited to just any single disaster.

At one time, HFAP’s EM standards only seemed to apply to weapons of mass-destruction!

Planning

09.00.02 – Hazard Vulnerability Analysis

The organization must conduct a risk assessment (i.e. Hazard Vulnerability Analysis, or HVA) to ascertain conceivable threats and disasters that could affect their ability to operate the facility.

The hospital's HVA must be shared with the community's emergency response agencies (documented evidence).



Planning

09.00.02 – Hazard Vulnerability Analysis

The HVA is reviewed annually by the over-sight committee on Emergency Management. This means, the HVA needs to be dated.

The organization may choose to have a single HVA that covers all of their facilities, or they may have multiple HVAs. Realistically, the HVA must identify potential issues unique to each facility. Any particular format or template to use for the HVA is not specified.



Planning

09.00.03 – Emergency Operations Plan

The organization must have a written Emergency Operations Plan (EOP) based on the priorities identified in the HVA.

The EOP is shared with the community emergency response agencies to synchronize responses to common emergency events.

Planning

09.00.03 – Emergency Operations Plan

The EOP is reviewed annually by the oversight committee on Emergency management to ensure relevancy and accuracy. This means it must be dated.

The organization may choose to have one EOP to cover all of their facilities, or they may have multiple EOPs to cover all of the facilities.

Planning

09.00.03 – Emergency Operations Plan

The EOP must assess the community's abilities to meet the needs of the hospital during an emergency event, and this assessment must be documented.

Planning

09.00.04 – Patient Population

The EOP must address patient population, including but not limited to persons at risk.

When creating the EOP, the hospital must consider emergency response activities to at-risk populations, such as individuals with disabilities, from diverse cultures, non-English speaking, etc.



Planning

09.00.05 – Services

The EOP must address the type of services the hospital has the ability to provide in an emergency.

The EOP includes a plan for the continuation of these services during the facility's response to the emergency event.

Planning

09.00.06 – Continuity of Operations

The EOP must address the continuity of operations, including the delegation of authority and succession plans.

The EOP must answer the questions....

1. How the hospital will continue to operate during an emergency?
2. Who is delegated as the authority during the emergency?
3. How the succession of the authority is provided?

Planning

09.00.07 – Collaboration

The EOP must include a process for cooperation and collaboration with local, tribal, regional, State, and Federal agencies to maintain an integrated response during the emergency event.

The EOP must explain how the hospital will cooperate with the authorities during the Planning process regarding emergency management.



Procedures

09.01.01 – Policies & Procedures

The hospital must develop emergency preparedness policies that are based on the EOP, HVA and the Communication Plan, and must be updated annually by the oversight committee on Emergency Management, which means they must be dated.

Procedures

09.01.01 – Policies & Procedures

The policies & procedures are not required to be included in the EOP, but if the hospital chooses not to include the policies & procedures in the EOP, then they must be referenced in the EOP as to where they may be located.

Procedures

09.01.02 – Nutritional Services

The hospital must have a policy on nutritional services that addresses the provision of subsistence needs for staff and patients during an emergency, especially when food supplies are interrupted and preparation equipment is no longer available.

The policy must explain how the hospital will feed staff, visitors and patients, and must have written agreements (that are updated annually) with food suppliers.



Procedures

09.01.03 – Supplies

The hospital must have a policy on medical supplies, pharmaceutical supplies, and general equipment for staff and patients that are sheltered in place.

The policy provides for how the hospital will replenish these supplies after the emergency event begins.



Procedures

09.01.03 – Supplies

The hospital must have an inventory of all the supplies (medical, pharmaceutical, and general) designated for emergency response.

There is no requirement for a 3-day supply, but the policy must explain what the hospital will do if the local community cannot replenish supplies for 3 days.

Procedures

09.01.04 – Utilities

The hospital must have policy on alternate sources of energy (such as an emergency power generator).

The policy must provide for the continuation of utilities, such as emergency power, fuel, sewage disposal, medical air, medical gases, and vacuum, during an emergency event.



Procedures

09.01.04 – Utilities

The policy needs to document what areas of the facility are served by EM power, and what areas are not.

The policy provides for written agreements with vendors on:

- Service of EM power generators
- Replenishment of fuel for generators and boilers
- Portable cylinders of medical air and medical gases
- Portable medical vacuum
- Non-potable water for processing



Procedures

09.01.05 – Patient and Staff Tracking

The hospital must have a policy on how they will track the location of on-duty staff, and the location of sheltered patients, in the hospital's care during an emergency.

If on-duty staff and sheltered patients are relocated during an emergency, the hospital must document the specific name and location of the receiving facility.



Procedures

09.01.06 – Evacuation

The hospital must have a policy that addresses the safe evacuation from the hospital, which includes:

- Consideration of care and treatment needs of the patients
- Staff responsibilities
- Transportation
- Identification of evacuation locations
- Primary and alternate means of communication with external sources of assistance

Procedures

09.01.06 – Evacuation

The policy identifies when and how the patients will be evacuated from the hospital.

The evacuation plan is reviewed by the community emergency response agency.



Procedures

09.01.07 – Shelter in Place

The hospital must have a policy that addresses a means to shelter in place for patients, staff and volunteers who remain in the facility during the emergency event.



Procedures

09.01.08 – Medical Documentation

The hospital must have a policy that preserves patient information during an emergency event, and ensures patient records are secure and readily available during an emergency.

This issue with this requirement concerns loss of electronic medical information with loss of power or internet connection.



Procedures

09.01.09 – Volunteers

The hospital must have a policy that addresses the use of volunteers during an emergency event. The policy (i.e. Volunteer Management Plan) assigns and supervises volunteers during an emergency event.

The policy must plan to verify volunteer's identify, license, certifications, malpractice insurance and hospital privileges before volunteer provides patient care.



Procedures

09.01.10 – Continuity of Services

The hospital must have a policy that addresses the development of arrangements with other hospitals to receive patients in the event of need to evacuate patients.

The hospital must have signed transfer agreements with the other hospitals in their region.



Procedures

09.01.11 – Invoking the 1135 Waiver

The hospital must have a policy that addresses the hospital's role under a 1135 waiver declared by the Secretary of HHS, in the provision of care at an alternate care site identified by emergency management officials.

An 1135 waiver is automatically authorized by the HHS Secretary when a public health emergency is declared.



Procedures

09.01.11 – Invoking the 1135 Waiver

This will allow hospitals who provide services in good faith to be reimbursed and be exempted from sanctions if they are unable to meet specific Medicare, Medicaid, or Children's Health Insurance Program requirements, during the public health emergency event.

The hospital simply notifies the CMS Regional Office (and copy HFAP or AAHHS) that they are invoking the 1135 waiver.

Procedures

09.01.12 – Security

The hospital must have a policy that addresses a process to provide for the security of the patients, staff, and visitors during an emergency.

The policy must address the following:

- The different needs of each location where the hospital operates
- The special needs of the patients treated at the hospital
- The security of patients and walk-in patients
- The security of supplies from misappropriation
- Identification of personnel needed to implement the hospital's plan



Procedures

09.01.13 – Decontamination

The hospital must have a policy that addresses how the hospital arranges for the chemical, biological and radioactive decontamination of patients brought to their facility.

The decontamination plan must address internal as well as external disasters.

Procedures

09.01.14 – Incident Command Center

The hospital must have a policy that addresses:

- The identification where the hospital's Incident Command Center will be located;
- Ensure essential equipment and support is intact and maintained for use in directing and controlling response and recovery operations;
- The process for activating the Incident Command Center

Procedures

09.01.14 – Incident Command Center

The policy must include:

- A list of the equipment needed in the Incident Command Center
- A layout diagram identifying where the equipment is to be set up in the Incident Command Center
- The locations of the emergency power available in the Incident Command Center



Communication

09.02.01 – Communication Plan

The hospital must have a policy on communicating during an emergency event (i.e. Communication Plan) that includes a tiered rapid process (i.e. call-back roster) to notify staff during an emergency.

Call-back rosters are dated and must be updated semi-annually, not annually.



Communication

09.02.02 – Contact Information

The communication plan must include the names and contact information for the following:

- Staff
- Entities providing services under arrangement
- Patient's physicians
- Other hospitals
- Volunteers
- Federal, state, tribal, regional, and local emergency preparedness staff
- Other sources of assistance



Communication

09.02.03 – Primary & Alternate Means of Communication

The communication plan must include primary and alternate means for communication with the following:

- The hospital's staff
- Federal, State, tribal, regional, and local emergency management agencies



Communication

Backup technology must be considered and utilized with the consideration that traditional methods of communication may not be available. Alternative methods must be explored and planned for in the written procedure, such as:

- Land-line telephones
- Pagers
- Internet provided by satellite or non-telephone cable systems
- Cellular telephones
- Radio transceivers (walkie-talkies)
- Various other radio devices, such as NOAA weather radio and amateur radio (HAM)
- Satellite telephone communication systems



Communication

09.02.04 – Information Sharing

The communication plan must include a method for sharing information and medical documentation for patients under the hospital's care, with other health care providers to maintain the continuity of care.



Communication

09.02.05 – Release of Information

The communication plan must include a means to release patient information in the event of evacuation of the hospital.

Communication

09.02.06 – Hospital Information

The communication plan must include a means of providing information about the hospital's occupancy, needs, and ability to provide assistance to the authorities having jurisdiction, through the Incident Command Center.



Training & Testing

09.03.01 – Emergency Training

The hospital must develop a training program that is based on the EOP, the HVA, the Policies & Procedures, and the Communication Plan.

All staff (new and existing) must be trained initially, and annually on emergency preparedness, on the roles they are expected to perform during an emergency event.

Training & Testing

09.03.02 – Emergency Exercises

The hospital must develop a testing program (emergency exercises) that is based on the EOP, HVA, the Policies & Procedures, and the Communication Plan.

The hospital must participate in two (2) exercises per calendar year:

1. A full-scale community-based exercise – If a community-based exercise is not available, then an individual facility-based full-scale exercise is acceptable.
2. Full-scale exercise that is facility based.



Training & Testing

09.03.02 – Emergency Exercises

Table-top drills are not an acceptable substitute for the 2 required emergency exercises per year.

If the hospital experiences an actual emergency event that stands-up the Incident Command Center, the hospital is exempt from engaging in one community-based or individual facility-based exercise for 1 year following the onset of the actual event.



Training & Testing

09.03.02 – Emergency Exercises

Each implementation (drill or actual event) must be analyzed and evaluated (i.e. critiqued) by the emergency management committee to make improvements to the EOP.

The emergency management committee submits reports to the hospital leadership, and as appropriate to other authorities.



Training & Testing

09.03.02 – Emergency Exercises

Hospitals (Healthcare occupancies) and ASCs (Ambulatory Healthcare occupancies) must conduct two (2) emergency exercises per calendar year.

Physician offices (Business occupancies) that provide patient care must perform one (1) emergency exercise per calendar year.



Operational Requirements

09.04.01 – Emergency Power

For new installations (since July 5, 2016) or renovated installations (since July 5, 2016), the emergency power generator must be located to minimize the damage from flooding (does not apply to existing conditions).

The hospital must maintain an onsite fuel source for the generator and must have a plan on how it will keep the emergency generator operational during the emergency event (i.e. re-fueling plan).



Operational Requirements

09.04.01 – Emergency Power

This standard does not require any additional inspections or testing of the generator that are not already required in the Life Safety chapter.



Operational Requirements

09.04.02 – Integrated Healthcare Systems

If the hospital is part of a healthcare system consisting of multiple separately certified healthcare facilities, then the hospital may choose to participate in a unified and integrated emergency preparedness program.



Operational Requirements

09.04.03 – Transplant Hospitals

If a hospital has one or more transplant centers then a representative from each transplant center must be included in the development and maintenance of the hospital's emergency preparedness program.



In Conclusion...

This latest Final Rule from CMS on Emergency Management is one of the best things they have done in a long time. It sets minimum standards for all healthcare providers to follow regardless of their accreditation organization's position.

It is apparent that CMS took their time and thoughtfully and carefully considered all aspects of Emergency Management and included those requirements that they felt were necessary.



Tools...

There is a handout available for you to use to help you become compliant with the requirements for documentation required by the hospital:

“Emergency Management Document Review”

Please use it to ensure you are compliant with the standards.



Questions?

Brad Keyes, CHSP

bkeyes@hfap.org

815-629-2240





Certificate of Attendance

Awarded 1.0 contact hours

HFAP 2017 v2 Manual Update: Requirements for Emergency Management

A 60 minute audio-conference

October 26, 2017

A handwritten signature in black ink, appearing to read "Brad Keyes", is written over a horizontal line.

Brad Keyes, Presenter
HFAP Engineering Advisor