

PART 403--SPECIAL PROGRAMS AND PROJECTS

1. The authority citation for part 403 continues to read as follows:

Authority: 42 U.S.C. 1395b-3 and Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§403.742 [Amended]

2. Amend §403.742 by--

- a. Removing paragraphs (a)(1), (4), and (5).
- b. Re-designating paragraphs (a)(2) and (3) as paragraphs (a)(1) and (2), respectively.
- c. Re-designating paragraphs (a)(6) through (8) as paragraphs (a)(3) through (5), respectively.

3. Add § 403.748 to read as follows:

§ 403.748 Condition of participation: Emergency preparedness.

The Religious Nonmedical Health Care Institution (RNHCI) must comply with all applicable Federal, State, and local emergency preparedness requirements. The RNHCI 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:

Tip #1 – When developing your emergency response plans, write them as if the person reading the plan knows nothing about your organization, the larger community, or your specific facility. Assume everyone who’s familiar with your operations are unavailable and the response actions are handled by others totally unaware of your circumstances.

- ***Include the name, address, and contact information for all key partners.***
- ***Ensure your local emergency management agency name, address, phone numbers, email address, and GIS coordinates (if you can get them) are included.***
- ***Include contact information and other details for your local health & medical lead agency (ESF8). This is usually the local public health department.***
- ***Ensure these contact names, addresses and contact information is verified at least annually***
- ***Be as specific as possible with every detail***

(A) Emergency Plan

The RNHCI must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of 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, persons at-risk; the type of services the RNHCI has the ability to provide in an emergency; and, continuity of operations, including delegations of authority and succession plans.

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(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the RNHCI's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

Tip #2 – We recommend ensuring the above elements are included in a Comprehensive Emergency Management Plan (CEMP). These types of documents are standard among most healthcare organizations in Florida. Contact the Tampa Bay Health & Medical Preparedness Coalition (TBHMPC) if you need assistance developing your CEMP.

Tip#3 – The TBHMPC already performs a regional hazard vulnerability assessment every year. We recommend using our hazard assessment as a basis for your internal risk assessment. Remember to include specific threats or hazards that your facility or specific location pose to your operations. These risk assessments are intended to formally identify the types and severity of weather or other potential disasters present in your local community. Having these details available gives your staff the threats they need to plan for.

Tip #4 – TBHMPC requires all “members in good standing” to sign a Memorandum of Agreement (MOA) committing the organization to helping / supporting / assisting other members during disasters. This MOA should be included as a strategy for addressing emergency events. It also means your organization should have a signed MOA on file with TBHMPC. If not, contact us to get that process started.

Tip #5 – Your organization’s active participation in the TBHMPC should be mentioned to specifically explain paragraph (4) above. The TBHMPC is established specifically to focus on the areas and functions mentioned above.

(B) Policies and Procedures

The RNHCI 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) The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
 - (i) Food, water, and supplies.
 - (ii) Alternate sources of energy to maintain the following:
 - (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
 - (B) Emergency lighting.
 - (C) Fire detection, extinguishing, and alarm systems.
 - (D) Sewage and waste disposal.

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Tip #6 – Most Florida based residential healthcare facilities already have a process in place to ensure there's ample food and water available in your facility to support patients and staff during tropical weather threats or events. Ensure these specific details are included in your plan. Make sure every vendor you use for food or other critical services is included in the plan and their full contact information. If your organization only has a primary vendor for a critical support service we recommend seeking a back-up vendor from an area outside the local area to ensure they're operational when you need them.

- (2) A system to track the location of on-duty staff and sheltered patients in the RNHCI's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the RNCHI must document the specific name and location of the receiving facility or other location.

Tip #7 – A “system to track the location of on-duty staff and sheltered patients” could be as simple as pen and paper, a hand-written form, or a laptop based spreadsheet. The important factor is that you have a reliable and robust process to track the location and assignments of on-duty staff and patients. This process is necessary to ensure the safety and health of ALL patients and staff. It also gives your leadership quick access to this information in case of an unforeseen emergency.

- (3) Safe evacuation from the RNHCI, which includes the following:
- (i) Consideration of care 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.

Tip #8 – If you had to evacuate your facility, how would you ensure patients were sent to the appropriate level of care? Can some patients be transferred to other RNHCI's, other long term care facilities, or would any patients need hospitalization? If so, which ones? Which patients could be moved using buses of some description and which patients need ambulance transport? How do you know which type of transportation is needed? Would your staff accompany the patients? If yes, which staff go to which facility? Typically, staff want to know where they might have to evacuate to in advance. Have you exercised this process with your ESF8 lead agency, emergency management, your local EMS agency, and local ambulance companies? Ensure ALL of these details are included in your CEMP and the full contact information for each outside partner is also included. If you need assistance, contact the TBHMPC.

- (4) A means to shelter in place for patients, staff, and volunteers who remain in the facility.

Tip #9 – Be specific about the locations within your facility where you would shelter-in-place. Don't assume the people reading your plan know where these sites or areas are. We recommend including a map of your building and / or campus showing specific shelter-in-place locations. Include this map in your CEMP.

- (5) A system of care documentation that does the following:
- (i) Preserves patient information.
 - (ii) Protects confidentiality of patient information.
 - (iii) Secures and maintains the availability of records.

Tip #10 – Consider how your staff would access electronic medical records if you lost both primary and back-up electrical power (this advice comes from recent real-world experience). Do your staff know how to complete paper medical records? Are there emergent procedures in-place to perform manual or paper patient charts? How would you medically transfer patients to another facility if there were no medical records available to send with the patient? How would you ensure these temporary paper records were maintained in a secure manner? Lastly, how would you incorporate any information updates from these paper records into the patient’s permanent electronic record once the emergency was over?

Tip #11 – If time permits, consider loading the patient’s medical records in .pdf format onto a jump drive and placing that drive around their neck with a lanyard. This will allow the patient’s records to travel with them during an evacuation and will ensure staff at a receiving facility can access those records. Take safeguards to ensure these jump drives are protected since they will contain very personal information about your patients.

- (6) The use of volunteers in emergency and other emergency staffing strategies to address surge needs during an emergency.

Tip #12 – Do you have the means to provide emergency credentialing to volunteers? Is there a system in-place to provide oversight to these volunteers? Would a Federal or State level disaster declaration change your volunteer credentialing? It’s best to have these issues answered in advance, and have them detailed in your CEMP, so your staff isn’t faced with addressing these challenges when the stakes are highest.

- (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of nonmedical services to NHCI patients.

Tip #13 – As mentioned in Tip #4 above, the TBHMPC already requires “members in good standing” to sign an MOA committing to helping / assisting each other during emergencies. This MOA could be referenced as one element to address paragraph (7) above. RNHCIs within larger corporate structures can also cite internal policies and procedures that require them to assist and support each other as evidence toward this CMS rule requirement.

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- (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternate care site identified by emergency management officials.

Tip #14 – The Florida Department of Health has developed an Alternate Treatment Site (ATS) plan that's designed to support any ATS operation at any location. Plus, there are State Medical Response Teams (SMRTs) across the state with volunteer staff and equipment capable of setting up a mobile hospital in a parking lot on your campus or nearby. The issue for RNHCI's to consider is the liability and volunteer credentialing (see Tip #12 above). These details together with recommended locations for an ATS should be addressed in detail in your CEMP.

(C) Communication Plan

The RNHCI must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least **annually**. The communication plan must include all of the following:

- (1) Names and contact information for the following:
- (i) Staff.
 - (ii) Entities providing services under arrangement.
 - (iii) Next of kin, guardian or custodian.
 - (iv) Other RNHCIs.
 - (v) Volunteers.

Tip #15 – Be specific and include these details in your CEMP. Ensure they are verified and updated at least annually. "Entities providing services" typically means any and all outside vendors that support your internal operations. This includes those providing direct patient care, maintenance and repair vendors, and the vendor that picks up the trash, food vendors, and all others.

- (2) Contact information for the following:
- (i) Federal, State, tribal, regional, and local emergency preparedness staff.
 - (ii) Other sources of assistance.

Tip #16 – See Tip 15 above.

- (3) Primary and alternate means for communicating with the following:
- (i) RNHCI's staff.
 - (ii) Federal, State, tribal, regional, and local emergency management agencies.

Tip #17 – Telephones and cell phones are probably your primary and back-up communication methods. What if they're not functioning? We recommend a third level of emergent communication capability. If all other options fail, sending a runner is still viable option.

- (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.

Tip #18 – See Tips #10 and #11 above.

- (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).

Tip #19 – See Tips #10 and #11 above.

- (6) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).

Tip #20 – See Tip #7 above.

- (7) A means of providing information about the RNHCI's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

Tip #21 – Contact your local emergency management agency and / or the local health & medical lead agency (usually the local health department) to determine the process they use to address this requirement. Include the details of this process and any contact information in your CEMP.

(D) Training and Testing

The RNHCI must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least **annually**.

Tip #21 – In Florida we refer to “training and testing” as training and exercises or drills. CMS has clearly indicated they want to see robust training and disaster drills of ALL healthcare facility staff. This includes staff who work nights and weekends. Ensure your facility maintains detailed records on ALL training and testing activities.

Tip #22 – Additionally, CMS is also expecting to see executives (CEOs, COOs, CNOs, and other senior leadership) DIRECTLY involved in training and drills. Ensure After Action Reports from emergency drills include detailed specifics on any senior executive involvement in that drill.

Tip #23 – Ensure all real-world emergencies and training drills are documented using the Homeland Security Exercise and Evaluation Program (HSEEP) standards and formats. If your facility is unaware of the HSEEP process contact the TBHMPC for assistance and training on the details. Using the HSEEP processes will show great benefit when CMS, ACHA, or accrediting agencies review your records.

- (1) **Training program.** The RNHCI must do all of the following:
- (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
 - (ii) Provide emergency preparedness training at least annually.
 - (iii) Maintain documentation of all emergency preparedness training.
 - (iv) Demonstrate staff knowledge of emergency procedures.

Tip #24 – We recommend incorporating the above training into your new-hire and annual training processes. Documentation should include details (by name) of who participated in the training and what they were trained on. The term “demonstrate staff knowledge of emergency procedures” can be accomplished by ensuring 100% of staff are directly involved in emergency drills. To accomplish a 100% participation in emergency drills will require having more than 2 drills per year and performing those drills at different times of the day (for all shifts) and on different days of the week to catch all work schedules.

- (2) **Testing.** The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:
- (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan

Tip #25 – Actively seek opportunities to participate in community-wide exercises and drills. These events are typically designed and executed by others. Plus, they’ll involve a wider range of community partners that a single facility can recruit.