PART 483.475 The Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

The Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) must comply with all applicable Federal, State, and local emergency preparedness requirements.

The ICF/IID 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 ICF/IID 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, including missing clients.

(2) Include strategies for addressing emergency events identified by the risk assessment.

(3) Address the special needs of its client population, including, but not limited to, persons at risk; the type of services the ICF/IID 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 ICF/IID efforts to contact such officials and, when applicable, of its participation in 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 ICF/IID 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 clients, whether they evacuate or shelter in place, include, but are not limited to the following:
  (i) Food, water, medical, and pharmaceutical supplies.
  (ii) Alternate sources of energy to maintain the following:
    (A) Temperatures to protect client 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 – Most Florida-based healthcare facilities are already required to develop a Comprehensive Emergency Management Plan (CEMP) and have that plan reviewed and approved by their local emergency management agency. We recommend ensuring the above elements are included in your existing CEMP. There's no need to create a completely new response plan to satisfy these CMS requirements. However, if your facility does not have a CEMP, developing one will be required to comply with

these new CMS Emergency Management Rules. Addressing 100% of the above requirements will be critical to maintaining your CMS Certificate of Participation.

Tip #7 – We recommend including every detail of your missing resident protocols in the CEMP to fully satisfy paragraph (1) above.

Tip#8 – 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 #9 – Include details in your CEMP addressing the unique needs of residents and how your staff should address those needs. Also include your succession plan. In other words, who's in charge if the Administrator or other leadership isn't available? We recommend using the Nursing Home Incident Command System (NHICS) available through the Florida Healthcare Association. Details on this process and required training are available at www.fhca.org . Using a formal incident management process (like the NHICS) will greatly enhance your consequence management capabilities and address many of the requirements of these CMS emergency management rules.

Tip #10 – Ensure your CEMP includes details on your Continuity of Operations Plan (COOP). COOP strategies are typically referred to as business continuity or risk management in the private sector. In general, these strategies address how your staff would continue providing necessary services to residents even if critical support services (such as electricity, water, sewer, garbage disposal, food service, or housekeeping) was temporarily unavailable. If evacuation of your facility was a necessity, address how that process should work in your CEMP. Remember, be as specific as possible and avoid reliance on public sector agencies to help with your facility evacuation.

Tip #11 – 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 #12 – 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.

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

Tip #13 – A "system to track the location of on-duty staff and sheltered clients" 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 clients and staff. It also gives you quick access to this information in case of an unforeseen emergency.

(3) Safe evacuation from the ICF/IID, 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 #14 – If you had to evacuate your facility, how would you ensure clients 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? Which clients would present a challenge or risk if they were not placed in another ICF/IID facility? If so, which ones? Which clients could be moved using buses of some description and which ones need more secure 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.

(4) A means to shelter in place for clients, 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.

(5) A system of medical documentation that preserves client information, protects confidentiality of client 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.

(6) 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? Are there additional certifications or credentials needed to work with your clients? If so, what are they? 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. If emergent credentialing isn't possible, include that in your CEMP and why.

(7) The development of arrangements with other ICF/IIDs or other providers to receive clients in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients.

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 (7) 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.

(8) The role of the ICF/IID 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 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 ICF/IID facilities 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.

(c) Communication Plan

The ICF/IID 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 the following:

(1) Names and contact information for the following:
- (i) Staff.
- (ii) Entities providing services under arrangement.
- (iii) Clients' physicians.
- (iv) Other ICF/IIDs.
- (v) Volunteers.

Tip #20 – 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 client services, 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.

(iii) The State Licensing and Certification Agency.
(iv) The State Protection and Advocacy Agency.

Tip #21 – See Tip 20 above. Ensure you include contact information for the local emergency management agency, local fire/rescue, local law enforcement, and preparedness staff at the local health department. Regular attendance at TBHMPC meetings will greatly enhance communications and partnership building with these agencies.

(3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.

Tip #22 – 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 clients under the ICF/IID's care, as necessary, with other health care providers to maintain the continuity of care.

Tip #23 – See Tip #16 above.

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

Tip #24 – 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 clients under the facility's care as permitted under 45 CFR 164.510(b)(4).

Tip #25 – See Tip #25 above.

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

Tip #26 – 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 #27 – 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 or health & medical). Let them know why you're evacuating, where you're clients and staff are evacuating to, the routes you're taking to get there, the number of clients and staff evacuating, their specific acuity levels, 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 on-going assistance.

(8) A method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives.

Tip #28 – See Tip #25 above.

(d) Training and Testing

The ICF/IID 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**. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).

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 ICF/IID must do all 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 the training.

(iv) Demonstrate staff knowledge of emergency procedures.

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 normally 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 ICF/IID must conduct exercises to test the emergency plan at least ***annually***. The ICF/IID 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 ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID 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 ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID'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 #31 and 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 an ICF/IID 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 ICF/IID may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:

(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, patient 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 all of 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 or more frequently if possible***
- ***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***