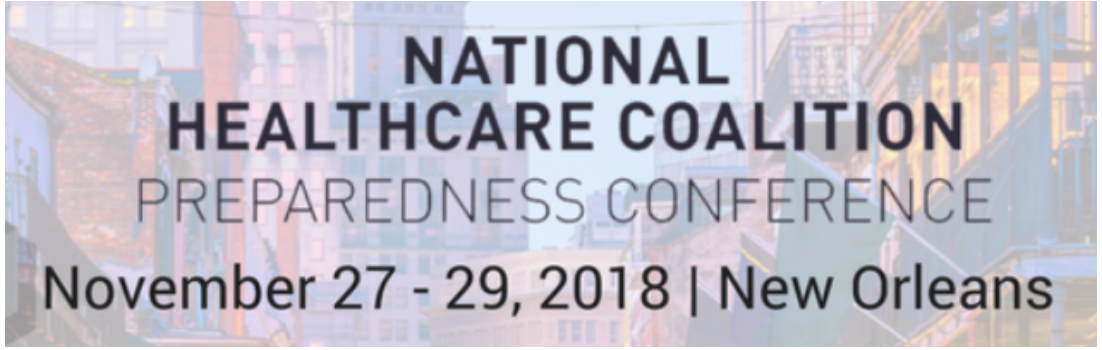


Learning from the CMS Emergency Preparedness Rule and Looking Forward

Melissa Harvey, RN, MSPH, Director HHS ASPR NHPP

Caecilia Blondiaux, CMS Quality, Safety & Oversight Group

Patrick Ashley, MS, MBA, State Hospital Coordinator, Office of Emergency Preparedness, Virginia Department of Health

Shayne Brannman, MS, ASPR TRACIE Program Director

National Healthcare Coalition Preparedness Conference

November 29, 2018

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

ASPR ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE

TRACIE HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

VDH VIRGINIA DEPARTMENT OF HEALTH

Disclaimer

This presentation was prepared as a tool to assist and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, HHS Office of the Assistant Secretary for Preparedness and Response (ASPR), and Virginia Department of Health (VDH), but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

The Centers for Medicare & Medicaid Services (CMS), VDH, and HHS ASPR employees, agents, and staff make no representation, warranty, or guarantee that this compilation of information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

Welcome and Introductions

Melissa Harvey, RN, MSPH
Director, Division of National Healthcare Preparedness Programs (NHPP), HHS ASPR

CMS Emergency Preparedness Rule

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

Understanding the Emergency Preparedness Final Rule

Where Are We Now?

Caecilia Blondiaux

Quality, Safety & Oversight Group

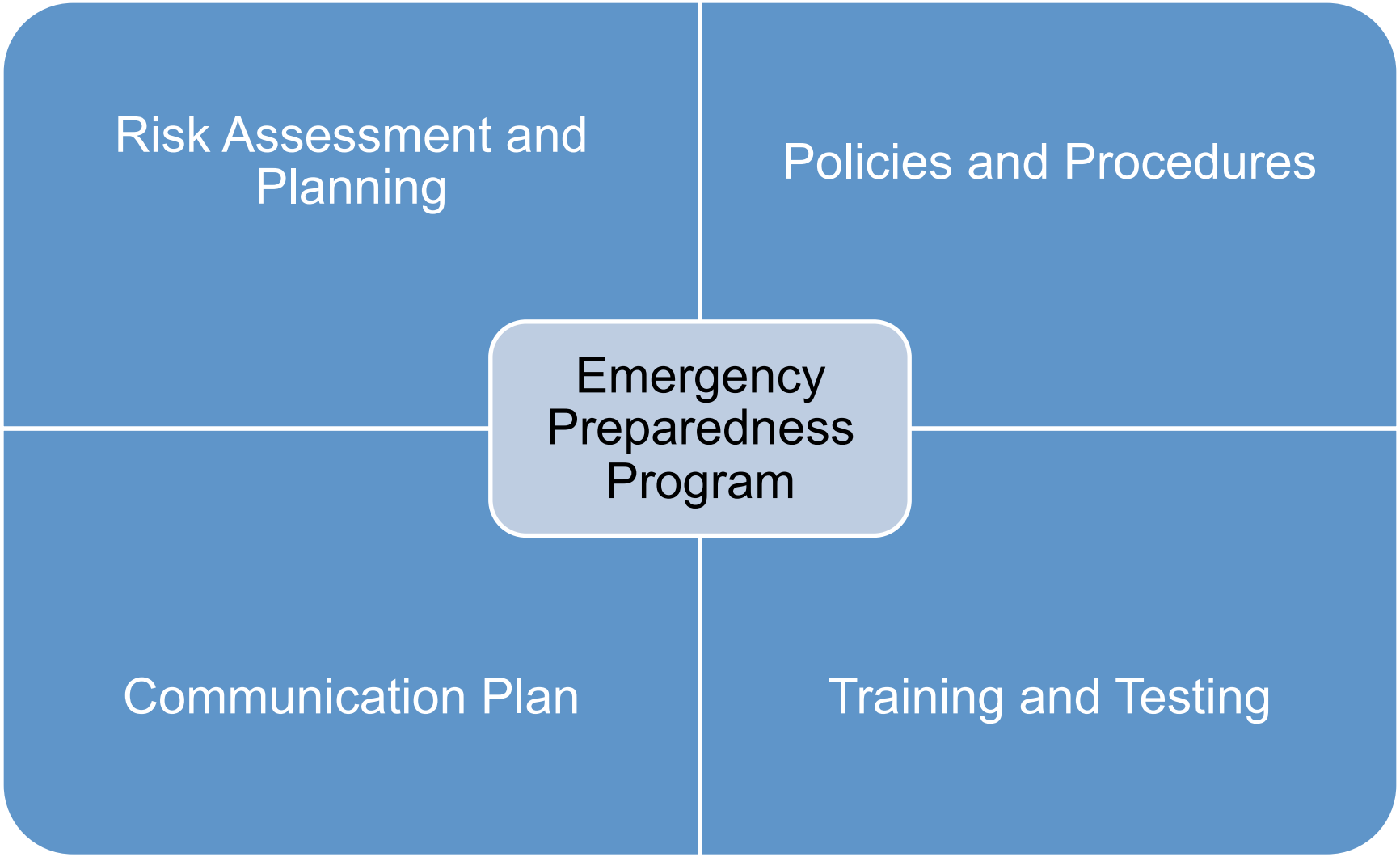
Center for Clinical Standards and Quality

Centers for Medicare & Medicaid Services

Final Rule

- Published September 16, 2016 with an implementation date of November 15, 2017
- Applies to all 17 provider and supplier types
- Compliance required for participation in Medicare (and Medicaid, as applicable)
- Emergency Preparedness is one new CoP/CfC of many already required
  - For example, many providers and suppliers are required to meet life safety codes that protect residents against fires and health safety codes that keep a reasonable temperature for residents.
- Facilities began being surveyed for the new requirements after November 2017 in conjunction with their existing survey cycles
- In the event 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.

Four Provisions for All Provider Types



Emergency Preparedness: An All-Hazards Approach

- An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters
- Includes internal emergencies; man-made emergencies; natural disaster; and/or emerging infectious diseases.
- Specific to geographic location of the provider or supplier including state and local requirements
- **These may include, but are 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.**

Available Training Resources

- In September, 2017, CMS launched the surveyor training for emergency preparedness requirements. Available at https://surveyortraining.cms.hhs.gov/

- Training through the Integrated Surveyor Training Website is also **available for providers/suppliers.**

- The website also provides important links to additional resources and organizations who can assist. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html

Where are we now?

- Surveys began in late November and are being conducted by either health surveyors or Life Safety Code (LSC) surveyors
- Surveys are in conjunction with regularly scheduled survey cycles
- Limited inquiries in recent months from providers and suppliers on what to do in order to be compliant
- CMS and ASPR continue to monitor compliance and work with health care entities.

Analysis of EP Rule Citations

- CMS and ASPR TRACIE reviewed recent emergency preparedness deficiencies among provider types from CMS surveys
- Updating and monitoring performance of health care providers and suppliers:
  - Analyzing citations based on surveys conducted by CMS between November 15, 2017 though September 30, 2018
  - Develop useful display templates
  - Update data every 6 months
- The purpose of this effort is to:
  - Identify ways to strengthen emergency preparedness efforts of health care providers and suppliers at all levels (National; State; Regional; and Local Healthcare Entity)
  - Enhance and hone future technical assistance efforts
  - Highlight geographic variances
  - Reduce surveyor variances
  - Create a reporting template
  - Create a baseline of information that can be updated and monitored

Overview of Current CMS EP Rule Surveys

- Collated preliminary citations based on CMS state surveys conducted between November 15, 2017 though September 30, 2018
- During that same time period:
  - 74,747 healthcare entities were eligible for EP Surveys (including entities that were terminated during this time)
  - 28,171 healthcare entities were surveyed one or more times
  - One facility can be subject to up to 39 Tags (44 Tags total but not all apply to each provider)
  - 6,251 healthcare entities were cited for at least one tag
    - 19,620 EP citations total were issued to these 6,251 health care entities

Note: Surveys conducted by State Survey Agencies in August and September 2018 may not be reflected in the analysis as they are given 70 days to report survey outcomes per reporting requirements.

What do the Data Show?

- As of September 30, 2018, we have surveyed over 90% of the nursing homes and 29% of hospitals for compliance with these requirements. Nursing homes receive an annual recertification survey, while hospitals are surveyed every three to five years.

- The majority of providers surveyed (78%) met the new emergency preparedness requirements.

- 78% of nursing homes and 96% of hospitals of those surveyed by September 30, 2018 fully in compliance with requirements.
  - 22% of nursing homes and 4% of the hospitals surveyed received at least one deficiency citation under Emergency Preparedness.

- All deficiencies cited require swift correction action to avoid termination. To date, all facilities cited corrected deficiencies and no facilities have been terminated for not meeting emergency preparedness requirements.

CMS Action/Next Steps

- With the data as the core driver, CMS will review the trends and continue to analyze citations on emergency preparedness.

- CMS plans to work closely with ASPR on potential areas of improvement, such as templates, additional resources, and more information to assist providers in compliance.

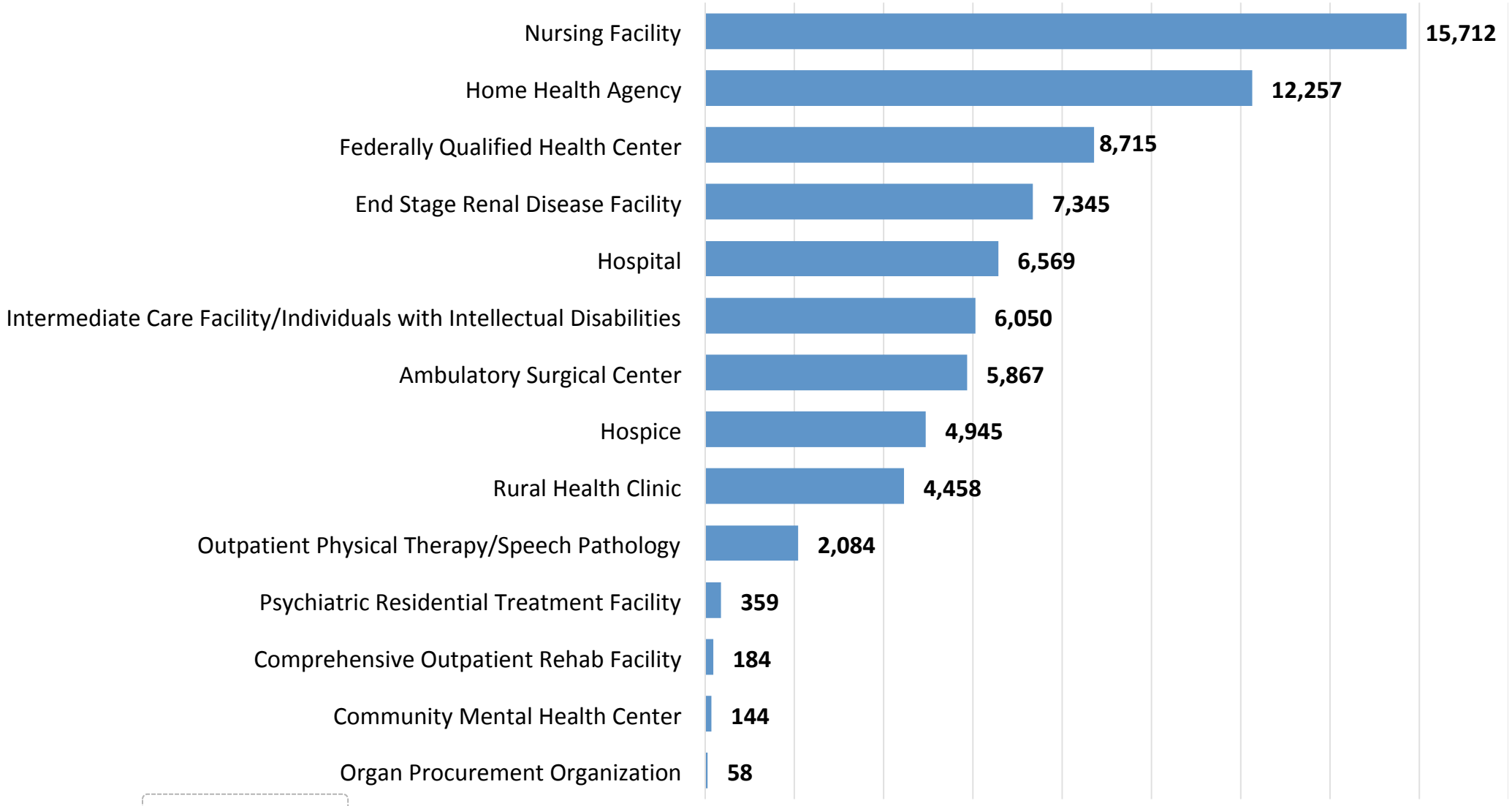
- CMS will also analyze the specific citations to determine the need for increased surveyor training opportunities and clarifications.

Survey Data Variability

- The data represented in this analysis has some variability because of survey cycles and does not include results of surveys conducted by Accrediting Organizations. The emergency preparedness requirements are surveyed based on the facility types regular scheduled survey cycle in conjunction with their health or Life Safety Code Surveys.
- For example:
  - Nursing Homes & ICF/IIDs: Annual-Not to Exceed 15 months
  - Home Health Agencies: Generally every 2 to 3 years
  - Hospitals: Generally every 3 to 5 years
  - ESRD: Generally every 3 years
  - Hospices: Generally every 3 years
  - RHCs & ASCs: Generally every 6 years
  - CMHCs: Generally every 5 years

For more information on survey cycles, please visit:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/QSOG-Mission-and-Priority-Information.html

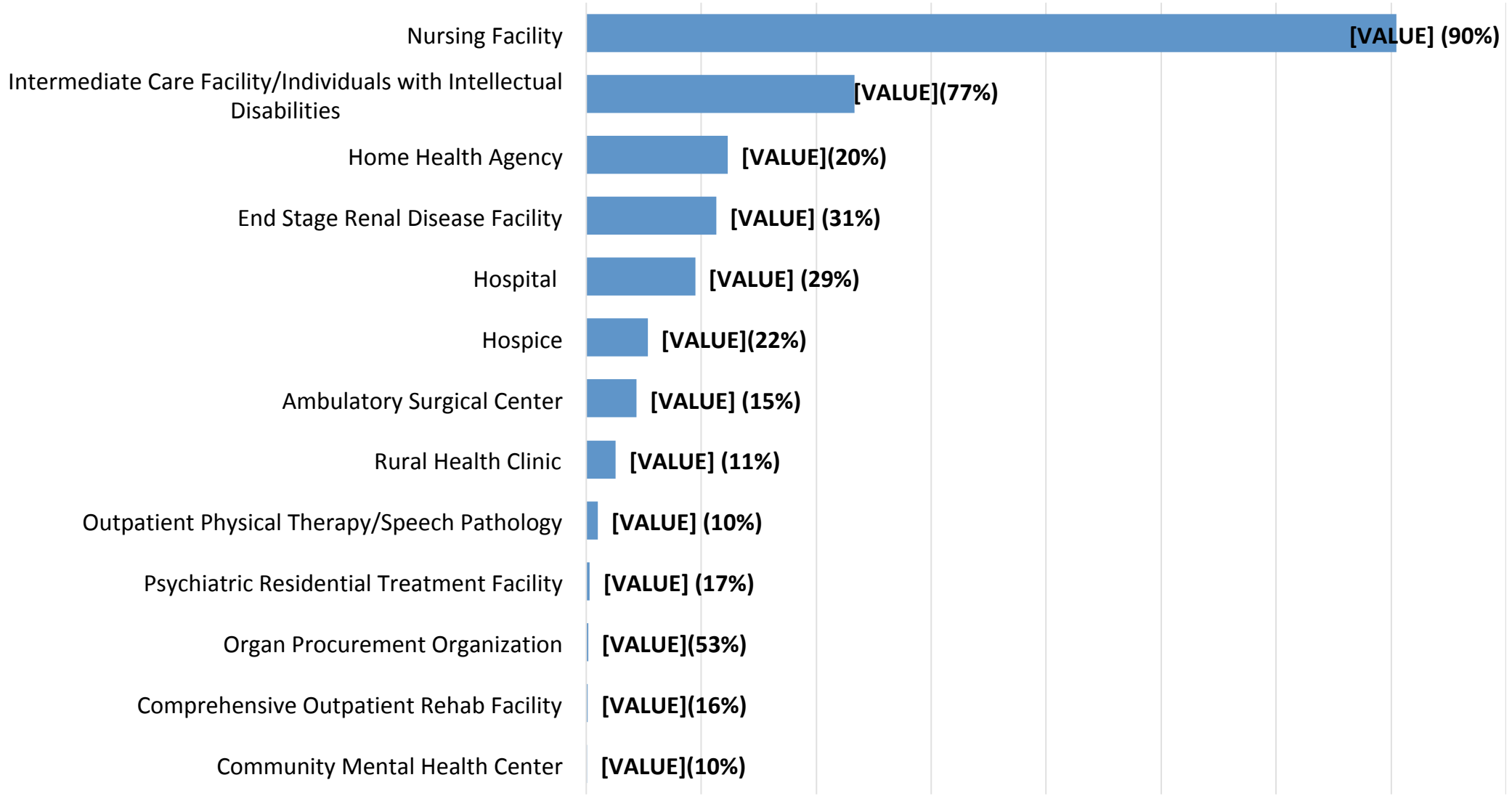
Number of Healthcare Entities Impacted by the CMS EP Rule By Provider Type (Nov 15, 2017 – Sept 30, 2018)



Total N= 74,747

Note: Nursing Facility includes Nursing Facility, Skilled Nursing Facility, and Skilled Nursing Facility/ Nursing Facility (Distinct Part and Dually Certified)

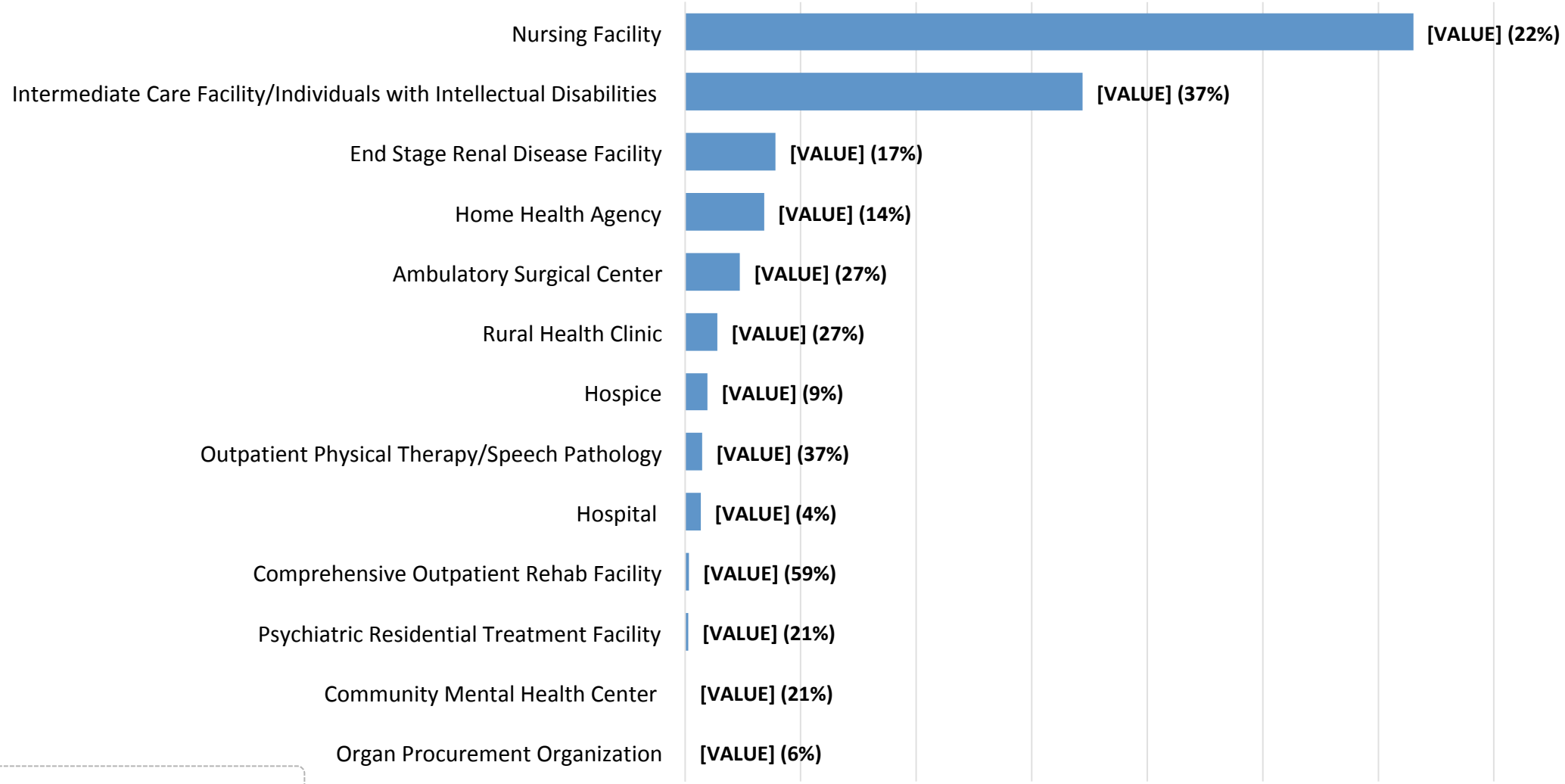
Number of Healthcare Entities Surveyed on the CMS EP Rule By Provider Type (Nov 15, 2017 – Sept 30, 2018)



Total N= 28,171

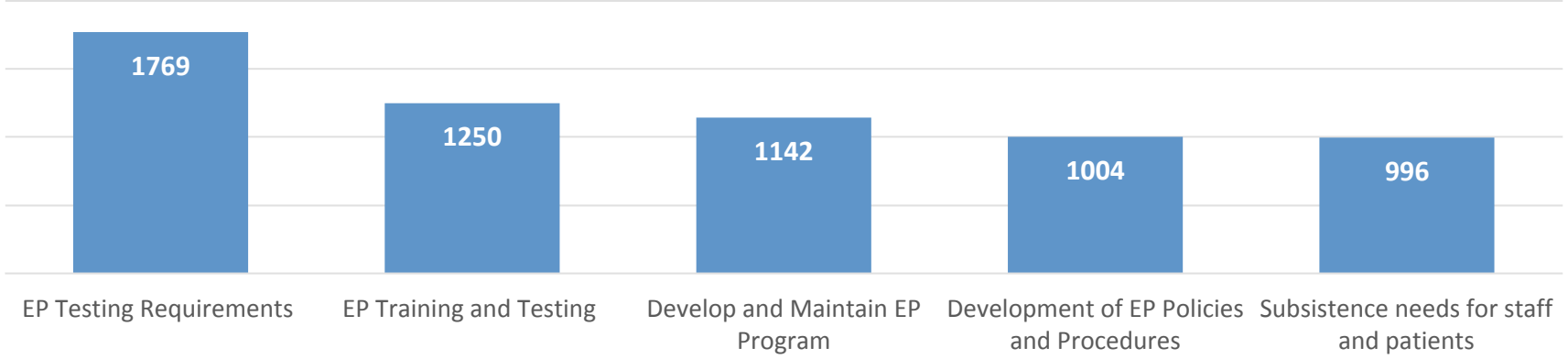
Note: Federally Qualified Health Centers were not surveyed during this time period.

Number of Healthcare Entities Surveyed that Received Citation by Provider Type (Nov 15, 2017 – Sept 30, 2018)



Total N= 6,251 (22%)

Top 5 National EP Citations
(Nov 15, 2017 – Sept 30, 2018)



EP Testing Requirements	• "Failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedure" • "Failed to provide documentation of participation in a community-based and tabletop drill"
EP Training and Testing	• "Failed to ensure EP training and testing for all staff was documented, reviewed and updated on an annual basis"
Develop and Maintain EP Program	• "Failed to develop and maintain an EP plan that was reviewed and updated at least annually" • "Failed to provide the annual review and update of their EP Program"
Development of EP Policies and Procedures	• "Failure to develop and implement policies and procedures that aligns with the hazards identified within the facility's risk assessment" • "Provided incomplete EP policies and procedures. This was evidenced by incomplete policies and procedures for disaster emergencies relating to sewage and waste disposal and the use of volunteers during a disaster scenario"
Subsistence needs for staff and patients	• The EPP did not include provisions for emergency food preparation, food service and water supply." • "Failed to provide documentation that the emergency preparedness plan address vendor contract agreements to provide provision of subsistence including food and water."

Top five national EP citations represent 31% (n=6,161) of the total number of citations (n=19,620).

Top 5 Citations by Providers (Nov 15, 2017 – Sept 30, 2018)

Nursing Facility	Intermediate Care Facility/Ind. with Intellectual Disabilities	Home Health Agency	End Stage Renal Disease Facility	Ambulatory Surgical Center
EP Training Program	Develop and Maintain EP Program	EP Testing Requirements	Dialysis Emergency Equipment	EP Testing Requirements
Develop and Maintain EP Program	EP Testing Requirements	EP Training Program	ESRD EP Training Program	Emergency Prep Training and Testing
Establishment of the Emergency Program	Emergency Prep Training and Testing	Policies and Procedures for Volunteers	EP Testing Requirements	Roles under a Waiver Declared by Secretary
Emergency Prep Training and Testing	Development of EP Policies and Procedures	Process for EP Collaboration	Process for EP Collaboration	Develop and Maintain EP Program
EP Testing Requirements	Development of Communication Plan	Maintain and Annual EP Updates	Emergency Prep Training and Testing	Development of Communication Plan
Rural Health Clinic	**Hospice**	**Hospital**	**Outpatient Physical Therapy/Speech Pathology**	**Comprehensive Outpatient Rehab Facility**
Development of EP Policies and Procedures	EP Training Program	EP Training Program	Policies and Procedures including Evacuation	Maintain and Annual EP Updates
Policies and Procedures for Volunteers	EP Testing Requirements	Subsistence needs for staff and patients	Process for EP Collaboration	Process for EP Collaboration
Emergency Prep Training and Testing	Maintain and Annual EP Updates	Develop and Maintain EP Program	EP Training Program	EP Training Program
Process for EP Collaboration	Names and Contact Information	Roles under a Waiver Declared by Secretary	Emergency Officials Contact Information	EP Testing Requirements
EP Training Program	Arrangement with other Facilities	Procedures for Tracking of Staff and Patients	Policies and Procedures for Volunteers	Development of Communication Plan

Highlighted citations indicate citations seen in 5 or more of the providers' top 5 citations list. Psychiatric Residential Treatment Facilities, Community Mental Health Centers, and Organ Procurement Organizations were not included in the table due to their low number of citations.

Training and Testing Program

- CMS has and will continue to reach out to local and state emergency officials to relay information on the EP Final Rule

- Challenges at state and local levels are:
  - Assisting multiple facilities in exercises with limited resources
  - Coordinating exercises relevant to facilities

- Risk Assessments & Compliant Training Exercises

The EP Final Rule & 1135 Waivers

- To be compliant with the requirement under the Emergency Preparedness Final Rule, facilities need to have a policy and procedure for addressing your facility's awareness of the 1135 waiver process.

- There is no specific form or document template for the policy or procedure to meet this requirement. Some elements that could be considered and reflected (but not limited to):
  - Facility role in providing care and treatment at alternate site – for example: equipment and supplies, command and control, staffing
  - Collaboration with local officials – proactive planning, pre-designated site? Predestinated roles, emergency credentialing procedures for providers to practice at alternate site (if waiver does not cover provider licensure)
  - The procedure for applying for an 1135 waiver and **contact information for Regional Office and State Survey Agency**.

Your Regional Offices

- **What is the role of CMS Regional Office 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.

Key Points

- State and Local Laws (must still comply)
- EP Final Rule does not take away any existing requirements
- Lessons Learned from Evacuations & Adherence to local/state mandates
- Strong and Effective Partnerships are Critical to Emergency Preparedness and Response
- Continue to analyze the data to ensure that we are learning from those areas that health care entities may continue to struggle with – to provide technical assistance and resources improving the preparedness of our healthcare system.

New Appendix Z Anticipated Changes

- Adding Emerging Infectious Diseases (guidance/recommendation only)
- Including New Citation References for Home Health Agencies
- Clarifications on use of portable generators:

- *Portable and mobile generators must:*
  - *Be connected to the facility electrical system through a compatible connecting device and transfer switch.*
  - *Be located where protected from damage during the course of an emergency.*
  - *Not be operated inside the facility, in an enclosed area such (e.g., garage, basement), or other location that would not allow for proper ventilation of the exhaust.*
  - *Not be located where exhaust from the engine would be brought into the facility through windows or other ventilation system intakes.*
  - *Not be located in proximity to the building where a generator fire could spread to the facility.*
  - *Be operated, tested and maintained in accordance with manufacturer, local and/or State requirements.*
  - *For requirements regarding permanently installed generators, please refer to existing Life Safety Code and NFPA guidance.*

Burden Reduction Proposed Rule

- CMS recently released the proposed Burden Reduction Rule for Non Long-Term Care

- The proposal asked for public feedback regarding changes to multiple areas, one being the requirements for EP (comment period closed 11/19)
  - Proposed Change to Documentation of collaboration with State and Local partners
  - Changes to frequency of updating from annual to bi-annual & as needed
  - Changes to training and Testing Requirements

- Proposed is not final. Facilities must continue to comply with the current requirements.

Resources for 1135 Waivers

- **Email Addresses for CMS Regional Offices:**
- 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.
- **Quality, Safety & Oversight Group 1135 Waiver Resource Website at:** https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers.html

Resources Available

- ASPR's TRACIE Website
  - Provider Checklists are available
  - Risk Assessment Examples

- CMS encourages facilities to use TRACIE to allow for some level of consistency in format & development of programs

- Our CMS Website https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html

Thank you!

SCGEmergencyPrep@cms.hhs.gov

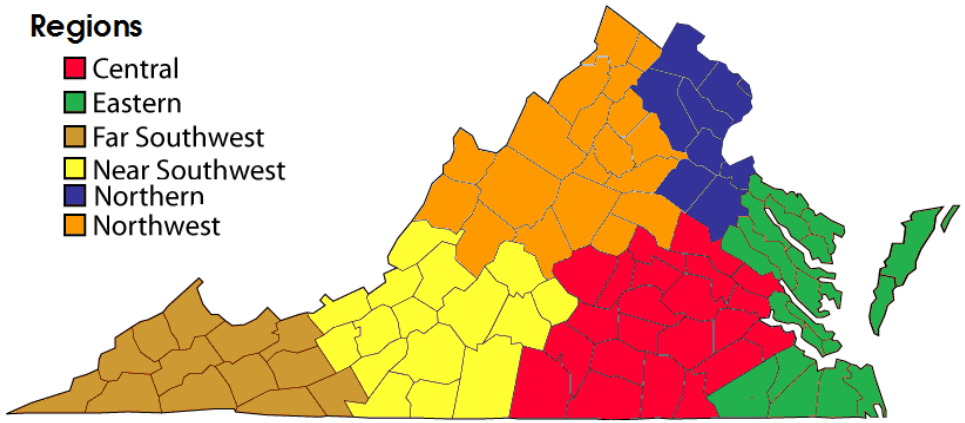
Virginia Healthcare Emergency Management Program

Learning from the CMS Emergency Preparedness Rule and Looking Forward

- Patrick Ashley, MS, MBA
- Patrick.Ashley@vdh.virginia.gov
- State Hospital Coordinator, Office of Emergency Preparedness, Virginia Department of Health

Virginia's System

- 6 Healthcare Coalitions
  - Mirror Public Health Regions
- COALITION Staff
  - Regional Healthcare Coordinator
  - RHCC Manager
  - Vulnerable Populations Coordinator
- Coalition Membership
  - HPP Core Membership
  - Additional Required: Long Term Care
  - Dialysis strongly encouraged



EVHC Eastern Virginia Healthcare Coalition

SW VA HOSPITAL

NSPA NEAR SOUTHWEST PREPAREDNESS ALLIANCE

NORTHWEST REGION HEALTHCARE COALITION NWRHC

CVHC CENTRAL VIRGINIA HEALTHCARE COALITION

NVHA Northern Virginia Hospital Alliance

Virginia's System, Continued

- 24/7 RHCC Activation
- Common Situational Awareness Product

Virginia's System, Continued

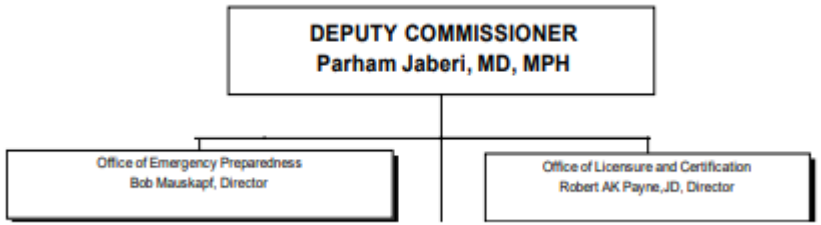
VDH

CMS Survey Agency

- VDH Office of Licensure and Certifications

HPP/PHEP Awardee

- VDH Office of Emergency Preparedness



Virginia Emergency Support Team

- VDEM
- VSP / VDOT
- VDH
- National Guard

What does the CMS rule mean to me?

Facilities

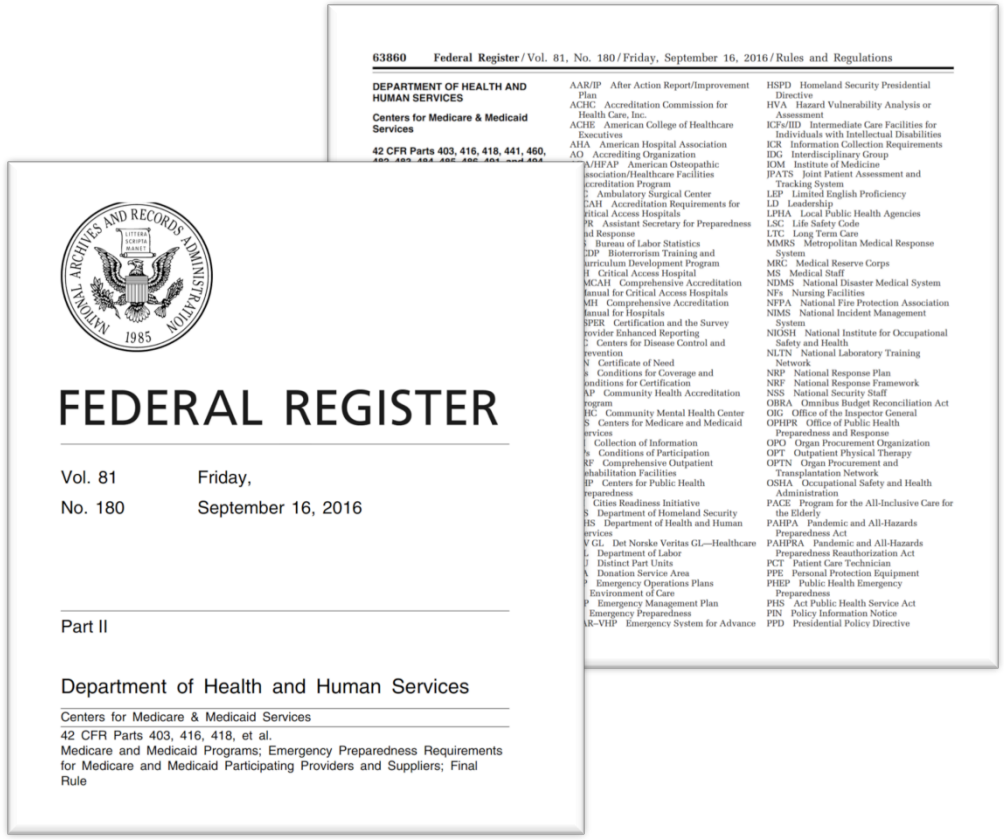
Emergency Managers

Public Health

Fire Department

EMS

Random People Off the Street!



63860 Federal Register / Vol. 81, No. 180 / Friday, September 16, 2016 / Rules and Regulations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 416, 418, 441, 460,

AAR/IP After Action Report/Improvement Plan
ACHC Accreditation Commission for Health Care, Inc.
ACHE American College of Healthcare Executives
AHA American Hospital Association
AO Accrediting Organization
A/HFAP American Osteopathic
ssociation/Healthcare Facilities
ccreditation Program
Ambulatory Surgical Center
CAH Accreditation Requirements for
itical Access Hospitals
PR Assistant Secretary for Preparedness
d Response
Bureau of Labor Statistics
CDP Bioterrorism Training and
urriculum Development Program
H Critical Access Hospital
MCAH Comprehensive Accreditation
anual for Critical Access Hospitals
MH Comprehensive Accreditation
anual for Hospitals
SPER Certification and the Survey
rovider Enhanced Reporting
Centers for Disease Control and
revention
N Certificate of Need
s Conditions for Coverage and
onditions for Certification
AP Community Health Accreditation
rogram
HC Community Mental Health Center
S Centers for Medicare and Medicaid
ervices
Collection of Information
s Conditions of Participation
RF Comprehensive Outpatient
ehabilitation Facilities
P Centers for Public Health
reparedness
Cities Readiness Initiative
S Department of Homeland Security
HS Department of Health and Human
ervices
V GL Det Norske Veritas GL—Healthcare
L Department of Labor
Distinct Part Units
A Donation Service Area
Emergency Operations Plans
Environment of Care
P Emergency Management Plan
Emergency Preparedness
AR-VHP Emergency System for Advance
HSPD Homeland Security Presidential Directive
HVA Hazard Vulnerability Analysis or Assessment
ICFs/IID Intermediate Care Facilities for Individuals with Intellectual Disabilities
ICR Information Collection Requirements
IDG Interdisciplinary Group
IOM Institute of Medicine
JPATS Joint Patient Assessment and Tracking System
LEP Limited English Proficiency
LD Leadership
LPHA Local Public Health Agencies
LSC Life Safety Code
LTC Long Term Care
MMRS Metropolitan Medical Response System
MRC Medical Reserve Corps
MS Medical Staff
NDMS National Disaster Medical System
NFs Nursing Facilities
NFPA National Fire Protection Association
NIMS National Incident Management System
NIOSH National Institute for Occupational Safety and Health
NLTN National Laboratory Training Network
NRP National Response Plan
NRF National Response Framework
NSS National Security Staff
OBRA Omnibus Budget Reconciliation Act
OIG Office of the Inspector General
OPHPR Office of Public Health Preparedness and Response
OPO Organ Procurement Organization
OPT Outpatient Physical Therapy
OPTN Organ Procurement and Transplantation Network
OSHA Occupational Safety and Health Administration
PACE Program for the All-Inclusive Care for the Elderly
PAHPA Pandemic and All-Hazards Preparedness Act
PAHPRA Pandemic and All-Hazards Preparedness Reauthorization Act
PCT Patient Care Technician
PPE Personal Protection Equipment
PHEP Public Health Emergency Preparedness
PHS Act Public Health Service Act
PIN Policy Information Notice
PPD Presidential Policy Directive

NATIONAL ARCHIVES AND RECORDS ADMINISTRATION 1985

FEDERAL REGISTER

Vol. 81 Friday,
No. 180 September 16, 2016

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

VDH VIRGINIA DEPARTMENT OF HEALTH

Initial Questions

How many facilities are we talking about?

What do facilities need to know?

What do partners need to know?

What do partners need to do?

What can we do to help?

Opportunity

Three Groups of Facilities

~~Hospitals~~*

In-Patient/Residential Providers

Dialysis Providers

Outpatient Providers

Identify **YOUR** Priorities

It's OK To Say No.

Take the Show on the Road

Meet Them Where They're Already At.

Education Sessions

- Local Emergency Managers
- Facility Groups
- Public Health
- Virginia Emergency Management Association
- Virginia Healthcare Association
- Leading Age
- Regional Groups
- Surveyors

Facility Education

What does Emergency Management actually mean?

What does the regulation ACTUALLY say?

How do I do this?

Can you hold my hand?

Can you do it for me?

Consulting

For those facilities that just can’t or wont.

Exercises

The 3 PM Phone Call.

Understanding what the rule says.

Regional Exercises.

Partnering with Existing Exercises.

Surveyor Education

Surveyor Training / Priorities.

What's the number to FEMA?

Two Way Dialogue.

- Funnel Facilities to Coalition for TA
- Event Notification

Joint Surveyor / EP Training.

Stakeholder Education

Why are these facilities calling me?

Can you make it stop?

Why do I want to engage with these facilities?

What can the coalition do to help?

Training

Hazard Vulnerability Analysis.

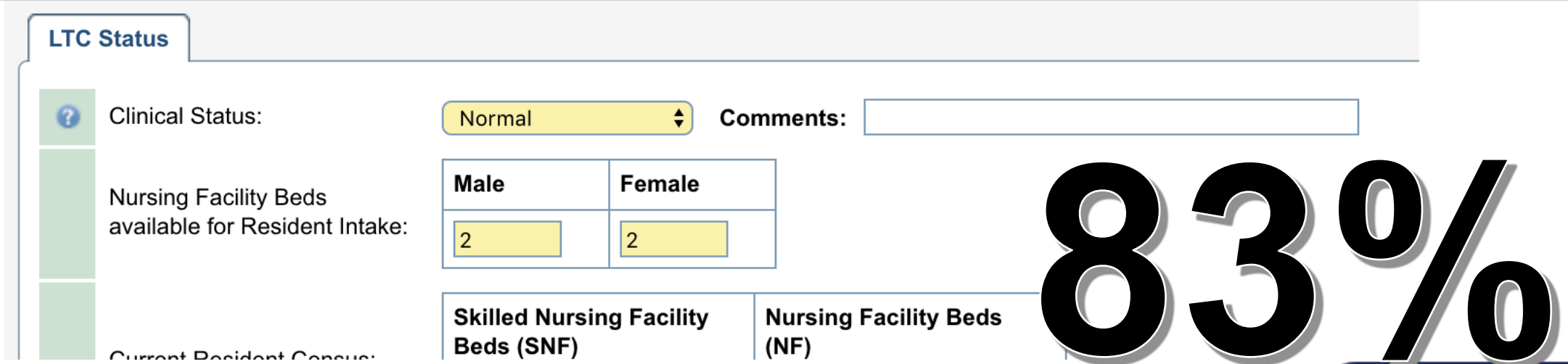
Brings people together. The topic doesn't really matter as long as it's interesting and starts a dialogue.

Respect their time. Bring food.

Interdisciplinary whenever possible.

Information Sharing

Organization Name	Jurisdiction	Clinical Status	Emer. Ops Status	ECC Status	Facility / Evac Status	Security Status	Resource Staffing	Facility Supplies	Clinical Supplies	Last Update
Near Southwest										
Alleghany Health & Rehab	Clifton Forge (Town)	Normal	Inactive	Inactive	Normal	Normal	Adequate	Adequate	Adequate	10/23/2018 12:10 PM
Appomattox Health & Rehabilitation Center	Appomattox	Normal	Inactive	Inactive	Normal	Normal	Adequate	Adequate	Adequate	10/24/2018 09:04 AM



83%

Evacuate or stay? For nursing homes in storm's path, the decision isn't easy

"You're damned if you do and you're damned if you don't," said a researcher who found evacuating increases the likelihood of death 90 days after a storm.

Norfolk nursing home evacuates ahead of Florence

Consulate Health Care started moving its residents to a safer lo on Wednesday morning.

Author: Laura Geller
Published: 12:43 PM EDT September 12, 2018
Updated: 3:44 PM EDT September 13, 2018

Nursing ho

With the Hurricane Florence Zone A evacuation n
Convalescent Center Mathews had to be evacuat
spokesperson Shannon Fedors. Throughout last
came together and moved their 60 residents to ot

According to Fedors, 25 members of the team we
Mathews residents while they were at each facilit

NORFOLK, Va. (WVEC) — Some of Norfolk's most vulnerable citizens have been moved out of
ahead of Hurricane Florence.

What did we learn?

- Full time "Medically Vulnerable Populations Coordinator" responsible for engaging these groups and getting face time in front of facility decision-makers. **Can't be other duties as assigned**.
- Annual regional exercise opportunities (tabletop and full scale).
- CMS providers often reach out to us following a negative survey or in preparation for a survey when they realize they are behind the ball.
- Quarterly MVP meetings/workshops on relevant emergency preparedness topics
- MVP representation on coalition executive board.
- Disclaimers.

What did we learn?

- These facilities are not hospitals and have different needs
- Many of these facilities are where hospitals were 20 years ago.
- Bringing emergency management and public health to the table as these discussions occur is also a feather in the cap for everyone. It lends credibility to the HCC and ensures engagement from other critical partners in the community's emergency response system.
- Make them sign an MOU with activities defined.
- Like to Like Collaboration and Mutual Aid.
- Engagement of Survey Agency is key.

ASPR's Technical Resources, Assistance Center, & Information Exchange

Shayne Brannman, MS, ASPR TRACIE Program Director

ASPR TRACIE: Three Domains

TECHNICAL RESOURCES

- Self-service collection of audience-tailored materials
- Subject-specific, SME-reviewed “Topic Collections”
- Unpublished and SME peer-reviewed materials highlighting real-life tools and experiences

ASSISTANCE CENTER

- Personalized support and responses to requests for information and technical assistance
- Accessible by toll-free number (1844-5-TRACIE), email (askasprtracie@hhs.gov), or web form (ASPRtracie.hhs.gov)

INFORMATION EXCHANGE

- Area for password-protected discussion among vetted users in near real-time
- Ability to support chats and the peer-to-peer exchange of user-developed templates, plans, and other materials

asprtracie.hhs.gov

1-844-5-TRACIE

askasprtracie@hhs.gov

ASPR TRACIE–Developed Resources

Since ASPR TRACIE's launch in 2015, our staff and Subject Matter Expert Cadre have developed resources to support healthcare system preparedness, public health preparedness, and disaster clinical professionals plan for, respond to, and recover from all hazards disasters and emergencies. This page provides a comprehensive list with hyperlinks to all ASPR TRACIE-developed materials.

Administrative/General

ASPR TRACIE Fact Sheet
CMS Resource Page
Full List of Topic Collections
Select Health Care Coalition Resources
Select Hurricane-Related Resources
Select Infectious Disease Resources
Select Mass Violence Resources
Select Materials on Drug Shortages and Scarce Resources
Summary of TA Requests

Completed Topic Collections

Access and Functional Needs Topic Collection
Alternate Care Sites (including shelter medical care)
Ambulatory Care and Federally Qualified Health Centers Topic Collection
Burn
Coalition Administrative Issues

Tools and Templates

EMS Infectious Disease Playbook
Health Care Coalition Pandemic Checklist
Health Care Coalition Preparedness Plan
Health Care Coalition Resource and Gap Analysis Tool
Healthcare Coalition Resource and Gap Analysis Aggregator
Health Care Coalition Response Plan
Health Care Coalition Surge Test Tool
Hospital Pharmacy Disaster Calculator

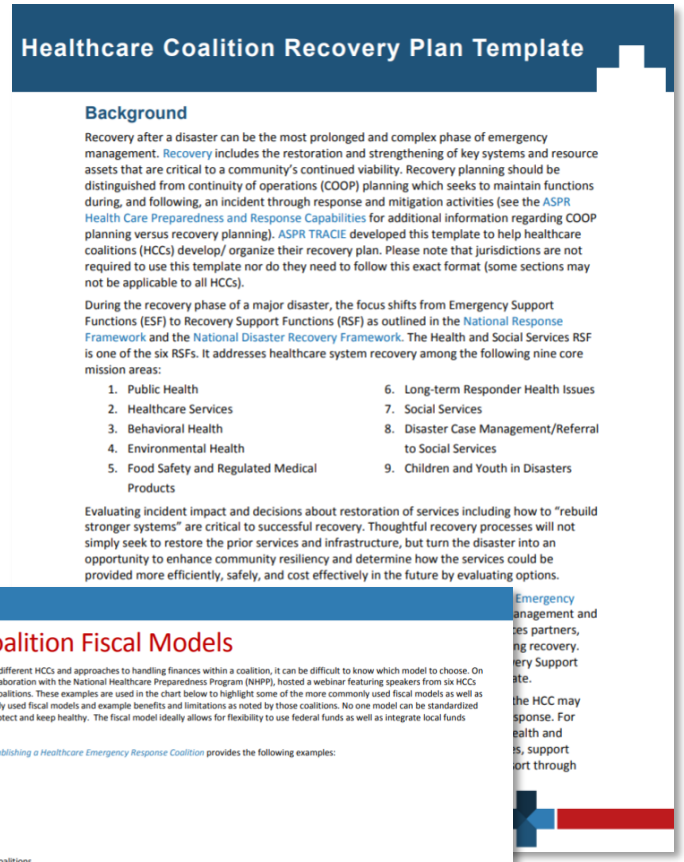
Website Tutorials

ASPR TRACIE Assistance Center
ASPR TRACIE Rating, Commenting On, and Saving Resources
ASPR TRACIE Technical Resources
ASPR TRACIE User Experience and Dashboard
Tips for Navigating the Information Exchange

ASPRtracie.hhs.gov/tracie-resources

Healthcare Coalition Resource Examples

- Coalition Administrative Issues TC
- Coalition Models and Functions TC
- Coalition Response Operations TC
- General Overview of Healthcare Coalitions
- HCC Fiscal Models
- HCC Preparedness Plan
- HCC Recovery Plan Template
- HCC Resource and Gap Analysis Aggregator
- HCC Resource and Gap Analysis Tool
- HCC Response Plan
- HCC Pandemic Checklist
- HCC Select Resources Page
- HCC Webinar Series



Healthcare Coalition Recovery Plan Template

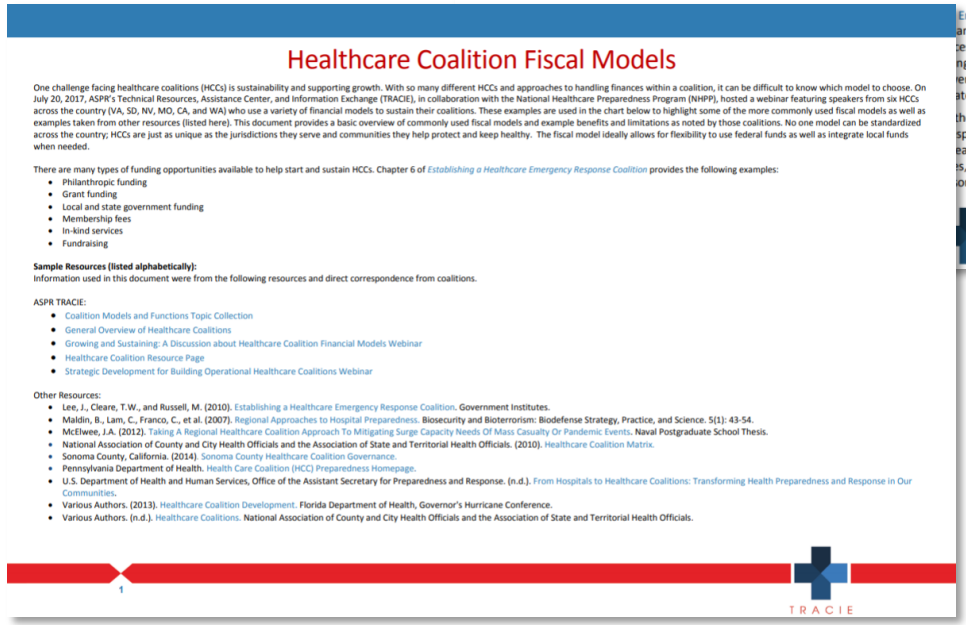
Background

Recovery after a disaster can be the most prolonged and complex phase of emergency management. Recovery includes the restoration and strengthening of key systems and resource assets that are critical to a community's continued viability. Recovery planning should be distinguished from continuity of operations (COOP) planning which seeks to maintain functions during, and following, an incident through response and mitigation activities (see the ASPR Health Care Preparedness and Response Capabilities for additional information regarding COOP planning versus recovery planning). ASPR TRACIE developed this template to help healthcare coalitions (HCCs) develop/ organize their recovery plan. Please note that jurisdictions are not required to use this template nor do they need to follow this exact format (some sections may not be applicable to all HCCs).

During the recovery phase of a major disaster, the focus shifts from Emergency Support Functions (ESF) to Recovery Support Functions (RSF) as outlined in the National Response Framework and the National Disaster Recovery Framework. The Health and Social Services RSF is one of the six RSFs. It addresses healthcare system recovery among the following nine core mission areas:

1. Public Health
2. Healthcare Services
3. Behavioral Health
4. Environmental Health
5. Food Safety and Regulated Medical Products
6. Long-term Responder Health Issues
7. Social Services
8. Disaster Case Management/Referral to Social Services
9. Children and Youth in Disasters

Evaluating incident impact and decisions about restoration of services including how to "rebuild stronger systems" are critical to successful recovery. Thoughtful recovery processes will not simply seek to restore the prior services and infrastructure, but turn the disaster into an opportunity to enhance community resiliency and determine how the services could be provided more efficiently, safely, and cost effectively in the future by evaluating options.



Healthcare Coalition Fiscal Models

One challenge facing healthcare coalitions (HCCs) is sustainability and supporting growth. With so many different HCCs and approaches to handling finances within a coalition, it can be difficult to know which model to choose. On July 20, 2017, ASPR's Technical Resources, Assistance Center, and Information Exchange (TRACIE), in collaboration with the National Healthcare Preparedness Program (NHPP), hosted a webinar featuring speakers from six HCCs across the country (VA, SD, NV, MO, CA, and WA) who use a variety of financial models to sustain their coalitions. These examples are used in the chart below to highlight some of the more commonly used fiscal models as well as examples taken from other resources (listed here). This document provides a basic overview of commonly used fiscal models and example benefits and limitations as noted by those coalitions. No one model can be standardized across the country; HCCs are just as unique as the jurisdictions they serve and communities they help protect and keep healthy. The fiscal model ideally allows for flexibility to use federal funds as well as integrate local funds when needed.

There are many types of funding opportunities available to help start and sustain HCCs. Chapter 6 of *Establishing a Healthcare Emergency Response Coalition* provides the following examples:

- Philanthropic funding
- Grant funding
- Local and state government funding
- Membership fees
- In-kind services
- Fundraising

Sample Resources (listed alphabetically):
Information used in this document were from the following resources and direct correspondence from coalitions.

ASPR TRACIE:

- Coalition Models and Functions Topic Collection
- General Overview of Healthcare Coalitions
- Growing and Sustaining: A Discussion about Healthcare Coalition Financial Models Webinar
- Healthcare Coalition Resource Page
- Strategic Development for Building Operational Healthcare Coalitions Webinar

Other Resources:

- Lee, J., Cleare, T.W., and Russell, M. (2010). Establishing a Healthcare Emergency Response Coalition. Government Institutes.
- Maldin, B., Lam, C., Franco, C., et al. (2007). Regional Approaches to Hospital Preparedness. Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science. 5(1): 43-54.
- McElwee, J.A. (2012). Taking A Regional Healthcare Coalition Approach To Mitigating Surge Capacity Needs Of Mass Casualty Or Pandemic Events. Naval Postgraduate School Thesis.
- National Association of County and City Health Officials and the Association of State and Territorial Health Officials. (2010). Healthcare Coalition Matrix.
- Sonoma County, California. (2014). Sonoma County Healthcare Coalition Governance.
- Pennsylvania Department of Health. Health Care Coalition (HCC) Preparedness Homepage.
- U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. (n.d.). From Hospitals to Healthcare Coalitions: Transforming Health Preparedness and Response in Our Communities.
- Various Authors. (2013). Healthcare Coalition Development. Florida Department of Health, Governor's Hurricane Conference.
- Various Authors. (n.d.). Healthcare Coalitions. National Association of County and City Health Officials and the Association of State and Territorial Health Officials.

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Technical Assistance Trends

Top Technical Assistance Request Topics

- CMS EP Rule*
- Natural Disaster
- Zika
- Crisis Standards of Care
- Healthcare Coalitions
- Radiological/Nuclear
- VHF/Ebola
- HVA/Risk Assessment
- Cybersecurity
- Mental/Behavioral Health

*This category overlaps with a variety of technical assistance topics (e.g., emergency and communications planning, evacuation, and exercises).

Who Requests Technical Assistance

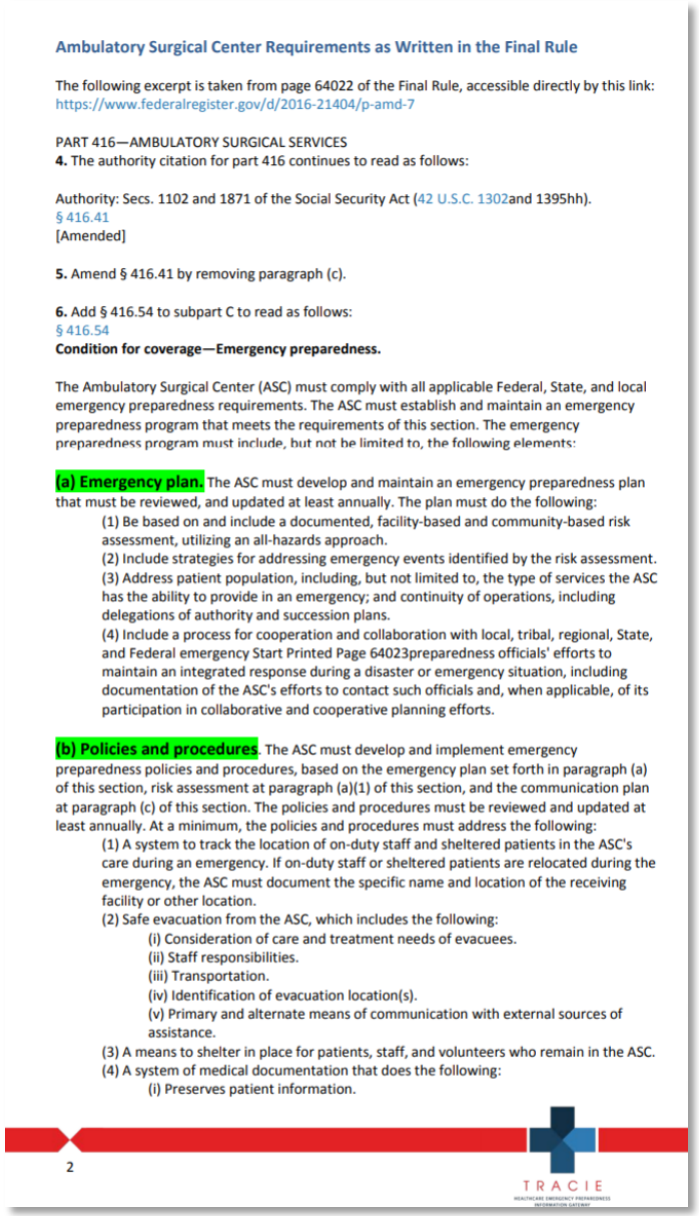
Federal Government	Private Healthcare Entity	HCC/Other	State/HPP Awardee	Local Government
36%	23%	20%	14%	7%

Our Subject Matter Experts

Healthcare	Federal	S&L Govt.	Private/ Non-Profit	EM/First Responder	Academia
37%	35%	15%	6%	4%	3%

ASPR TRACIE CMS EP Rule Resource Examples

- CMS EP Rule Resource Page
- CMS and Disasters: Resources at Your Fingertips
- CMS EP Rule General Briefing Slides
- Integrated Healthcare Systems Implications
- Provider and Supplier Types Covered by the EP rule Facility-Specific Requirement Overviews
- EP Rule Citation Analysis Project



Ambulatory Surgical Center Requirements as Written in the Final Rule

The following excerpt is taken from page 64022 of the Final Rule, accessible directly by this link: https://www.federalregister.gov/d/2016-21404/p-amd-7

PART 416—AMBULATORY SURGICAL SERVICES
4. The authority citation for part 416 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302and 1395hh).
§ 416.41
[Amended]

5. Amend § 416.41 by removing paragraph (c).

6. Add § 416.54 to subpart C to read as follows:
§ 416.54
Condition for coverage—Emergency preparedness.

The Ambulatory Surgical Center (ASC) must comply with all applicable Federal, State, and local emergency preparedness requirements. The ASC must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

(a) Emergency plan. The ASC must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
(2) Include strategies for addressing emergency events identified by the risk assessment.
(3) Address patient population, including, but not limited to, the type of services the ASC has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency Start Printed Page 64023preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the ASC's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

(b) Policies and procedures. The ASC must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:
(1) A system to track the location of on-duty staff and sheltered patients in the ASC's care during an emergency. If on-duty staff or sheltered patients are relocated during the emergency, the ASC must document the specific name and location of the receiving facility or other location.
(2) Safe evacuation from the ASC, which includes the following:
(i) Consideration of care and treatment needs of evacuees.
(ii) Staff responsibilities.
(iii) Transportation.
(iv) Identification of evacuation location(s).
(v) Primary and alternate means of communication with external sources of assistance.
(3) A means to shelter in place for patients, staff, and volunteers who remain in the ASC.
(4) A system of medical documentation that does the following:
(i) Preserves patient information.

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ASPR TRACIE and the CMS EP Rule Analysis Project

- ASPR TRACIE created a baseline EP Rule reporting template that will be routinely updated and monitored
- Continue identifying ways to strengthen emergency preparedness, response, and recovery efforts at all levels
- Hone future technical assistance efforts, based on identified knowledge gaps
- Continue highlighting geographic variances
- Continue to be a force multiplier and thought leader
- Listen (and act upon) feedback
  - ✓ *How can we enhance the reporting template*?
- Keep pushing the envelope, with our partners, so we can all learn together

Contact Us

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Audience Discussion and Q&A