PART 460—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

12. The authority citation for part 460 continues to read as follows:

Authority: Secs: 1102, 1871, 1894(f), and 1934(f) of the Social Security Act (42 U.S.C. 1302, 1395, 1395eee(f), and 1396u-4(f)).

§ 460.72 [Amended]

13. Amend § 460.72 by removing and reserving paragraph (c).

14. Add § 460.84 to subpart E to read as follows:

§ 460.84 Emergency preparedness.

The Program for the All-Inclusive Care for the Elderly (PACE) organization must comply with all applicable Federal, State, and local emergency preparedness requirements. The PACE organization 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 target audience 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)***
- ***Ensure these contact names, addresses and contact information is verified at least annually***
- ***Be as specific as possible with every detail***
- ***Due to the sensitivity of information contained in your disaster plans treating these documents as proprietary is acceptable***
- ***Lastly, gathering the necessary details to fully develop your disaster plan will take time and much effort. We recommend working diligently to fully develop your disaster plan.***

(A) Emergency Plan

The PACE organization 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 participant population, including, but not limited to, the type of services the PACE organization 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 preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the PACE's efforts to contact such officials and, when applicable, of its participation in organization's collaborative and cooperative planning efforts.

Tip #2 –Many Florida-based healthcare organizations already have a disaster plan due to our constant hurricane threats. These plans are typically called Comprehensive Emergency Management Plans (CEMP). We recommend ensuring the above elements are included in your existing CEMP, if you have one. There's no need to create a completely new response plan to satisfy these CMS requirements. However, if your agency does not have a CEMP (or similar) these new CMS Rules will require the development of one.

Tip#3 – The Tampa Bay Health & Medical Preparedness Coalition (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.

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 PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. 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 participants, whether they evacuate or shelter in place, include, but are not limited to the following:
   (i) Food, water, and medical supplies.
   (ii) Alternate sources of energy to maintain the following:

(A) Temperatures to protect participant 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.

Tip #6 – If your organization provides food, water, or other subsistence needs to clients / patients then include extremely specific details in your CEMP on how this process would work during a tropical weather event.

Tip #7 – if your organization does not provide food, water, or other subsistence needs to client / patients, then explain those details in your CEMP.

Tip #8 – Florida operates a robust Special Needs Sheltering program specifically for vulnerable populations to use during tropical weather events or other emergencies. Special Needs Shelters are specifically designed and organized to support the needs of frail, elderly, or vulnerable populations living within the local community. These programs require pre-registration with the local emergency management agency or health department and have limitations of the level of medical care they can provide. Also, the specifics for this pre-registration are different in each county. We strongly recommend your PACE organization ensure the client, their family members, or legal guardians are fully aware of this pre-registration process and the benefits. Contact the local emergency management agency or the preparedness office at your local health department for more information and to begin the pre-registration process.

(2) A system to track the location of on-duty staff and sheltered participants under the PACE center(s) care during and after an emergency. If on-duty staff and sheltered participants are relocated during the emergency, the PACE must document the specific name and location of the receiving facility or other location.

Tip #9 – 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 you quick access to this information in case of an unforeseen emergency.

Tip #10 – If your agency does not allow or support sheltering of client / patients or staff during tropical weather events ensure this detail is clearly explained in your CEMP. You'll also need to identify steps taken to protect the safety of clients / patients during tropical weather events. See Tip #8 above for more.

(3) Safe evacuation from the PACE center, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

Tip #11 – If you had to evacuate your facility, how would you ensure clients / patients were sent to the appropriate level of care? Can some individuals be transferred to a

Skilled Nursing Facility, long term care facility, or nursing home? If so, which ones? Which clients / patients could be moved using buses of some description and which ones need ambulance transport? How do you know which type of transportation is needed? 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.

Tip #12 - If you don't operate an in-resident center explain this in your CEMP and how the safety of patients / clients is addressed in disasters. See Tip #8 for more details.

(4) The procedures to inform State and local emergency preparedness officials about PACE participants in need of evacuation from their residences at any time due to an emergency situation based on the participant's medical and psychiatric conditions and home environment.

Tip #13 – See Tip #8. Pre-registration in the Special Needs Sheltering Program allows local first response agencies to know where their most vulnerable residents live and allows pre-planning of transportation to a shelter for these residents. However, the best arrangements for any vulnerable resident is to evacuate the area with family members. Your client will generally be safer and happier.

Tip #14 – Include in your CEMP the specific steps your staff must take to ensure your clients / patients are either registered in the Special Needs Sheltering program or pre-planning efforts to evacuate the area with family or friends.

(5) A means to shelter in place for participants, staff, and volunteers who remain in the facility.

Tip #15 – 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.

(6) A system of medical documentation that preserves participant information, protects confidentiality of participant information, and secures and maintains the availability of records.

Tip #16 – 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? Include these details in your CEMP.

(7) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.

Tip #17 – Do you have the means to provide emergency credentialing to licensed volunteers? Is there a system in-place to provide clinical oversight to these volunteers? How would you ensure during a disaster that someone who presents as an MD or RN actually holds that medical license? 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.

(8) The development of arrangements with other PACE organizations, PACE centers, or other providers to receive participants in the event of limitations or cessation of operations to maintain the continuity of services to PACE participants.

Tip #18 – 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 (8) above. Healthcare agencies 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.

(9) The role of the PACE organization under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

Tip #19 – 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 PACE centers to consider is the liability and volunteer credentialing (see Tip #17 above). These details together with recommended locations for an ATS should be addressed in detail in your CEMP.

(10) Emergency Equipment

(i) Emergency equipment, including easily portable oxygen, airways, suction, and emergency drugs.

(ii) Staff who knows how to use the equipment must be on the premises of every center at all times and be immediately available.

(iii) A documented plan to obtain emergency medical assistance from outside sources when needed.

Tip #20 – Include a detailed inventory and storage location for the above items in your CEMP. We also recommend including inspection and maintenance details and responsibilities in the CEMP as well. The CEMP should also address how you ensure there are staff trained on this equipment available at all times. Calling 911 to obtain outside medical assistance is a viable option to address sub-paragraph (iii) above.

(C) Communication Plan

The PACE organization 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 staff; entities providing services under arrangement; participants' physicians; other PACE organizations; and volunteers.

> ***Tip #21 – 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, 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 #22 – See Tip 21 above.***

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

> ***Tip #23 – 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 a viable option.***

(4) A method for sharing information and medical documentation for participants under the organization's care, as necessary, with other health care providers to maintain the continuity of care.

> ***Tip #24 – See Tip #16 above.***

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

> ***Tip #25 – See Tip #9 above. Who in your organization is authorized to release this type of information? Those specific staff should be identified in your CEMP. We recommend using position titles versus individual names to identify those authorized to release information. This approach avoids updating your CEMP every time there's a staffing change.***

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

> ***Tip #26 – See Tip #25 above.***

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

Tip #27 – The Florida Department of Health maintains a healthcare facility tracking system for bed capacity and facility operational status. Your facility's regular updates in that system would address this requirement (daily updates are preferred). All "authorities having jurisdiction" have access to this state-wide healthcare facility tracking system. The Agency for Healthcare Administration (AHCA) also mandates select healthcare facility participation to ensure there's rapid information sharing during emergent events. If your facility isn't participating in this system, or if you're unsure, contact your local ESF8 lead agency for more information.

Tip #28 – If you're evacuating your facility for any reason, ensure there's clear and regular communication with the health & medical lead agency at your local emergency operations center (normally called ESF8). Let them know why you're evacuating, where you're residents and staff are evacuating to, the routes you're taking to get there, the number of residents and staff involved, their specific acuity levels, the number of staff evacuating with residents, and any assistance needed along the way or upon arrival. Once you've arrived at the evacuation site, your local health & medical lead agency may refer you to a similar organization in the local area for assistance.

(D) Training and Testing

The PACE organization 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 #29 – 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 #30 – Additionally, CMS is also expecting to see healthcare executives (CEOs, COOs, CNOs, Facility Administrators, 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 #31 – 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 HSEEP. Using the HSEEP processes will show great benefit when CMS, ACHA, or accrediting agencies review your records.

(1) **Training program**. The PACE organization must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least ***annually***.

(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.

(iv) Maintain documentation of all training.

Tip #32 – 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 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 PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:

(i) Participate in a full-scale exercise that is community-based or when a community based exercise is not accessible, an individual, facility-based. If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

(ii) Conduct an additional exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility based.

(B) A tabletop exercise that includes 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.

(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

Tip #33 – While the CMS Emergency Management rules only require 2 exercises per year (1 full-scale and 1 table-top) you may find a need for a more frequent exercise schedule to ensure all staff on all shifts are given an opportunity to demonstrate their emergency duty skills (see Tip #32 above).

Tip #34 – 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 than a single healthcare facility can recruit. Then, ensure your organization participates in the After Action Report process and obtains a copy of that final report. This documentation will address the expectations spelled out in paragraph (iii) above. Regular attendance at TBHMPC meetings is the best way to learn about these community-wide exercise opportunities.

(E) Integrated Healthcare Systems

If a PACE is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the PACE may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must:

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

(2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, participant populations, and services offered.

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:

(i) A documented community–based risk assessment, utilizing an all-hazards approach.

(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

Tip #35 – If a multi-facility healthcare organization elects use this provision we recommend the following:

- ***Establish a corporate level emergency preparedness committee chaired by someone from executive leadership and hold meetings at least quarterly***
- ***Ensure active and in-person attendance and participation from key staff at all participating healthcare facilities. The use of video conferencing may suffice to meet the "active participation" element but we recommend saving those video files as evidence of participation.***
- ***Maintain detailed records of meeting agendas, meeting minutes, sign-in rosters, and formal presentations of each meeting***