# Emergency Preparedness: Then and Now

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# OBJECTIVES

- Review a typical disaster plan
- Identify emergency preparedness tools past and present
- Discuss lesson lessons learned from the current pandemic
- Address steps to prepare us for future challenges

# EVOLUTION OF DISASTER RESPONSE

- American Red Cross (1881): Clara Barton
- Flood Control Act (1917)
- Reconstruction Finance Corporation (1932) Disaster loans
- Bureau of Public Road (1934)
- Disaster Relief Act of 1950: Disaster relief
- Federal Civil Defense Act of 1950
- Office of Emergency Preparedness (1960)
- National Flood Insurance Act of 1968
- Federal Emergency Management Agency ( FEMA) (1970)
- Oil Pollution Act of 1990 (OPA90
- Federal Response Plan (1992)
- September 11, 2001
- Homeland Security Act of 2002
- National Response Plan (2004): Replaced the Federal Response Plan
- National Response Framework (2008): enhance the principles of the National Response Plan

# EMERGENCY PREPAREDNESS(EP) RULE

- On September 16, 2016 CMS published in the Federal Register the *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule.*
- The regulation became effective November 16, 2016 with healthcare providers and suppliers having until November 15, 2017 to be compliant and implement all regulations.


- On September 30, 2019 CMS published in the Federal Register the *Medicare and Medicaid Programs: Regulatory Provisions To Promote Program Efficiency, Transparency and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility and Improvement in Patient Care Final Rule* which revised some of the emergency preparedness requirements for providers and suppliers.

# PURPOSE OF EP RULE

- Establish national EP requirements to ensure adequate planning for both natural and man-made disasters and coordinate with federal, state, tribal, regional and local emergency preparedness systems
- Requirements will apply to all 17 provider and supplier type
- Each provider/supplier with have its own set of EP regulations incorporated into its set of conditions or requirements for certification
- Must be in compliance with EP regulations to participate in Medicare and Medicaid program.

# 17 CMS PROVIDER AND SUPPLIER TYPES IMPACTED

- Hospitals
- Religious Nonmedical Health Care Institutions (RNHCIs)
- Ambulatory Surgical Centers (ASCs)
- Hospices
- Psychiatric Residential Treatment Facilities (PRTFs)
- All-Inclusive Care for the Elderly (PACE)
- Transplant Centers
- Long-Term Care (ICF/IID) Facilities
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Critical Access Hospitals (CAHs)
- Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services
- Community Mental Health Centers (CMHCs)
- Organ Procurement Organizations (OPOs)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- End-Stage Renal Disease (ESRD) Facilities

# Four Provisions for All Provider Types

# CORE ELEMENTS OF EMERGENCY PREPAREDNESS

- *Risk Assessment and Emergency Planning*, including but not limited to:
  - Hazards likely in geographic area
  - Care related emergencies
  - Equipment and power failures
  - Interruption in Communications, including cyber attacks
  - Loss of all, portion of facility
  - Loss of all/portion of supplies

- Plan is to be reviewed and updated at least annually

# CORE ELEMENTS OF EMERGENCY PREPAREDNESS

- *Communication Plan*
  - Primary and alternate means of communicating
  - System to contact staff, including patient's physicians, other necessary persons
  - Well-coordinated within the facility, across healthcare providers and state and local public health departments and emergency management systems
  - Complies with Federal and State laws
  - Review and Update plan annually
- *Policies and Procedures*
  - Develop and implement based on the emergency plan and risk assessment
  - Address a range of issues including subsistence needs, evacuation plans, system for tracking residents and staff during the emergency
  - Complies with Federal and State laws
  - Review and update policies and procedures at least annually

# Core Elements of Emergency Preparedness

- *Testing and Training*
  - Develop and maintain training and testing programs, including initial training in facility policies and procedures
  - New hires, existing staff, volunteers, contracted staff (Therapy, RD, etc.)
  - Training tailored to specific staff roles taking into account risk assessment (e.g. evacuation, sheltering in place)
  - Documentation of training
  - Complies with Federal and State laws
  - Maintain and at a minimum update annually
  - Two testing exercises annually: one community-based full-scale (when available) or individual facility-based, second exercise may be table top, full-scale or individual facility-based

# Training & Testing Program Definitions

- **Facility-Based:** When discussing the terms “all-hazards approach” and facility-based risk assessments, we consider the term “facility-based” to mean that the emergency preparedness program is specific to the facility. Facility-based includes, but is not limited to, hazards specific to a facility based on the geographic location; Patient/Resident/Client population; facility type and potential surrounding community assets (i.e. rural area versus a large metropolitan area).

- **Full-Scale Exercise:** A full scale exercise is a multi-agency, multijurisdictional, multi-discipline exercise involving functional (for example, joint field office, emergency operation centers, etc.) and “boots on the ground” response (for example, firefighters decontaminating mock victims).

# Training & Testing Program Definitions

- **Table-top Exercise (TTX):** A table-top exercise is a group discussion led by a facilitator, using narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. It involves key personnel discussing simulated scenarios, including computer-simulated exercises, in an informal setting. TTXs can be used to assess plans, policies, and procedures.

# Hot Off the Press 2020

**Center for Clinical Standards and Quality/Quality, Safety & Oversight Group**

**Ref: QSO-20-41-ALL**

**DATE:** **September 28, 2020**

**TO:** State Survey Agency Directors

**FROM:** Director
Quality, Safety & Oversight Group

**SUBJECT:** Guidance related to the Emergency Preparedness Testing Exercise Requirements- Coronavirus Disease 2019 (COVID-19)

**Memorandum Summary**

- ***Emergency Preparedness Testing Exemption and Guidance*** - CMS regulations for Emergency Preparedness require specific testing exercises be conducted to validate the facility's emergency program. During or after an actual emergency, the regulations allow for an exemption to the testing requirements based on real world actions taken by providers and suppliers.

- This worksheet presents guidance for surveyors, as well as providers and suppliers, with relevant scenarios on meeting the testing requirements in light of many of the response activities associated with the COVID-19 Public Health Emergency (PHE).

# Hot Off the Press 2021/FAQs

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

**Center for Clinical Standards and Quality/Quality, Safety & Oversight Group**

**Ref: QSO-20-31-All**
***REVISED 01/04/2021***

**DATE:** **June 1, 2020**

**TO:** State Survey Agency Directors

**FROM:** Director
Quality, Safety & Oversight Group

**SUBJECT:** ***Revised*** COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes

- ***CMS is committed*** *to taking critical steps to protect vulnerable Americans to ensure America's health care facilities are prepared to respond to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).*
- ***CMS has implemented*** *a new COVID-19 reporting requirement for nursing homes, and is partnering with CDC's robust federal disease surveillance system to quickly identify problem areas and inform future infection control actions.*
- ***Following the March 6, 2020 survey prioritization,*** *CMS has relied on State Survey Agencies to perform Focused Infection Control surveys of nursing homes across the country. We are now initiating a performance-based funding requirement tied to the Coronavirus Aid, Relief and Economic Security (CARES) Act supplemental grants for State Survey Agencies. Further, we are providing guidance for the limited resumption of routine survey activities.* ***CMS has revised the criteria requiring states to conduct focused infection control surveys due to the increased availability of resources for the testing of residents and staff and factors related to the quality of care.***
- ***CMS is providing Frequently Asked Questions related to health, emergency preparedness and life-safety code surveys***

**Q19. Have Emergency Preparedness requirements been adjusted under the PHE?**

**A.** A limited number of blanket waivers were issued by CMS in relation to Emergency Preparedness for hospitals, Critical Access Hospitals (CAH), and End-Stage Renal Dialysis (ESRD) facilities. For all other provider types (including LTC facilities), Emergency Preparedness requirements remain unchanged. *Refer to emergency preparedness waivers at the following link:* https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

Released: 1/4/2021 Page **8** of **8**

# Changes Specific to Testing Exercise Requirements

**For providers of inpatient services:** The testing exercises were expanded to include workshops as an exercise of choice. However these providers are still required to conduct two emergency preparedness testing exercises annually.

*Inpatient providers and suppliers include:* Inpatient hospice facilities, Psychiatric Residential Treatment Facilities (PRTFs), hospitals, long-term care (LTCs) facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IIDs), and Critical Access Hospitals (CAHs).

# Exemption based on Actual Natural or Man-Made emergency

- Facilities that activate their emergency plans are **exempt** from the next full-scale community-based or individual, facility-based functional exercise.
- Facilities must be able to demonstrate through written documentation that they activated their program due to the emergency.

- CMS requires facilities to conduct an exercise of choice **annually for inpatient providers** and every two years for outpatient providers (opposite the year of the full-scale or facility-based functional exercise). For the "exercise of choice," facilities must conduct one of the testing exercises below:
  - Another full-scale exercise
  - Individual-facility-based functional exercise
  - Mock disaster drill
  - A tabletop exercise or workshop.

## Requirement for Inpatient Providers

**Requirement & Guidance:** Inpatient providers must conduct a full-scale exercise (or individual facility-based exercise when a full-scale is not available) annually pursuant to standard (d)(2) of their respective "Emergency Preparedness" regulation, and also conduct any one exercise of the "exercises of choice" which include another full-scale or individual facility-based exercise, table top exercise, workshop or mock drill annually.

**The Exemption Clause**: In the event a facility activates its emergency program due to an actual emergency, the inpatient provider would be exempt from engaging in its **next required** community-based full-scale exercise or individual facility-based exercise following the onset of the emergency event. Facilities must be able to demonstrate through written documentation, that they activated their program due to the emergency.

## Inpatient Provider Scenarios

**Scenario #1**. Facility X conducted a full-scale exercise in January 2019 and a table-top exercise as their exercise of choice in November 2019. It also conducted another full-scale exercise in January 2020, and is scheduled to conduct its workshop in November 2020. In March 2020, Facility X activates its emergency preparedness program due to the COVID-19 Public Health Emergency (PHE).

When must the facility conduct its next required full-scale exercise? What is the exemption based on the requirements?

**Answer**: Since the facility already conducted its full-scale requirement for 2020, it is only required to conduct the scheduled workshop for November 2020. The facility is exempt from its next required full-scale, in January 2021. However, the facility must still complete an exercise of choice by November 2021.


**Scenario #2**. Facility Y conducted a table-top exercise in January 2020 as the exercise of choice and is scheduled to conduct its full-scale exercise in November 2020. In March 2020, Facility Y activates its emergency preparedness program due to the COVID-19 PHE.

When must the facility conduct its next required full-scale exercise? What is the exemption based on the requirements?

# Tools Past and Present

- AHRQ Appendix B: Model Long Term Care Preparedness Needs Assessment
- Facility Needs Assessment Tool
- DHSS COOP Planning Templates and Worksheets
- CMS Emergency Preparedness Checklist

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## Nursing Homes in Public Health Emergencies

**Public Health Emergency Preparedness**

This resource was part of AHRQ's Public Health Emergency Preparedness program, which was discontinued on June 30, 2011, in a realignment of Federal efforts.

This information is for reference purposes only. It was current when produced and may now be outdated. Archive material is no longer maintained, and some links may not work. Persons with disabilities having difficulty accessing this information should contact us at: https://info.ahrq.gov. Let us know the nature of the problem, the Web address of what you want, and your contact information.

Please go to www.ahrq.gov for current information.

# Appendix B: Model Long-term Care Preparedness Needs Assessment

## Contents

## Section E. Emergency Plan

| Question No. | Question | Answer |
|---|---|---|
| E1 | Does your facility have an emergency plan for use in case of natural disaster, act of terrorism, or infectious disease emergency?<br>**If No, Please Skip to Section F** | __ Yes |
| | | __ No |
| | | __ Don't Know |
| E2 | Has your facility's emergency plan been reviewed by state or local officials? | __ Yes |
| | | __ No |
| | | __ Don't Know |
| E3 | Does the emergency plan call for an on-site designated command center? | __ Yes |
| | | __ No |
| | | __ Don't Know |
| E4 | If your answer to E3 is yes, does the command center have access to... (check all that apply) | __ Radio |
| | | __ 2-Way Radio |
| | | __ NOAA Radio |
| | | __ Telephone |
| | | __ Multiple Phone lines |
| | | __ Internet |
| | | __ TV, Local |
| | | __ TV, Cable |
| | | __ Satellite |
| | | __ Video Conferencing |
| E5 | In case of an emergency (after calling 911) who is your facility's first contact? | __ Medical Director |
| | | __ Administrative Director |
| | | __ Nursing Director |
| | | __ 911 or external source |
| | | __ Other |
| | | List: _____ |
| Does the facility's emergency plan address the following...? | | |

# Example of Emergency Plan

## Section E. Emergency Plan

| Question No. | Question | Answer |
|---|---|---|
| E1 | Does your facility have an emergency plan for use in case of natural disaster, act of terrorism, or infectious disease emergency?<br>**If No, Please Skip to Section F** | __ Yes<br>__ No<br>__ Don't Know |
| E2 | Has your facility's emergency plan been reviewed by state or local officials? | __ Yes<br>__ No<br>__ Don't Know |
| E3 | Does the emergency plan call for an on-site designated command center? | __ Yes<br>__ No<br>__ Don't Know |
| E4 | If your answer to E3 is yes, does the command center have access to... (check all that apply) | __ Radio<br>__ 2-Way Radio<br>__ NOAA Radio<br>__ Telephone<br>__ Multiple Phone lines<br>__ Internet<br>__ TV, Local<br>__ TV, Cable<br>__ Satellite<br>__ Video Conferencing |
| E5 | In case of an emergency (after calling 911) who is your facility's first contact? | __ Medical Director<br>__ Administrative Director<br>__ Nursing Director<br>__ 911 or external source<br>__ Other<br>List: _____ |

| | | |
|---|---|---|
| | | List: _____ |
| Does the facility's emergency plan address the following...? | | |
| E6 | Evacuation planning? | __ Yes<br>__ No |
| E7 | Isolation of infected patients? | __ Yes<br>__ No |
| E8 | Triage of casualties? | __ Yes<br>__ No |
| E9 | Quarantine? | __ Yes<br>__ No |
| E10 | Decontamination? | __ Yes<br>__ No |
| E11 | Contingency for power failure? | __ Yes<br>__ No |
| E12 | Reconfiguration of facility space for quarantine of communicable diseases and treatment of infectious disease epidemics? | __ Yes<br>__ No |
| E13 | Transfer of multiple or mass casualties? | __ Yes<br>__ No |
| E14 | Credentialing, orientation and supervision of clinicians not normally working in facility responding to a bioterrorism event or infectious disease outbreak? | __ Yes<br>__ No |
| E15 | Mechanisms to manage unsolicited clinical help and donated items? | __ Yes<br>__ No |
| E16 | An abbreviated patient registration process for disaster victims? | __ Yes<br>__ No |
| E17 | A process for identifying and incorporating spokespersons and/or subject matter experts to provide information to the media? | __ Yes<br>__ No |
| E18 | A process for sharing patient information and/or victim's lists with other hospitals/providers/public agencies? | __ Yes<br>__ No |

# CMS EMERGENCY PREPAREDNESS RULE TOOLKITS

Each of these toolkits gives facilities that fall under the new rule an overview of the requirements for their provider type, as well as some sample templates that can be used in their planning efforts. In topic areas where there was not a tool or template readily available, the toolkit offers planning worksheets that feature a list of example questions to help facilities think through relevant issues that can help them draft their plans and policies. For more information, please contact your region's healthcare emergency readiness coalition coordinator, P-02587 (PDF).

- Ambulatory Surgical Centers
- End State Renal Disease Facilities (Dialysis)
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Long Term Care: Skilled Nursing Facilities
- Home Health Agencies
- Hospices
- Hospitals
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services

# LTC FACILITY ASSESSMENT TOOL

- Overview of the tool:
- Facility profile
- Care and competency requirements
- Workforce profile
- Services
- Physical plant
- Contracts, MOU's and agreements
- *Hazards vulnerability (natural, technological, human, hazardous materials*): should be both facility and community based using an all hazards approach to risk assessment.
- Action plan

Resident population

Resident acuity

Training evaluation

Ethnic, cultural, religious needs

Facility resources

# HAZARD AND VULNERABILITY ASSESSMENT TOOL
## NATURALLY OCCURRING EVENTS

| EVENT | PROBABILITY | SEVERITY = (MAGNITUDE - MITIGATION) | | | | | | RISK |
|---|---|---|---|---|---|---|---|---|
| | | HUMAN IMPACT | PROPERTY IMPACT | BUSINESS IMPACT | PREPARED-NESS | INTERNAL RESPONSE | EXTERNAL RESPONSE | |
| | *Likelihood this will occur* | *Possibility of death or injury* | *Physical losses and damages* | *Interuption of services* | *Preplanning* | *Time, effectivness, resouces* | *Community/ Mutual Aid staff and supplies* | *Relative threat** |
| **SCORE** | *0 = N/A*<br>*1 = Low*<br>*2 = Moderate*<br>*3 = High* | *0 = N/A*<br>*1 = Low*<br>*2 = Moderate*<br>*3 = High* | *0 = N/A*<br>*1 = Low*<br>*2 = Moderate*<br>*3 = High* | *0 = N/A*<br>*1 = Low*<br>*2 = Moderate*<br>*3 = High* | *0 = N/A*<br>*1 = High*<br>*2 = Moderate*<br>*3 = Low or none* | *0 = N/A*<br>*1 = High*<br>*2 = Moderate*<br>*3 = Low or none* | *0 = N/A*<br>*1 = High*<br>*2 = Moderate*<br>*3 = Low or none* | 0 - 100% |
| Tornado | | | | | | | | 0% |
| Severe Thunderstorm | | | | | | | | 0% |
| Snow Fall | | | | | | | | 0% |
| Blizzard | | | | | | | | 0% |
| Ice Storm | | | | | | | | 0% |
| Earthquake | | | | | | | | 0% |
| Heat/Humidity | | | | | | | | 0% |

# TECHNOLOGICAL

| EVENT | PROBABILITY | HUMAN IMPACT | PROPERTY IMPACT | BUSINESS IMPACT | PREPARED-NESS |
|---|---|---|---|---|---|
| | *Likelihood this will occur* | *Possibility of death or injury* | *Physical losses and damages* | *Interuption of services* | *Preplanning* |
| **SCORE** | *0 = N/A<br>1 = Low<br>2 = Moderate<br>3 = High* | *0 = N/A<br>1 = Low<br>2 = Moderate<br>3 = High* | *0 = N/A<br>1 = Low<br>2 = Moderate<br>3 = High* | *0 = N/A<br>1 = Low<br>2 = Moderate<br>3 = High* | *0 = N/A<br>1 = High<br>2 = Moderate<br>3 = Low or none* |
| Electrical Failure | | | | | |
| Generator Failure | | | | | |
| Transportation Failure | | | | | |
| Fuel Shortage | | | | | |
| Communications Failure | | | | | |
| Information Systems Failure | | | | | |
| Fire, Internal | | | | | |
| Flood, Internal | | | | | |
| Hazmat Exposure, Internal | | | | | |
| Supply Shortage | | | | | |
| Structural Damage | | | | | |

# HUMAN

| EVENT | PROBABILITY | SEVERITY = (MAGNITUDE - MITIGATION) | | | |
|---|---|---|---|---|---|
| | | HUMAN IMPACT | PROPERTY IMPACT | BUSINESS IMPACT | PREPARED-NESS |
| | *Likelihood this will occur* | *Possibility of death or injury* | *Physical losses and damages* | *Interuption of services* | *Preplanning* |
| **SCORE** | *0 = N/A<br>1 = Low<br>2 = Moderate<br>3 = High* | *0 = N/A<br>1 = Low<br>2 = Moderate<br>3 = High* | *0 = N/A<br>1 = Low<br>2 = Moderate<br>3 = High* | *0 = N/A<br>1 = Low<br>2 = Moderate<br>3 = High* | *0 = N/A<br>1 = High<br>2 = Moderate<br>3 = Low or none* |
| Mass Casualty Incident (trauma) | | | | | |
| Mass Casualty Incident (medical/infectious) | | | | | |
| Terrorism, Biological | | | | | |
| VIP Situation | | | | | |
| Hostage Situation | | | | | |
| Active Shooter | | | | | |
| Missing Resident | | | | | |
| Bomb Threat | | | | | |

# HAZARD AND VULNERABILITY ASSESSMENT TOOL

## Hazardous Materials

| EVENT | PROBABILITY | SEVERITY = (MAGNITUDE - MITIG | | | |
|---|---|---|---|---|---|
| | | HUMAN IMPACT | PROPERTY IMPACT | BUSINESS IMPACT | PREPARED-NESS |
| | *Likelihood this will occur* | *Possibility of death or injury* | *Physical losses and damages* | *Interuption of services* | *Preplanning* |
| **SCORE** | *0 = N/A*<br>*1 = Low*<br>*2 = Moderate*<br>*3 = High* | *0 = N/A*<br>*1 = Low*<br>*2 = Moderate*<br>*3 = High* | *0 = N/A*<br>*1 = Low*<br>*2 = Moderate*<br>*3 = High* | *0 = N/A*<br>*1 = Low*<br>*2 = Moderate*<br>*3 = High* | *0 = N/A*<br>*1 = High*<br>*2 = Moderate*<br>*3 = Low or none* |
| Mass Casualty Hazmat Incident *(From historic events at your LTC with >= 5 victims)* | | | | | |
| Small Casualty Hazmat Incident *(From historic events at your LTC with < 5 victims)* | | | | | |
| Chemical Exposure | | | | | |
| Terrorism, Chemical | | | | | |
| Radiologic Exposure, External | | | | | |
| Terrorism, Radiologic | | | | | |

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# DHSS Disaster and Emergency Planning

- Information for Medical and Public Health Professionals
- Health Alerts, Advisories, Updates and Guidances
- Ebola and Other Highly Infectious Diseases Webinar
- Biological Terrorism/Emergencies
- Chemical Terrorism/Emergencies
- Radiological and Nuclear Terrorism/Emergencies
- Explosions and Traumatic Injuries
- Influenza (Pandemic and Seasonal)
- Coronavirus (COVID-19) Pandemic
- Medical Countermeasures/Strategic National Stockpile (SNS)
- Pediatric Disaster Resources
- Additional Resources for Disasters and Emergencies
- Volunteer Opportunities
- Continuity of Operations (COOP)
- Missouri Healthcare Coalitions
- Emergency Response Public Information Toolkit for Local Public Health Agencies
- Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Rule Information



# Continuity of Operations (COOP) Planning Template and Worksheets

2014

## COOP

Serves as a road map to prepare for and respond to any event that disrupts operations.

Prioritizes essential business functions the organization must perform in an emergency.

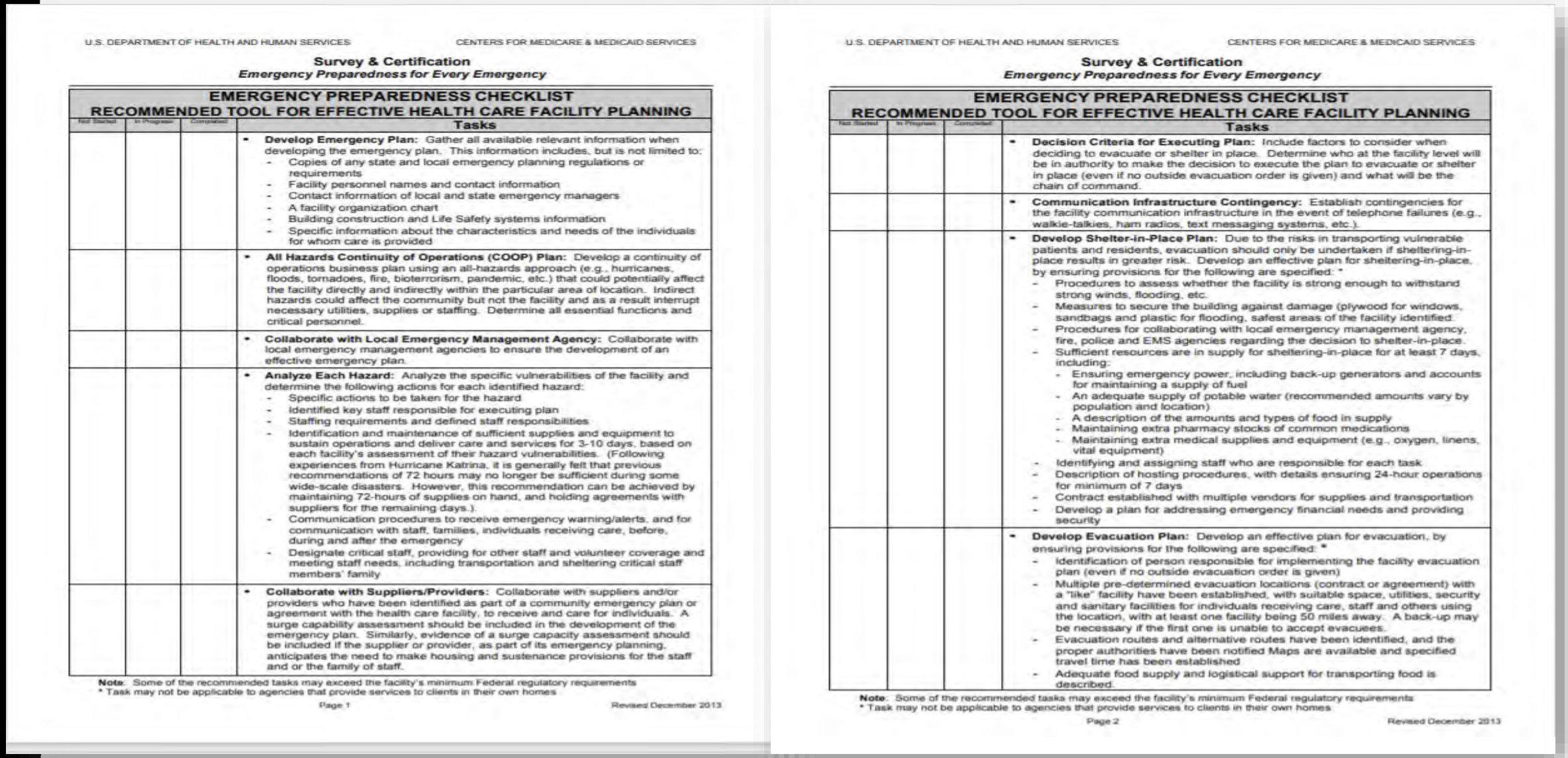
Establishes a means for ensuring continuation of services to current patients and identifies capacity for a surge.

# COOP PLAN

- Record of Changes
- Signature of Administrator
- Orders of Succession
- Delegation of Authority
- Determination of Essential Functions
- Prioritize Essential Functions
- Identify Staff Performing Essential Functions
- Create Drive Away Kits
- Inventory of Vital Records
- Notification of Staff and Business Partners
- Alternate Worksites
- Training and Exercises

Template to develop a basic functional COOP plan

# CMS EP CHECKLIST
# EMERGENCY PREPAREDNESS FOR EVERY EMERGENCY



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

**Survey & Certification**
***Emergency Preparedness for Every Emergency***

**EMERGENCY PREPAREDNESS CHECKLIST**
**RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING**

| Not Started | In Progress | Completed | Tasks |
|---|---|---|---|
| | | | • **Develop Emergency Plan:** Gather all available relevant information when developing the emergency plan. This information includes, but is not limited to:<br>- Copies of any state and local emergency planning regulations or requirements<br>- Facility personnel names and contact information<br>- Contact information of local and state emergency managers<br>- A facility organization chart<br>- Building construction and Life Safety systems information<br>- Specific information about the characteristics and needs of the individuals for whom care is provided |
| | | | • **All Hazards Continuity of Operations (COOP) Plan:** Develop a continuity of operations business plan using an all-hazards approach (e.g., hurricanes, floods, tornadoes, fire, bioterrorism, pandemic, etc.) that could potentially affect the facility directly and indirectly within the particular area of location. Indirect hazards could affect the community but not the facility and as a result interrupt necessary utilities, supplies or staffing. Determine all essential functions and critical personnel. |
| | | | • **Collaborate with Local Emergency Management Agency:** Collaborate with local emergency management agencies to ensure the development of an effective emergency plan. |
| | | | • **Analyze Each Hazard:** Analyze the specific vulnerabilities of the facility and determine the following actions for each identified hazard:<br>- Specific actions to be taken for the hazard<br>- Identified key staff responsible for executing plan<br>- Staffing requirements and defined staff responsibilities<br>- Identification and maintenance of sufficient supplies and equipment to sustain operations and deliver care and services for 3-10 days, based on each facility's assessment of their hazard vulnerabilities. (Following experiences from Hurricane Katrina, it is generally felt that previous recommendations of 72 hours may no longer be sufficient during some wide-scale disasters. However, this recommendation can be achieved by maintaining 72-hours of supplies on hand, and holding agreements with suppliers for the remaining days.).<br>- Communication procedures to receive emergency warning/alerts, and for communication with staff, families, individuals receiving care, before, during and after the emergency<br>- Designate critical staff, providing for other staff and volunteer coverage and meeting staff needs, including transportation and sheltering critical staff members' family |
| | | | • **Collaborate with Suppliers/Providers:** Collaborate with suppliers and/or providers who have been identified as part of a community emergency plan or agreement with the health care facility, to receive and care for individuals. A surge capability assessment should be included in the development of the emergency plan. Similarly, evidence of a surge capacity assessment should be included if the supplier or provider, as part of its emergency planning, anticipates the need to make housing and sustenance provisions for the staff and or the family of staff. |

**Note**: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

**Survey & Certification**
***Emergency Preparedness for Every Emergency***

**EMERGENCY PREPAREDNESS CHECKLIST**
**RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING**

| Not Started | In Progress | Completed | Tasks |
|---|---|---|---|
| | | | • **Decision Criteria for Executing Plan:** Include factors to consider when deciding to evacuate or shelter in place. Determine who at the facility level will be in authority to make the decision to execute the plan to evacuate or shelter in place (even if no outside evacuation order is given) and what will be the chain of command. |
| | | | • **Communication Infrastructure Contingency:** Establish contingencies for the facility communication infrastructure in the event of telephone failures (e.g., walkie-talkies, ham radios, text messaging systems, etc.). |
| | | | • **Develop Shelter-in-Place Plan:** Due to the risks in transporting vulnerable patients and residents, evacuation should only be undertaken if sheltering-in-place results in greater risk. Develop an effective plan for sheltering-in-place, by ensuring provisions for the following are specified: *<br>- Procedures to assess whether the facility is strong enough to withstand strong winds, flooding, etc.<br>- Measures to secure the building against damage (plywood for windows, sandbags and plastic for flooding, safest areas of the facility identified.<br>- Procedures for collaborating with local emergency management agency, fire, police and EMS agencies regarding the decision to shelter-in-place.<br>- Sufficient resources are in supply for sheltering-in-place for at least 7 days, including:<br>  - Ensuring emergency power, including back-up generators and accounts for maintaining a supply of fuel<br>  - An adequate supply of potable water (recommended amounts vary by population and location)<br>  - A description of the amounts and types of food in supply<br>  - Maintaining extra pharmacy stocks of common medications<br>  - Maintaining extra medical supplies and equipment (e.g., oxygen, linens, vital equipment)<br>- Identifying and assigning staff who are responsible for each task<br>- Description of hosting procedures, with details ensuring 24-hour operations for minimum of 7 days<br>- Contract established with multiple vendors for supplies and transportation<br>- Develop a plan for addressing emergency financial needs and providing security |
| | | | • **Develop Evacuation Plan:** Develop an effective plan for evacuation, by ensuring provisions for the following are specified: *<br>- Identification of person responsible for implementing the facility evacuation plan (even if no outside evacuation order is given)<br>- Multiple pre-determined evacuation locations (contract or agreement) with a "like" facility have been established, with suitable space, utilities, security and sanitary facilities for individuals receiving care, staff and others using the location, with at least one facility being 50 miles away. A back-up may be necessary if the first one is unable to accept evacuees.<br>- Evacuation routes and alternative routes have been identified, and the proper authorities have been notified Maps are available and specified travel time has been established<br>- Adequate food supply and logistical support for transporting food is described. |

**Note**: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

Page 2 — Revised December 2013

# EP CHECKLIST



**Survey & Certification**
***Emergency Preparedness for Every Emergency***

**EMERGENCY PREPAREDNESS CHECKLIST**
**RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING**

| Not Started | In Progress | Completed | Tasks |
|---|---|---|---|
| | | | - The amounts of water to be transported and logistical support is described (1 gal/person).<br>- The logistics to transport medications is described, including ensuring their protection under the control of a registered nurse.<br>- Procedures for protecting and transporting resident/patient medical records.<br>- The list of items to accompany residents/patients is described.<br>- Identify how persons receiving care, their families, staff and others will be notified of the evacuation and communication methods that will be used during and after the evacuation<br>- Identify staff responsibilities and how individuals will be cared for during evacuation and the back-up plan if there isn't sufficient staff.<br>- Procedures are described to ensure residents/patients dependent on wheelchairs and/or other assistive devices are transported so their equipment will be protected and their personal needs met during transit (e.g., incontinent supplies for long periods, transfer boards and other assistive devices).<br>- A description of how other critical supplies and equipment will be transported is included.<br>- Determine a method to account for all individuals during and after the evacuation<br>- Procedures are described to ensure staff accompany evacuating residents.<br>- Procedures are described if a patient/resident becomes ill or dies in route.<br>- Mental health and grief counselors are available at reception points to talk with and counsel evacuees.<br>- Procedures are described if a patient/resident turns up missing during an evacuation:<br>• Notify the patient/resident's family<br>• Notify local law enforcement<br>• Notify Nursing Home Administration and staff<br>- Ensure that patient/resident identification wristband (or equivalent identification) must be intact on all residents.<br>- Describe the process to be utilized to track the arrival of each resident at the destination.<br>- It is described whether staff's family can shelter at the facility and evacuate |
| | | | • **Transportation & Other Vendors:** Establish transportation arrangements that are adequate for the type of individuals being served. Obtain assurances from transportation vendors and other suppliers/contractors identified in the facility emergency plan that they have the ability to fulfill their commitments in case of disaster affecting an entire area (e.g., their staff, vehicles and other vital equipment are not "overbooked," and vehicles/equipment are kept in good operating condition and with ample fuel.). Ensure the right type of transportation has been obtained (e.g., ambulances, buses, helicopters, etc.). * |

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

**Survey & Certification**
***Emergency Preparedness for Every Emergency***

**EMERGENCY PREPAREDNESS CHECKLIST**
**RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING**

| Not Started | In Progress | Completed | Tasks |
|---|---|---|---|
| | | | • **Train Transportation Vendors/Volunteers:** Ensure that the vendors or volunteers who will help transport residents and those who receive them at shelters and other facilities are trained on the needs of the chronic, cognitively impaired and frail population and are knowledgeable on the methods to help minimize transfer trauma. * |
| | | | • **Facility Reentry Plan**: Describe who will authorizes reentry to the facility after an evacuation, the procedures for inspecting the facility, and how it will be determined when it is safe to return to the facility after an evacuation. The plan should also describe the appropriate considerations for return travel back to the facility. * |
| | | | • **Residents & Family Members:** Determine how residents and their families/guardians will be informed of the evacuation, helped to pack, have their possessions protected and be kept informed during and following the emergency, including information on where they will be/go, for how long and how they can contact each other. |
| | | | • **Resident Identification:** Determine how residents will be identified in an evacuation; and ensure the following identifying information will be transferred with each resident:<br>- Name<br>- Social security number<br>- Photograph<br>- Medicaid or other health insurer number<br>- Date of birth, diagnosis<br>- Current drug/prescription and diet regimens<br>- Name and contact information for next of kin/responsible person/Power of Attorney)<br>Determine how this information will be secured (e.g., laminated documents, water proof pouch around resident's neck, water proof wrist tag, etc.) and how medical records and medications will be transported so they can be matched with the resident to whom they belong. |
| | | | • **Trained Facility Staff Members:** Ensure that each facility staff member on each shift is trained to be knowledgeable and follow all details of the plan. Training also needs to address psychological and emotional aspects on caregivers, families, residents, and the community at large. Hold periodic reviews and appropriate drills and other demonstrations with sufficient frequency to ensure new members are fully trained. |
| | | | • **Informed Residents & Patients:** Ensure residents, patients and family members are aware of and knowledgeable about the facility plan, including:<br>- Families know how and when they will be notified about evacuation plans, how they can be helpful in an emergency (example, should they come to the facility to assist?) and how/where they can plan to meet their loved ones.<br>- Out-of-town family members are given a number they can call for information. Residents who are able to participate in their own evacuation are aware of their roles and responsibilities in the event of a disaster. |

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# EP CHECKLIST



**Survey & Certification**
***Emergency Preparedness for Every Emergency***

| EMERGENCY PREPAREDNESS CHECKLIST<br>RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING | | | |
|---|---|---|---|
| Not Started | In Progress | Completed | Tasks |
| | | | • **Needed Provisions:** Check if provisions need to be delivered to the facility/residents -- power, flashlights, food, water, ice, oxygen, medications -- and if urgent action is needed to obtain the necessary resources and assistance. |
| | | | • **Location of Evacuated Residents:** Determine the location of evacuated residents, document and report this information to the clearing house established by the state or partnering agency. |
| | | | • **Helping Residents in the Relocation:** Suggested principles of care for the relocated residents include:<br>- Encourage the resident to talk about expectations, anger, and/or disappointment<br>- Work to develop a level of trust<br>- Present an optimistic, favorable attitude about the relocation<br>- Anticipate that anxiety will occur<br>- Do not argue with the resident<br>- Do not give orders<br>- Do not take the resident's behavior personally<br>- Use praise liberally<br>- Include the resident in assessing problems<br>- Encourage staff to introduce themselves to residents<br>- Encourage family participation |
| | | | • **Review Emergency Plan:** Complete an internal review of the emergency plan on an annual basis to ensure the plan reflects the most accurate and up-to-date information. Updates may be warranted under the following conditions:<br>- Regulatory change<br>- New hazards are identified or existing hazards change<br>- After tests, drills, or exercises when problems have been identified<br>- After actual disasters/emergency responses<br>- Infrastructure changes<br>- Funding or budget-level changes<br>Refer to FEMA (Federal Emergency Management) to assist with updating existing emergency plans.<br>Review FEMA's new information and updates for best practices and guidance, at each updating of the emergency plans. |
| | | | • **Emergency Planning Templates:** Healthcare facilities should appropriately complete emergency planning templates and tailor them to their specific needs and geographical locations. |
| | | | • **Collaboration with Local Emergency Management Agencies and Healthcare Coalitions:** Establish collaboration with different types of healthcare providers (e.g. hospitals, nursing homes, hospices, home care, dialysis centers etc.) at the State and local level to integrate plans of and activities of healthcare systems into State and local response plans to increase medical response capabilities. * |

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

**Survey & Certification**
***Emergency Preparedness for Every Emergency***

| EMERGENCY PREPAREDNESS CHECKLIST<br>RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING | | | |
|---|---|---|---|
| Not Started | In Progress | Completed | Tasks |
| | | | • **Communication with the Long-Term Care Ombudsman Program:** Prior to any disaster, discuss the facility's emergency plan with a representative of the ombudsman program serving the area where the facility is located and provide a copy of the plan to the ombudsman program. When responding to an emergency, notify the local ombudsman program of how, when and where residents will be sheltered so the program can assign representatives to visit them and provide assistance to them and their families. |
| | | | • **Conduct Exercises & Drills:** Conduct exercises that are designed to test individual essential elements, interrelated elements, or the entire plan:<br>- Exercises or drills must be conducted at least semi-annually<br>- Corrective actions should be taken on any deficiency identified. |
| | | | • **Loss of Resident's Personal Effects**: Establish a process for the emergency management agency representative (FEMA or other agency) to visit the facility to which residents have been evacuated, so residents can report loss of personal effects. * |

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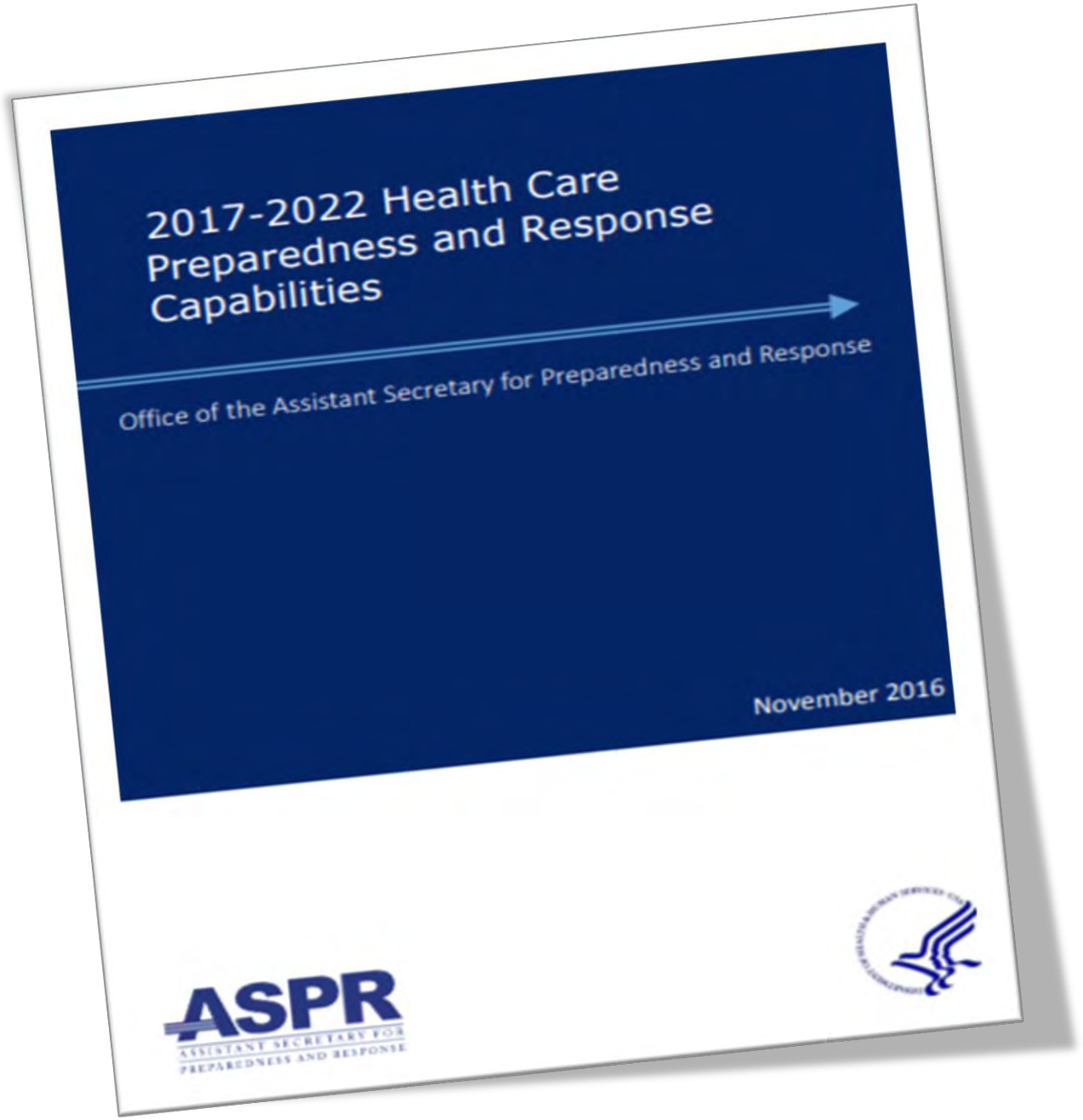


# ASPR

ASPR developed the 2017-2022 Health Care Preparedness and Response Capabilities guidance to describe what the health care delivery system, including HCCs, hospitals, and emergency medical services (EMS), have to do to effectively prepare for and respond to emergencies that impact the public's health.

# Goal of ASPR Guidance

- Individual health care organizations, HCCs, jurisdictions, and other stakeholders that develop the capabilities outlined in the 2017-2022 Health Care Preparedness and Response Capabilities document will:
- Help patients receive the care they need at the right place, at the right time, and with the right resources during emergencies
- Decrease deaths, injuries, and illnesses resulting from emergencies
- Promote health care delivery system resilience in the aftermath of emergencies

# Intended Stakeholders

- The intended audience for this document is any health care delivery system organization, HCC, or state or local agency that supports the provision of care during emergencies, including but not limited to:
- Behavioral health services and organizations
- Child care providers (e.g., daycare centers)
- Community Emergency Response Teams (CERT) and Medical Reserve Corps (MRC)
- Dialysis centers and regional Centers for Medicare & Medicaid Services (CMS)-funded end-stage renal disease (ESRD) networks3
- EMS (including inter-facility and other non-EMS patient transport systems)
- Emergency management organizations
- Faith-based organizations
- Federal facilities (e.g., U.S. Department of Veterans Affairs (VA) Medical Centers, Indian Health Service facilities, military treatment facilities
- Home health agencies, including home and community-based services
- Hospitals (e.g., acute care hospitals, trauma centers, burn centers, children's hospitals, rehabilitation hospitals)

# Intended Stakeholders

- Infrastructure companies (e.g., utility and communication companies)
- Cities, counties, parishes, townships, and tribes
- Local chapters of health care professional organizations (e.g., medical societies, professional societies, hospital associations)
- Local public safety agencies (e.g., law enforcement and fire services)
- Medical equipment and supply manufacturers and distributors
- Non-governmental organizations (e.g., American Red Cross, voluntary organizations active in disasters, amateur radio operators, etc.)
- Outpatient health care delivery (e.g., ambulatory care, clinics, community and tribal health centers, Federally Qualified Health Centers (FQHCs). urgent care centers, freestanding emergency rooms, stand-alone surgery centers)
- Primary care providers, including pediatric and women's health care providers
- Public health agencies
- Schools and universities, including academic medical centers
- Skilled nursing, nursing, and long-term care facilities
- Social work services
- Support service providers (e.g., clinical laboratories, pharmacies, radiology, blood banks, poison control centers

# Using the Capabilities Document

- The 2017-2022 Health Care Preparedness and Response Capabilities document is organized into four sections—one for each capability. Each capability has a goal and a set of objectives with associated activities.
- The capabilities are a high-level overview of the objectives and activities that the nation's health care delivery system, including HCCs and individual health care organizations, should undertake to prepare for, respond to, and recover from emergencies
- Definitions of capability goal, objective, and activity are defined below.
  - Goal: The outcome of developing the capability
  - Objective: Overarching component of the capability that, when completed, helps achieve the goal
  - Activity: A task critical for achieving an objective

# Four Capabilities

- **Capability 1**: Foundation for Health Care and Medical Readiness
  - Goal of Capability 1: The community's health care organizations and other stakeholders—coordinated through a sustainable HCC—have strong relationships, identify hazards and risks, and prioritize and address gaps through planning, training, exercising, and managing resources
- **Capability 2**: Health Care and Medical Response Coordination
  - Goal of Capability 2: Health care organizations, the HCC, their jurisdiction(s), and the ESF-8 lead agency plan and collaborate to share and analyze information, manage and share resources, and coordinate strategies to deliver medical care to all populations during emergencies and planned events

# Four Capabilities

- **Capability 3**: Continuity of Health Care Service Delivery
  - Goal of Capability 3: Health care organizations, with support from the HCC and the ESF-8 lead agency, provide uninterrupted, optimal medical care to all populations in the face of damaged or disabled health care infrastructure. Health care workers are well-trained, well-educated, and well-equipped to care for patients during emergencies. Simultaneous response and recovery operations result in a return to normal or, ideally, improved operations
- **Capability 4:** Medical Surge
  - Goal of Capability 4: Health care organizations—including hospitals, EMS, and out-of-hospital providers—deliver timely and efficient care to their patients even when the demand for health care services exceeds available supply. The HCC, in collaboration with the ESF-8 lead agency, coordinates information and available resources for its members to maintain conventional surge response. When an emergency overwhelms the HCC's collective resources, the HCC supports the health care delivery system's transition to contingency and crisis surge response and promotes a timely return to conventional standards of care as soon as possible.

# MISSOURI HEALTHCARE COALITIONS


| Healthcare Coalition (HCC) Contacts | | |
|---|---|---|
| **Region A** | **Non-Urban Rural** | **Region C** |
| Jennifer Sutherlin<br>Mid-America Regional Council<br>kcrhcc@gmail.com<br>913-608-9425 | Stacie Hollis<br>Missouri Hospital Association<br>nonurbanmohcc@mhanet.com<br>573-893-3700 | Brad Zoref<br>St. Louis Area Regional Response System<br>COVID-19@ewgateway.org<br>314-421-4220 |

| Region A Healthcare Coalition (MARC) | | | Region C Healthcare Coalition (STARRS) | Non-Urban Healthcare Coalition (MHA) | | | | |
|---|---|---|---|---|---|---|---|---|
| Metro | Northern District | Southern District | | Sub -Region B | Sub-Region F | Sub-Region H | Southeast Sub-Region | Southwest Sub-Region |
| CASS | CARROLL | BATES | FRANKLIN | ADAIR | AUDRAIN | ANDREW | BOLLINGER | BARRY |
| CLAY | LAFAYETTE | BENTON | JEFFERSON | CHARITON | BOONE | ATCHISON | BUTLER | BARTON |
| JACKSON | RAY | HENRY | LINCOLN | CLARK | CALLAWAY | BUCHANAN | CALDWELL | CARTER |
| PLATTE | SALINE | JOHNSON | PIKE | KNOX | CAMDEN | CLINTON | CAPE GIRARDEAU | CEDAR |
| | | PETTIS | ST CHARLES | LEWIS | COLE | DAVIESS | DUNKLIN | CHRISTIAN |
| | | | ST FRANCOIS | LINN | COOPER | DEKALB | IRON | CRAWFORD |
| | | | ST LOUIS | MACON | GASCONADE | GENTRY | MADISON | DADE |
| | | | ST LOUIS CITY | MARION | HOWARD | GRUNDY | MISSISSIPPI | DALLAS |
| | | | WARREN | MONROE | MILLER | HARRISON | NEW MADRID | DENT |
| | | | WASHINGTON | PUTNAM | MONITEAU | HOLT | PEMISCOT | DOUGLAS |
| | | | | RALLS | MONTGOMERY | LIVINGSTON | PERRY | GREENE |
| | | | | RANDOLPH | MORGAN | MERCER | RIPLEY | HICKORY |
| | | | | SCHUYLER | OSAGE | NODAWAY | SCOTT | HOWELL |
| | | | | SCOTLAND | | WORTH | STE GENEVIEVE | JASPER |
| | | | | SHELBY | | | STODDARD | LACLEDE |
| | | | | SULLIVAN | | | WAYNE | LAWRENCE |
| | | | | | | | | MARIES |
| | | | | | | | | MCDONALD |
| | | | | | | | | NEWTON |
| | | | | | | | | OREGON |
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| | | | | | | | | REYNOLDS |
| | | | | | | | | SHANNON |
| | | | | | | | | ST CLAIR |
| | | | | | | | | STONE |
| | | | | | | | | TANEY |
| | | | | | | | | TEXAS |
| | | | | | | | | VERNON |
| | | | | | | | | WEBSTER |
| | | | | | | | | WRIGHT |

Effective Date: July 1, 2010

# Lessons Learned from the Pandemic

PERSONAL PROTECTIVE EQUIPMENT

STAFFING

INFECTION CONTROL PRACTICES

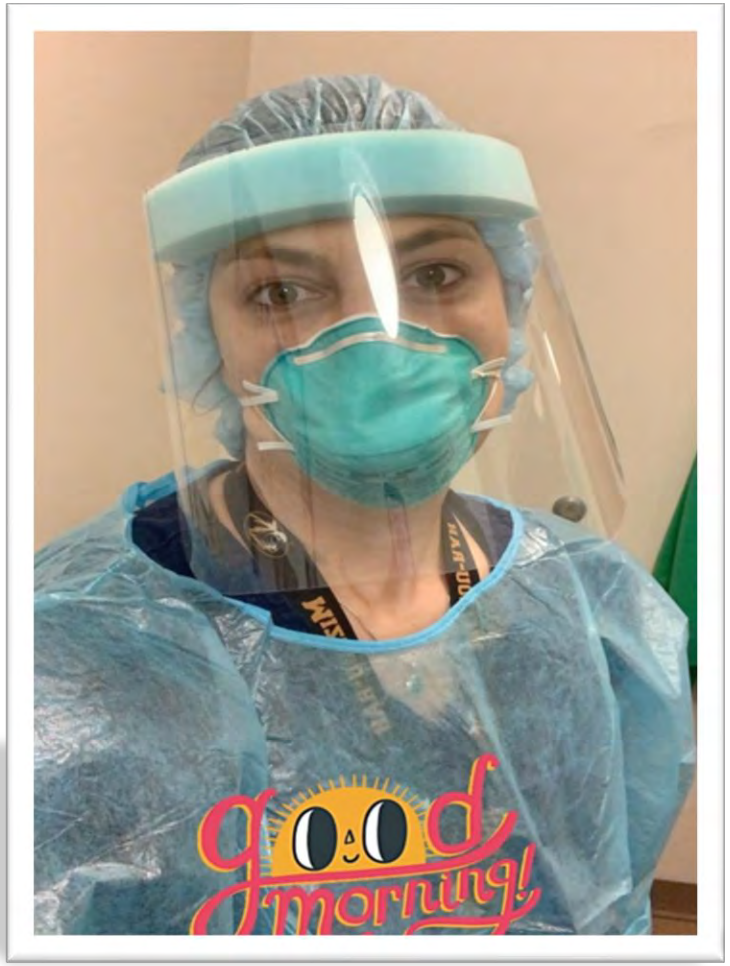
COMMUNICATION

INTANGIBLES

Sinclair School of Nursing
*University of Missouri Health Care*

# Personal Protective Equipment

- Supply management/inventory control
- Burn rate calculation
- Procedures for donning/doffing
- Guidelines for use/reuse
- Vendor relationships



# STAFFING

- Availability of current staffing, numbers
- Required staff for influx of admissions, surge of cases
- Willingness to care for positive Covid-19 cases
- Family obligations: child care, parents, grandparents
- Cross-training of ancillary staff
- Burnout
- Hazard pay, benefits (sick leave)

# Infection Control Practices

- Cohorting/isolation
- Hand hygiene
- Surveillance
- Testing: large numbers, cumbersome process
- Infection Preventionist
- Orientation/Education

# COMMUNICATION

- Open lines of communication with stakeholders: staff, residents, families by phone, zoom, skype, FaceTime, newsletters, flyers, staff meetings, 1:1 or small groups
- Protocols for notification of DHSS, local public health agencies, NHSN…
- Open lines of communication with hospitals, EMS, vendors/contractors
- Non-essential visitor restrictions
- Partnerships with hospitals, hospice, other SNF/ICF/ALF/RCF, vendors
- Mutual aide agreements
- Advance care planning

# INTANGIBLES

- Isolation
- Vulnerability
- Compassion
- Fortitude
- Resilience


# What Lies Ahead?

INFECTION PREVENTION EDUCATION
COLLABORATION
COMMUNICATION

# Infection Prevention Education

- Critical Element Pathways (CEP):
  - CMS 20054 Infection Prevention, Control and Immunizations (5/2017)
  - COVID-19 Focused Survey for Nursing Homes (updated 8/25/2020)
- Infection Control and Assessment Response (ICAR) tool. The items assessed support the key strategies of:
  - Keeping COVID-19 out of the facility
  - Identifying infections as early as possible
  - Preventing spread of COVID-19 in the facility
  - Assessing and optimizing personal protective equipment (PPE) supplies
  - Identifying and managing severe illness in residents with COVID-19

Findings from the assessment can be used to target specific IPC preparedness activities that nursing homes can immediately focus on while continuing to keep their residents and HCP safe.

- After contact with blood, body fluids, or visibly contaminated surfaces or other objects and surfaces in the resident's environment;
- After removing personal protective equipment (e.g., gloves, gown, facemask); and
- Before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, manipulation of a central venous catheter, and/or dressing care).

☐ When being assisted by staff, resident hand hygiene is performed after toileting and before meals.

☐ Interview appropriate staff to determine if hand hygiene supplies are readily available and who they contact for replacement supplies.

☐ Soap, water, and a sink are readily accessible in appropriate locations including, but not limited to, resident care areas, food and medication preparation areas.

**1. Did staff implement appropriate hand hygiene?** ☐ Yes ☐ **No F880**

**Personal Protective Equipment (PPE):**

☐ Determine if staff appropriately use and discard PPE including, but not limited to, the following:

- Gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin;
- Gloves are removed after contact with blood or body fluids, mucous membranes, or non-intact skin;
- Gloves are changed and hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care;
- A gown is worn for direct resident contact if the resident has uncontained secretions or excretions;
- A facemask is worn if contact (i.e., within 3 feet) with a resident with new acute cough or symptoms of a respiratory infection (e.g., influenza-like illness);
- Appropriate mouth, nose, and eye protection (e.g., facemasks, face shield) is worn for performing aerosol-generating and/or procedures that are likely to generate splashes or sprays of blood or body fluids;
- PPE is appropriately discarded after resident care, prior to leaving room, followed by hand hygiene; and
- Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (i.e., nursing units, therapy rooms).

☐ Interview appropriate staff to determine if PPE supplies are readily available and who they contact for replacement supplies.

**2. Did staff implement appropriate use of PPE?** ☐ Yes ☐ **No F880**

**Transmission-Based Precautions:**

☐ Determine if appropriate transmission-based precautions are implemented, including but not limited to:

- PPE use by staff (i.e., don gloves and gowns before contact with the resident and/or his/her environment while on contact precautions; don facemask within three feet of a resident on droplet precautions; don a fit-tested N95 or higher level respirator prior to room entry of a resident on airborne precautions;

# COVID-19 Focused Survey for Nursing Homes

**Surveyor(s) reviews for:**

- The overall effectiveness of the Infection Prevention and Control Program (IPCP) including IPCP policies and procedures;
- Standard and Transmission-Based Precautions *(review care of a resident under observation, suspected of, or confirmed to have COVID-19 infection);*
- Quality of resident care practices, including those *under observation, suspected of, and confirmed to have* COVID-19 *infection*, if applicable;
- The surveillance *and testing* process;
- Visitor entry and facility screening practices;
- Education, monitoring, and screening practices of staff;
- *Actions taken to prevent transmission, such as cohorting and managing care for residents suspected of having or confirmed to have COVID-19*;
- Facility policies and procedures to address staffing issues during emergencies, such as transmission of COVID-19;
- How the facility informs residents, their representatives, and families of suspected or confirmed COVID-19 cases in the facility*; and*
- *The infection preventionist role*.

*The survey team will select a random sample of three residents, and if not already sampled, add one additional resident who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19, for purposes of determining compliance.*

*The survey team will select a random sample of three staff, and if not already sampled, add one additional staff who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19, for purposes of determining compliance.*

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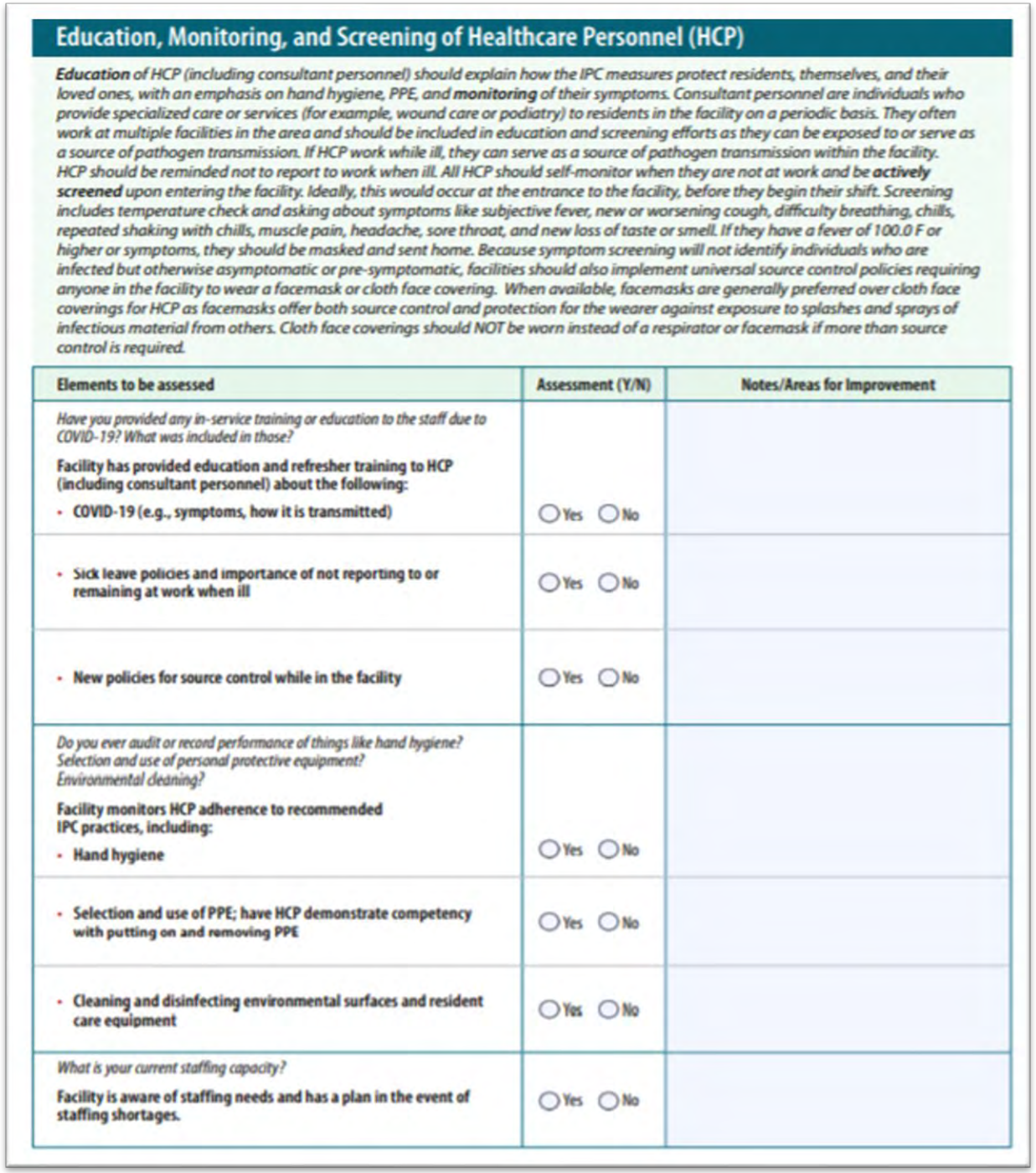
**1. Standard and Transmission-Based Precautions (TBPs)**

CMS is aware that there is a scarcity of some supplies in certain areas of the country. State and Federal surveyors should not cite facilities for not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks) if they are having difficulty obtaining these supplies for reasons outside of their control. However, we do expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of PPE (e.g., due to supplier shortage, which may be a regional or national issue), the facility should contact their healthcare coalition for assistance (https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx), follow national and/or local guidelines for optimizing their current supply, or identify the next best option to care for residents. Among other practices, optimizing their current supply may mean prioritizing use of gowns based on risk of exposure to infectious organisms, blood or body fluids, splashes or sprays, high contact procedures, or aerosol generating procedures (AGPs), as well as possibly extending use of PPE (follow national and/or local guidelines). Current CDC



## Education, Monitoring, and Screening of Healthcare Personnel (HCP)

***Education*** *of HCP (including consultant personnel) should explain how the IPC measures protect residents, themselves, and their loved ones, with an emphasis on hand hygiene, PPE, and* ***monitoring*** *of their symptoms. Consultant personnel are individuals who provide specialized care or services (for example, wound care or podiatry) to residents in the facility on a periodic basis. They often work at multiple facilities in the area and should be included in education and screening efforts as they can be exposed to or serve as a source of pathogen transmission. If HCP work while ill, they can serve as a source of pathogen transmission within the facility. HCP should be reminded not to report to work when ill. All HCP should self-monitor when they are not at work and be* ***actively screened*** *upon entering the facility. Ideally, this would occur at the entrance to the facility, before they begin their shift. Screening includes temperature check and asking about symptoms like subjective fever, new or worsening cough, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, and new loss of taste or smell. If they have a fever of 100.0 F or higher or symptoms, they should be masked and sent home. Because symptom screening will not identify individuals who are infected but otherwise asymptomatic or pre-symptomatic, facilities should also implement universal source control policies requiring anyone in the facility to wear a facemask or cloth face covering. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required.*

| Elements to be assessed | Assessment (Y/N) | Notes/Areas for Improvement |
|---|---|---|
| *Have you provided any in-service training or education to the staff due to COVID-19? What was included in those?*<br>**Facility has provided education and refresher training to HCP (including consultant personnel) about the following:**<br>• **COVID-19 (e.g., symptoms, how it is transmitted)** | ◯ Yes ◯ No | |
| • **Sick leave policies and importance of not reporting to or remaining at work when ill** | ◯ Yes ◯ No | |
| • **New policies for source control while in the facility** | ◯ Yes ◯ No | |
| *Do you ever audit or record performance of things like hand hygiene? Selection and use of personal protective equipment? Environmental cleaning?*<br>**Facility monitors HCP adherence to recommended IPC practices, including:**<br>• **Hand hygiene** | ◯ Yes ◯ No | |
| • **Selection and use of PPE; have HCP demonstrate competency with putting on and removing PPE** | ◯ Yes ◯ No | |
| • **Cleaning and disinfecting environmental surfaces and resident care equipment** | ◯ Yes ◯ No | |
| *What is your current staffing capacity?*<br>**Facility is aware of staffing needs and has a plan in the event of staffing shortages.** | ◯ Yes ◯ No | |

# ICAR

The areas assessed include:

- Visitor restriction
- Education, monitoring, and screening of healthcare personnel (HCP)
- Education, monitoring, and screening of residents
- Ensuring availability of PPE and other supplies
- Ensuring adherence to recommended infection prevention and control (IPC) practices
- Communicating with the health department and other healthcare facilities

Sinclair School of Nursing

# QIPMO's ICAR Project

QIPMO

QUALITY IMPROVEMENT PROGRAM FOR MISSOURI'S NURSING HOMES

Sinclair School of Nursing

**INFECTION CONTROL ASSESSMENT AND RESPONSE PROJECT: A COLLABORATION BETWEEN THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES AND THE QUALITY IMPROVEMENT PROGRAM FOR MISSOURI NURSING HOMES**

The Quality Improvement Program for Missouri's Nursing Homes (QIPMO) is partnering with the Missouri Department of Health and Senior Services (DHSS) in response to the novel Coronavirus known as COVID-19. In doing so, QIPMO has formed a new Infection Control Assessment and Response (ICAR) team with a primary goal of assisting Missouri Long-Term Care Facilities to navigate the challenges of the COVID-19 pandemic and other infectious diseases.

**Members of the ICAR Team are available for voluntary, no cost visits (virtual and/or in-person) to any residential care, assisted living, and skilled nursing facility in Missouri**. These visits are intended to be consultative and collaborative in nature with a non-regulatory focus to evaluate infection control practices. Visits will consist of:

- completion of a standardized assessment of infection control processes, focusing on highly transmittable infectious diseases
- observations of infection control practices
- preliminary feedback with supplemental educational resources

Participating facilities will receive a comprehensive feedback report following the visit. Additionally, the QIPMO ICAR team will be available to participating homes for follow-up assistance and education as requested.

It is the goal of this project to visit (virtual or in-person) 60% of all long-term care facilities in Missouri by the end of 2022. Assisted living facilities and residential care facilities, along with prioritized skilled nursing facilities, will be among the first recruited for an ICAR Team assessment. In person visits will only take place once facilities reopen and can safely allow visitors.

Funding for this project was made possible through the ELC Enhancing Detection Emerging Issues (E) Project: Funding for the Detection, Response, Surveillance, and Prevention of COVID-19 which is supported through the Paycheck Protection Program and the Health Care Enhancement Act of 2020.

Facilities interested in assessing their infection prevention programs and partnering to enhance patient safety through quality facility assessment, staff education and training can contact the QIPMO ICAR Team at musonicarproject@missouri.edu or at (573) 882-0241. *Please be sure to include your facility name, your name, and your title in your email request.*

# Infection Prevention Education

*Staff education* to include review of current policies/procedures, bloodborne pathogens, standard and transmission-based precautions, PPE usage, cohorting, hand hygiene, infection surveillance, etc.

- New hire orientation
- Annual
- Plan of correction (POC) compliance
- Monthly staff meetings
- 1:1 when individual staff non-compliance identified

*Resident/family education* to include:

- Hand hygiene reminders
- Wearing of cloth face coverings or face masks
- Social distancing requirements

# Collaboration

- Partnerships with hospitals, hospice, other SNF/ICF/ALF/RCF, Health Care Coalitions (HCC), vendors
  - Admissions, discharges, transfers
  - Testing with rapid results
  - PPE supply management
  - Equipment needs
- Mutual aide agreements
- VOYCE, HQIN, DHSS, Local Public Health Agencies (LPHA), other entities
- QIPMO nurses and leadership coaches, CAT team, ICAR team

# COMMUNICATION

- Open lines of communication with staff, residents, families
  - Phone, zoom, Skype, FaceTime
  - Newsletters, flyers
  - Staff meetings
  - 1:1, small groups
- Open lines of communication with other stakeholders: hospitals, EMS, LPHA, vendors/contractors
  - Bed availability
  - Medical equipment needs
  - + COVID cases

# Resources

- www.cms.gov Emergency Preparedness Rule, Core EP Rule Elements, QSO19-06-ALL (2/1/2019), QSO-20-38-NH Revised COVID-19 Focused Survey Tool, LTC Survey Pathways (CMS 20054), CMS QSO-20-41-ALL (9/28/2020)
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule Quality, Safety and Oversight Group Emergency Preparedness
- www.emergency-response-planning.com/blog/bid/72134/the-evolution-of-emergency-management-and-disaster-response
- www.asprtracie.hhs.gov CMS Emergency Preparedness Rule Toolkits
- www.nursinghomehelp.org Facility Assessment Tool, Emergency Preparedness Resource List
- www.ahrq.gov Nursing Homes in Public Health Emergencies

# Resources

- www.health.mo.gov Continuity of Operations(COOP) Planning Templates and Worksheets
- www.phe.gov 2017-2022 Health Care Preparedness and Response Capabilities
- https://www.cdc.gov/aging/advancecareplanning/index.html
- www.cdc.gov Infection Control and Assessment Response tool CS316947 (May 8, 2020)
- www.fema.gov Coronavirus (COVID-19) Pandemic: Personal Protective Equipment Preservation Best Practices
- musonicarproject@missouri.edu or (573) 882-0241 QIPMO ICAR Team Please be sure to include your facility name, your name, and your title in your email request

# Additional Resources

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Core-EP-Rule-Elements Core EP Rule Elements
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html Emergency Preparedness Appendix Z
- https://qsep.cms.gov/welcome.aspx Register as Providers and Others, "Emergency Preparedness Provider Readiness" Content: 1135 Waivers, Final Rule, Lessons Learned, Best Practices (90" webinar)

# Additional Resources McKnight's Blog

- https://www.mcknights.com/blogs/second-responders-answering-the-call-for-help-in-long-term-care/?utm_source=newsletter&utm_medium=email&utm_campaign=MLT_DailyUpdate_20200827&hmSubId=&hmEmail=&email_hash=6f527dc75d338734c6a832e74b1569ac&mpweb=1326-11455-598891 Article written by Debbie Pool and Wendy Boren, QIPMO
- https://www.mcknights.com/blogs/guest-columns/i-survived-covid-an-advanced-practice-nurse-on-the-front-lines-of-long-term-care/ Article written by Julia Slavik, APRN MOQI

# Additional Resources

Emergency Preparedness Rule (CMS 3178-F)
Website Resources
(To include on SCG EP Website in lieu of in Interpretive Guidelines)

World Health Organization (WHO). (2011). Hospital Emergency Response Checklist. *An All-Hazards Tool for Hospital Administrators and Emergency Managers*.
http://www.euro.who.int/__data/assets/pdf_file/0008/268766/Hospital-emergency-response-checklist-Eng.pdf

The document provides key components of command control, communication, safety and security, triage, surge capacity and continuity of operations in preparation and during an emergency within a hospital setting. This document provides checklists and recommendations to facilities to guide the emergency preparedness plan and considerations to take when preparing the elements of the emergency plan and communication plans.

Health Lawyers' Public Information Series. (2004). *Emergency Preparedness, Response & Recovery Checklist: Beyond the Emergency Management Plan*.
http://www.in.gov/isdh/files/AHLAEmergency_Preparedness_Checklist.pdf

This emergency preparedness guiding document provides information and questions to consider for facilities in planning for emergencies. Additionally, the document provides a review of key positions within the National Incident Command System (i.e. Incident Commander; Public Information Officer; Liaison Officer; Communication Officer; etc.) and what questions should be considered in the planning stages. The questions posed within this document can provide areas of consideration to guide an emergency plan, policies and procedures and the communication plan.

Murray, Rick; Elmes, Pat; Fly, Deb. American College of Emergency Physicians (ACEP). Hospital Disaster Preparedness Self-Assessment Tool.
http://www.acep.org/content.aspx?id=91205

This assessment tool can allow hospitals and other facilities to begin self-assessing their current emergency preparedness capabilities and identify additional areas which would need to be addressed in emergency planning and the creation of the emergency preparedness plans. The document provides sample checklists which could be changes to adapt to any facility and provides areas of considerations for planning and preparedness. Additionally, the self-assessment tool provides key areas of consideration, to include but not limited to the bed capacity; security and safety; logistics and emergency power; and succession planning.

The National Association for Home Care & Hospice (2008). *Emergency Preparedness Packet for Home Health Agencies*. http://www.nahc.org/assets/1/7/ep_binder.pdf

This document provides a basic overview and considerations for Home Health Agencies to consider when organizing the emergency preparedness plans. The document itself includes checklists; areas for consideration in assigning roles and responsibilities as well as a sample Emergency Preparedness Plan. Additionally, the plan provides an ability for Home Health Agencies to consider potential hazards and threats given their geographical locations, which could assist in providing planning considerations in high hazard areas, such as winter storm affected areas. Agencies could use this to begin prioritizing their planning and needs assessments.

# Additional Resources

Emergency Preparedness Rule (CMS 3178-F)
Website Resources
(To include on SCG EP Website in lieu of in Interpretive Guidelines)

South Carolina Department of Health and Environmental Control in Coordination with the South Carolina Emergency Management Division. (2013). *Emergency Operations Plan Development Guide and Template for Extended Care Facilities.* https://www.scdhec.gov/health/docs/hlgeop.pdf

The resource developed by the state of South Carolina, provides a detailed overview for long-term care facilities to consider when preparing their emergency and communication plans, as well as outlining policies in procedures. The document not only provides potential situations to consider in planning, but also provides the Federal Emergency Management Agency (FEMA) critical areas of preparedness, planning, mitigation, response, and recovery. Additionally, the documents appendices provide sample checklists for long-term care facilities to be able to consider in preparation of their own plans.

Guenther, Robin, FAIA; Balbus, John, MD. *Primary Protection: Enhancing Health Care Resilience for a Changing Climate*. (2014). Department of Health and Human Services. http://toolkit.climate.gov/topics/human-health/building-climate-resilience-health-sector.

The resource provides extensive research and a tool kit for providers, primarily hospital settings, in establishing the framework for emergency preparedness and planning for severe weather incidents. The website and documents, including the toolkit, provide groundwork for common understanding of climate changes; adverse events and challenges that this poses to the health care community and provides a suite of online tools and resources that highlight emerging best practices for developing sustainable and climate-resilient health care facilities.

Resources provided by National Center for Disaster Medicine & Public Health

Several online lessons for health professionals:
Tracking and Reunification of Children in Disasters
Psychosocial Impacts of Disasters on Children
Radiation Issues in Children: Knowledge Check, Primer, & Case-Based Activity

**Caring for Older Adults in Disasters: A Curriculum for Health Professionals.** Developed through the support of the U.S. Department of Veterans Affairs, the Caring for Older Adults in Disasters (COAD) curriculum is comprised of 24 lessons in 7 modules covering topics ranging from special considerations for older adults in specific types of disasters to ethical and legal issues related to the care of the senior population during a disaster. The COAD curriculum's lessons range from 30 to 120 minutes in length based on the particular learning context. They include suggested learning activities for educators to engage their learners, as well as required and supplemental readings for both learners and educators. The curriculum can be used in its entirety, teaching all lessons in the order provided, or trainers may select individual lessons or portions of lessons most relevant to their learners. The curriculum's material can be adapted to best meet a specific setting and learner needs by substituting resources, modifying activities, or augmenting content.

**A video series (currently two videos) on healthcare professionals working with individuals with access and functional needs for disaster preparedness.**

- To access the first video in this series, click here: It's Empowering the Community
- The second video in the series: Everyone in the Community Involved


## CEUs for Today!

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**In order to get the credit, you will need to complete the brief survey/evaluation that will pop up at the end of the webinar. An automated email from GoToWebinar will also be sent to all attendees that will include a link to the survey/evaluation.**

*Please note: the certificate that will be linked in GoToWebinar's automated "thank you for attending" email is* ***not your CEU certificate****. Your official certificate will be sent out by QIPMO staff within 1-2 weeks of the webinar.*

# Evaluation

https://www.surveymonkey.com/r/QIPMOVirtualSG


QUESTIONS