Implications of the CMS Emergency Management Rule



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Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 416, 418, et al.

Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; Final Rule



Jonathan Flannery, MHSA, CHFM, FASHE, FACHE
Senior Associate Director, ASHE/AHA

jflannery@aha.org – 312-422-3825



Effectivity vs Implementation

- Effective date:
 - November 15, 2016
- Implementation date:
 - November 15, 2017
- Provides opportunity to:
 - Evaluate plans
 - Update plans
 - Perform training





Purpose of Rule

- Establish national emergency preparedness requirements to:
 - Plan adequately for disasters
 - Coordinate with federal, state, tribal, regional, and local emergency preparedness systems
 - Prepare to meet the needs of patients, residents, clients, and participants during disasters and emergency situations





§ 482.15 (Hospital) & § 485.625 (CAH) Condition of Participation

Hospitals must

- Comply with all applicable federal, state, and local emergency preparedness requirements
- Develop and maintain a comprehensive emergency preparedness program utilizing an all-hazards approach
- Program must include:
 - Hospitals 8 Elements
 - CAHs 7 Elements





§ 482.15 Hospital Overview

Program must include

- (a) Emergency Plan
- (b) Policies and Procedures
- (c) Communication Plan
- (d) Training and Testing
- (e) Emergency and Standby Power Systems
- (f) Integrated Healthcare Systems (Optional)
- (g) Transplant Hospitals (If Applicable)
- (h) Reference Standards





485.625 CAH Overview

Program Must Include

- (a) Emergency Plan
- (b) Policies and Procedures
- (c) Communication Plan
- (d) Training and Testing
- (e) Emergency and Standby Power Systems
- (f) Integrated Healthcare Systems (Optional)
- (g) Reference Standards





- Generator location and testing
 - Inspect, test, and maintain per
 - NFPA 101, 99 & 110
 - Locate per
 - NFPA 99 & 110
 - New construction
 - Renovation





- Community involvement
 - To cooperate with LTRSF EPOs
 - To document efforts
 - CMS intent:
 - Responsibility for ensuring a community-wide coordinated disaster preparedness response is under the state and local emergency authorities





- Integrated system-wide planning
 - May elect to participate in coordinated EPP
 - Each facility must participate in development
 - Must reflect uniqueness of each facility
 - Demonstrate each facility is capable of actively using integrated system





- Communication plan
 - Heavy emphasis on communications
 - Must:
 - Include contact information for staff, physicians, service providers, volunteers, and emergency preparedness officials
 - Define primary and alternate means for communications
 - Include method for sharing information about medical documentation for patients







- Policies and procedures
 - Based on risk assessment, emergency plan and communication plan
 - At minimum need to address:
 - Subsistence needs for staff and patients
 - Tracking the location of on-duty staff and sheltered patients and use of volunteers
 - Safe evacuation as well as sheltering in place
 - System of medical documentation



Arrangements with others to receive patients
 and the role of the hospital under an 1135

- Testing of emergency plan
 - Two exercises annually
 - 1 community-based full scale
 - If not available facility-based
 - 1 tabletop (TJC not approved)
 - Monitor (analyze), Document, Update
 - Make update to EPP as needed





- Differences between Hospital/CAHs
 - No Transplant Center for CAHs
 - Additional Training Requirements for CAHs
 - Prompt reporting and extinguishing of fires
 - Protection/evacuation of:
 - Patients, personnel and guests
 - Fire prevention

American Society for Healthcare Engineering of the American Hospital Association

Cooperation with firefighting and disaster authorities

A personal membership group of



Questions?

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