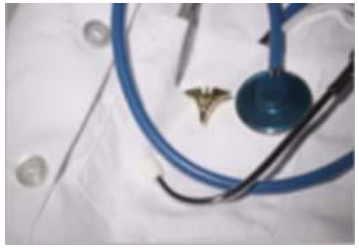
Emergency Preparedness:
WHAT, WHY, WHEN, WHO and HOW



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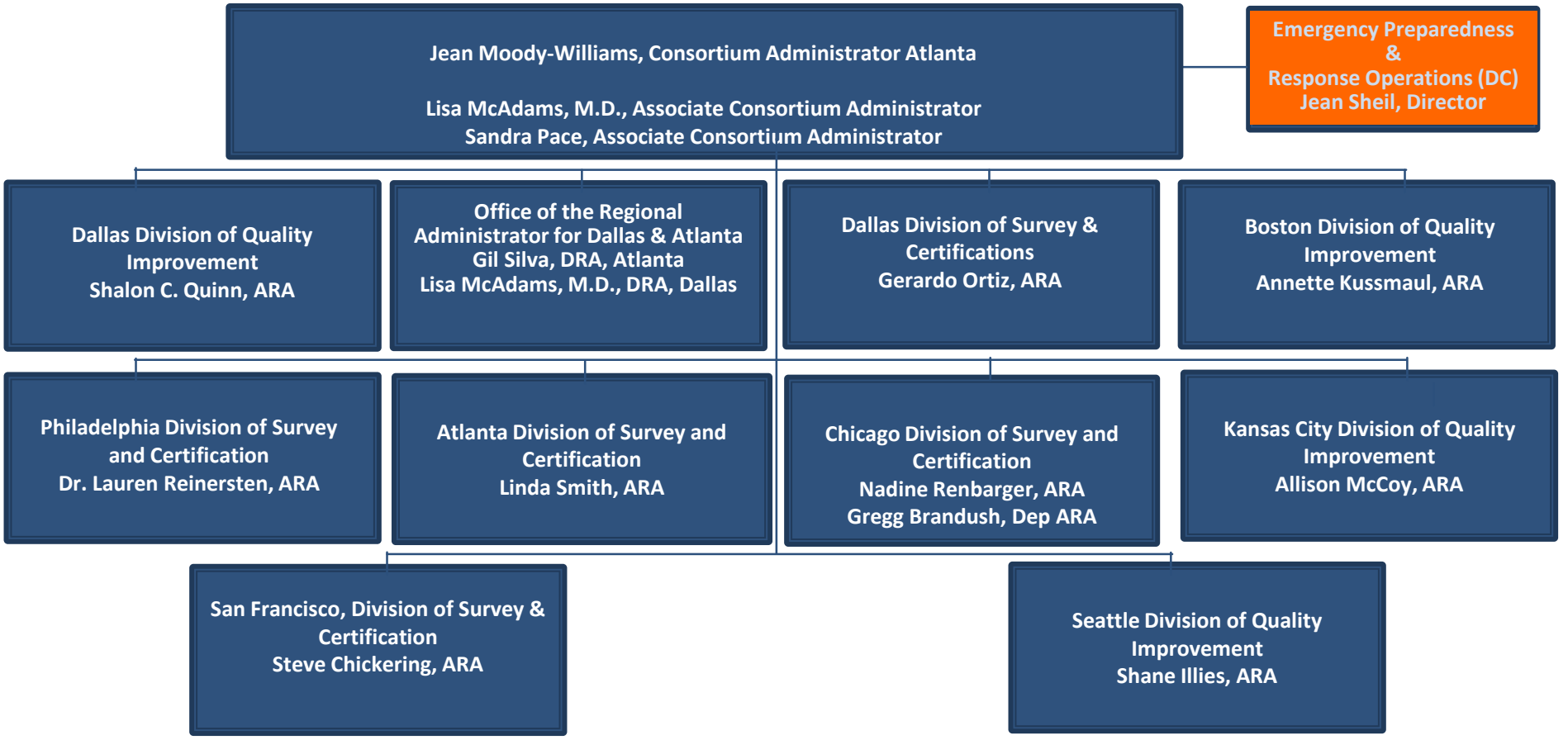
Consortium for Quality Improvement & Survey & Certification Operations (CQISCO)



DRA- Deputy Regional Administrator; **ARA**- Associate Regional Administrator;
ACA- Associate Consortium Administrator

CQISCO

CQISCO accomplishes our goals through the work of four components:

- Emergency Preparedness and Response Operations (EPRO) is responsible for the overall coordination of information and logistics during a continuity or emergency event and for development of a robust test, training and exercise program.

- The Divisions of Survey & Certification (DSC) provide oversight of state survey agencies and ensure that providers such as hospitals, long-term care facilities, home health agencies and hospice organizations and many other provider types, adhere to Medicare's Conditions of Participation;

- Chief Medical Officers (CMOs) serve as medical and scientific leads for Regional Office quality improvement efforts, as chief clinicians for all regional components and as liaisons with health care providers; and

- The Divisions of Quality Improvement (DQI) provide oversight of Quality Improvement Organization (QIO) & End-Stage Renal Disease Network (NW) programs

WHAT?

Emergency Preparedness Final Rule

FINAL RULE (81 FR 63860): National Emergency Preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems.

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Emergency Preparedness Final Rule

- Compliance required for participation in Medicare (and Medicaid, as applicable)
- Emergency Preparedness is one new Condition of Participation/Condition for Coverage of many already required
- If facilities are non-compliant, the same general enforcement procedures will occur as is currently in place for any other conditions or requirements cited for non-compliance

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WHY?

Why Emergency Preparedness?

Emergencies can happen at any time due to severe weather, infectious disease outbreaks or intentional acts --- they are unpredictable and may change in scope and impact. During an emergency, there are consequences for every moment that a provider or supplier is unable to function effectively. Examples of emergencies are September 11th, Ebola, Zika Virus and Hurricane Maria.

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Why Emergency Preparedness?

From all perspectives, health care providers and suppliers have a critical role to play in preparedness and response discussions. Preparedness addresses how the provider or supplier will meet the needs of patients and residents if essential services break down as a result of a disaster/emergency. A coordinated response is essential.

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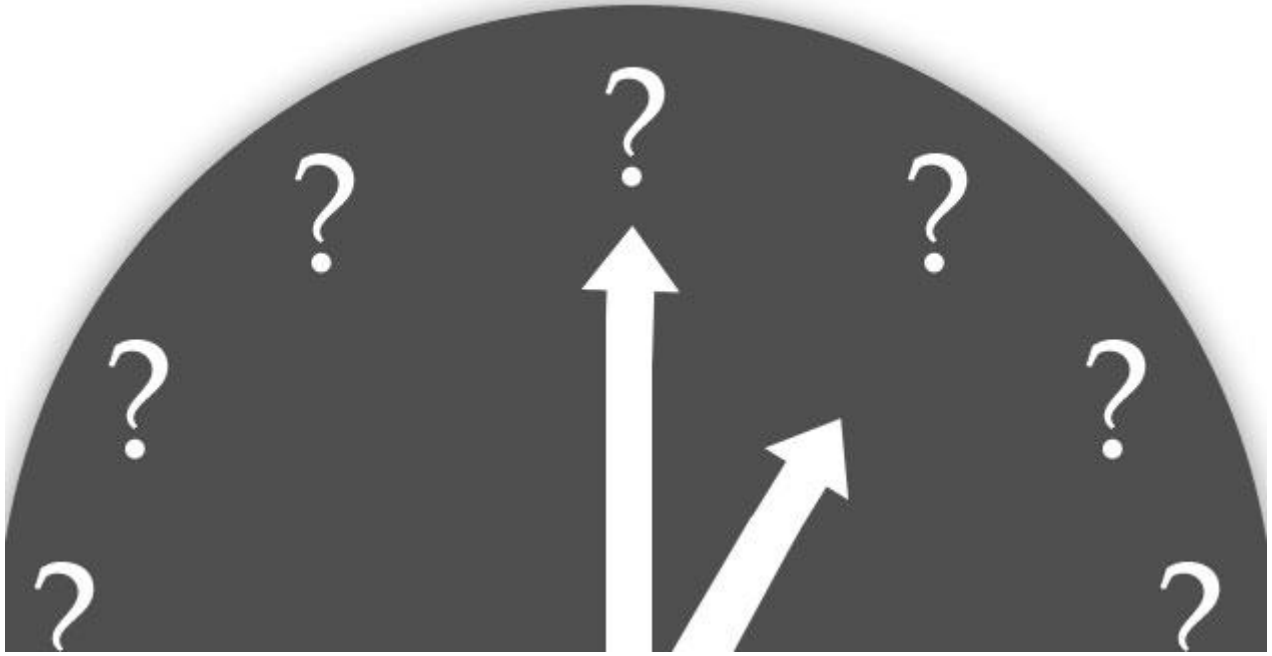
WHEN?



Published, Effective and Implementation Dates

- Federal Register published September 16, 2016
- Effective November 16, 2016
- **Implementation date November 15, 2017**

WHO?

Provider/Supplier Types Impacted by EP Rule

1. Religious Non-Medical Health Care Institution (RNCHI)
2. Ambulatory Surgical Center (ASC)
3. Hospice
4. Psychiatric Residential Treatment Facility (PRTF)
5. Programs of All-Inclusive Care for the Elderly (PACE)
6. Hospital
7. Transplant Center
8. Nursing Homes
9. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
10. Home Health Agencies (HHA)

Provider/Supplier Types Impacted by EP Rule

11. Comprehensive Outpatient Rehabilitation Facility (CORF)
12. Critical Access Hospital (CAH)
13. Clinics, Rehab, Public Health Agency (PHA) as OPT/Speech
14. Community Mental Health Center (CMHC)
15. Organ Procurement Organization (OPO)
16. Rural Health Clinic/Federally Qualified Health Center (RHC/FQHC)
17. End Stage Renal Disease (ESRD)

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HOW?

Collaboration

- Challenges evolve during different phases of a disaster
- CMS works closely with State and other Federal Agencies before, during and after the disaster to ensure safe, quality care is provided
- Communication, collaboration, and coordination among state and local emergency management, public health, and health care entities are essential to promoting effective emergency preparedness and response.
- **Remember, personal preparedness is your foundation to be best prepared!**

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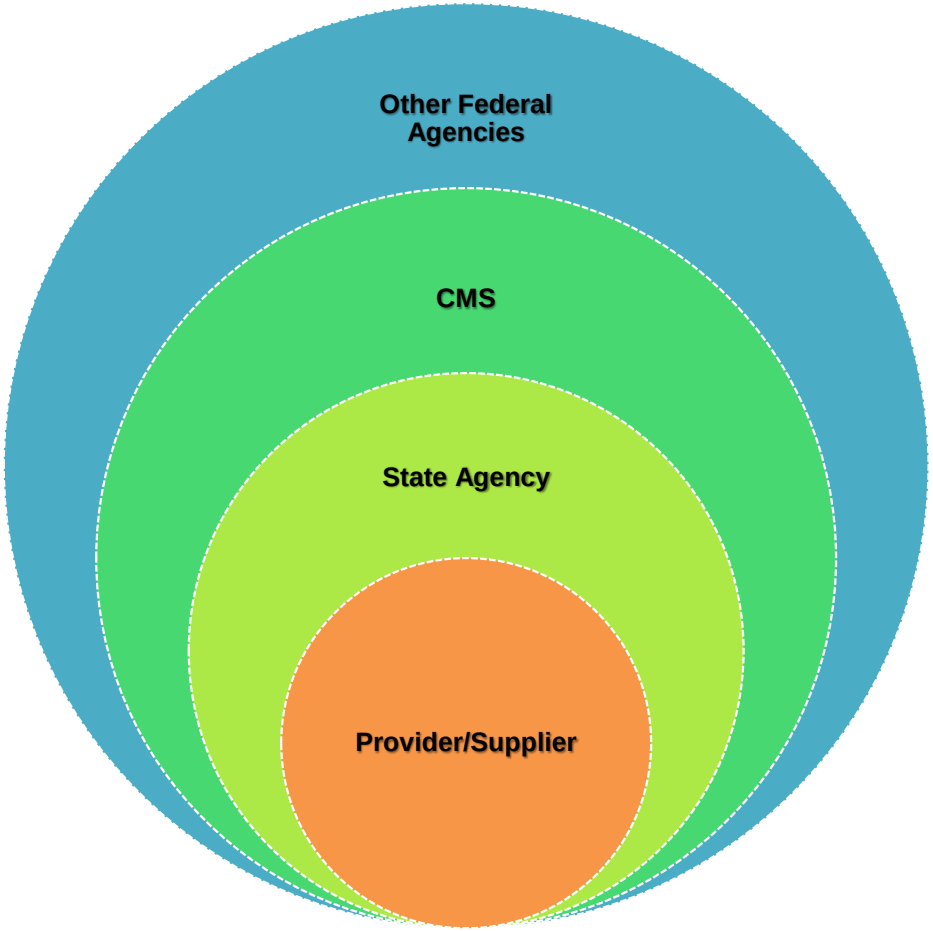
We're ALL Working Together



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Before the Emergency:

PREPARATION

Four Provisions for All Provider Types

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During the Emergency:

RESPONSE

Types of Emergencies

- Hurricanes
- Flooding
- Wildfires
- Infectious Diseases
- Tornadoes
- Earthquakes
- Volcanoes
- Cyber Security
- Shootings
- Other natural and person-made emergencies and disasters

Role of CMS Regional Offices During an Emergency

During a disruptive event, the Regional Office's (RO) primary role is to provide guidance to affected SAs regarding health care providers' CoP/CfC and potential altered care decisions, while ensuring the health and safety of patients and residents. The RO's essential functions include the following:

- Establishing an emergency point of contact
- Ensuring communication links with designated emergency points of contact at affected State Agencies

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Role of CMS Regional Offices During an Emergency

- Responding promptly to requests for 1135(b) waiver
- Referring questions and waiver/suspension of regulation requests to CMS Central Office, as needed.
- Requesting status reports from the State Agency regarding affected health care providers
- Assisting affected State Agencies to provide essential monitoring and enforcement activities if the State Agency is overwhelmed/unable to meet their survey and certification obligations.

Evacuation and Tracking

- In the event that evacuation may be necessary, it is essential to be able to track evacuees.
- Establish a stable information system that is designed for concurrent use by multiple users.
- It is important to consider confidentiality issues, particularly in a database with multiple end users, although it can be tempting to track individual residents by name.

After the Emergency:

RECOVERY

After the Emergency

- New gaps in health care continuum may occur
- Emergent mental health issues/stress rooted in the trauma of the event
- 1135 Waivers/ CMS and State Agency considerations
- Flexibility vs Waiver

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The 1135 Waiver Process

Purpose of an 1135 Waiver

- Sufficient health care items and services are available to meet the needs of Medicare, Medicaid and CHIP beneficiaries;
- Health care providers that provide such services in good faith can be reimbursed for them and not subjected to sanctions for noncompliance, absent any fraud or abuse.

Disaster Management Cycle

Emergency Preparedness:

RESOURCES

EP Resources/ Web Links

- Centers for Medicare & Medicaid (CMS) Survey and Certification Emergency Preparedness Website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html
- Assistant Secretary for Preparedness and Response (ASPR) TRACIE Website: https://asprtracie.hhs.gov/
- State Operations Manual Appendix Z- Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Advanced-Copy-SOM-Appendix-Z-EP-IGs.pdf

CMS Email Addresses for 1135 Requests/EP Questions

- ROATLHSQ@cms.hhs.gov (**Atlanta RO**): Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee
- RODALDSC@cms.hhs.gov (**Dallas RO**): Arkansas, Louisiana, New Mexico, Oklahoma, and Texas
- ROPHIDSC@cms.hhs.gov (**Northeast Consortium**): Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia, New York, New Jersey, Puerto Rico, Virgin Islands, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
- ROCHISC@cms.hhs.gov (**Midwest Consortium**): Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, and Nebraska
- ROSFOSO@cms.hhs.gov (**Western Consortium**): Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming, Alaska, Idaho, Oregon, Washington, Arizona, California, Hawaii, Nevada, and the Pacific Territories.

Questions?