


Emergency Preparedness Plan (EPP) Series
4: Know Thy Neighbors Near and Far

Jason Belden, Director of Emergency Preparedness and Physical Plant Services,
California Association of Health Facilities

Ryan Dickerson, MHA, Executive Director, Northern California
Providence Health and Services

Stephanie Meeks, MBA, CHEP, HACP, Emergency Management & Regulatory Compliance Manager,
Ridgecrest Regional Hospital

Wednesday, May 17, 2023

HSAG HEALTH SERVICES ADVISORY GROUP

Agenda

- QSO-23- 13-ALL
- Transportation Considerations
- Q&A

QSO-23-13

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-23-13-ALL

DATE: May 01, 2023

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Guidance for the Expiration of the COVID-19 Public Health Emergency (PHE)

Memorandum Summary

- Social Security Act Section 1135 emergency waivers for health care providers will terminate with the end of the COVID-19 Public Health Emergency (PHE) on May 11, 2023.
- Certain regulations or other policies included in Interim Final Rules with Comments (IFCs) will be modified with the ending the PHE. Certain policies, such as the Acute Hospital at Home initiative and telehealth flexibilities have been extended by Congress through December 31, 2024.
- Long Term Care and Acute and Continuing Care providers are expected to be in compliance with the requirements according to the timeframes listed below.

QSO-23-13-ALL - End of Public Health Emergency (PHE).pdf

QSO-23-13 (An Excerpt)

Emergency Preparedness

Training and Testing Program Exemption

The following information supersedes the previously issued QSO-20-41-ALL-REVISED memo for all certified providers/suppliers. CMS regulations for Emergency Preparedness (EP) require the provider/supplier to conduct exercises to test their EP plan to ensure that it works and that staff are trained appropriately about their roles and the provider/supplier's processes. During or after an actual emergency, the EP regulations allow for a one-year exemption from the requirement that the provider/supplier perform testing exercises. The exemption only applies to the next required full-scale exercise (not the exercise of choice), based on the 12-month exercise cycle. The cycle is determined by the provider/supplier (e.g., calendar, fiscal or another 12-month timeframe). The exemption only applies when a provider/supplier activates its emergency preparedness program for an emergency event.

Providers/suppliers are expected to return to normal operating status and comply with the regulatory requirements for emergency preparedness with the conclusion of the PHE. This includes conducting testing exercises based on the regulatory requirements for specific provider/supplier types as follows:

- **Inpatient Providers and Suppliers[1]:** The provider/supplier must conduct a full-scale exercise within its annual cycle for 2023 and an exercise of choice.

[1] 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).

Poll Questions

Q: Do you readily know the ambulation status of all your patients/residents?

A. Yes B. No

Q: Do you have a Memorandum of Understanding in place for transportation?

A. Yes B. No

Q: Do you have a transfer agreement with other providers, both near and far?

A. Yes B. No

Evacuations for LTC Providers:

Know Thy Neighbor Transportation, ACSs, and MOUs

Presented by CAHF's **Disaster Preparedness Program**

HSAG EP Webinar Series

Reacting to disaster or crisis...

It’s not what you think…

Why do some people fail to respond?

- Subconscious Need for Normalcy
- Overwhelming Sense of Denial
- Optimistic Bias
- Unable to Comprehend Scope of Event
- Lack of Safety Culture
- No Planning/Preparedness
- Poor Training and No Practice
- NO LEADERSHIP

Activate EOP – Deciding to Evacuate

The first phase of every unexpected event is <u>CHAOS</u>

Leadership is critical to:

- Set the tone of calm
- Assess the situation
- Guide the response

Decisions need to be made about what to DO:

- **NOW!**
  - **Next and Later**

QUESTION – WHAT TRIGGERS COULD MAKE YOU EVACUATE YOUR FACILITY?

EVACUATION vs. SHELTER IN PLACE

IS EVACUATION ALWAYS THE BEST CHOICE?

…preliminary data suggests that evacuation has unintended consequences in terms of mortality, hospitalization, and functional decline.

Vincent Mor, PhD
Center for Gerontology and Healthcare Research, Brown University, Providence, RI, USA

The Rehabilitation Center at Hollywood Hills, FL

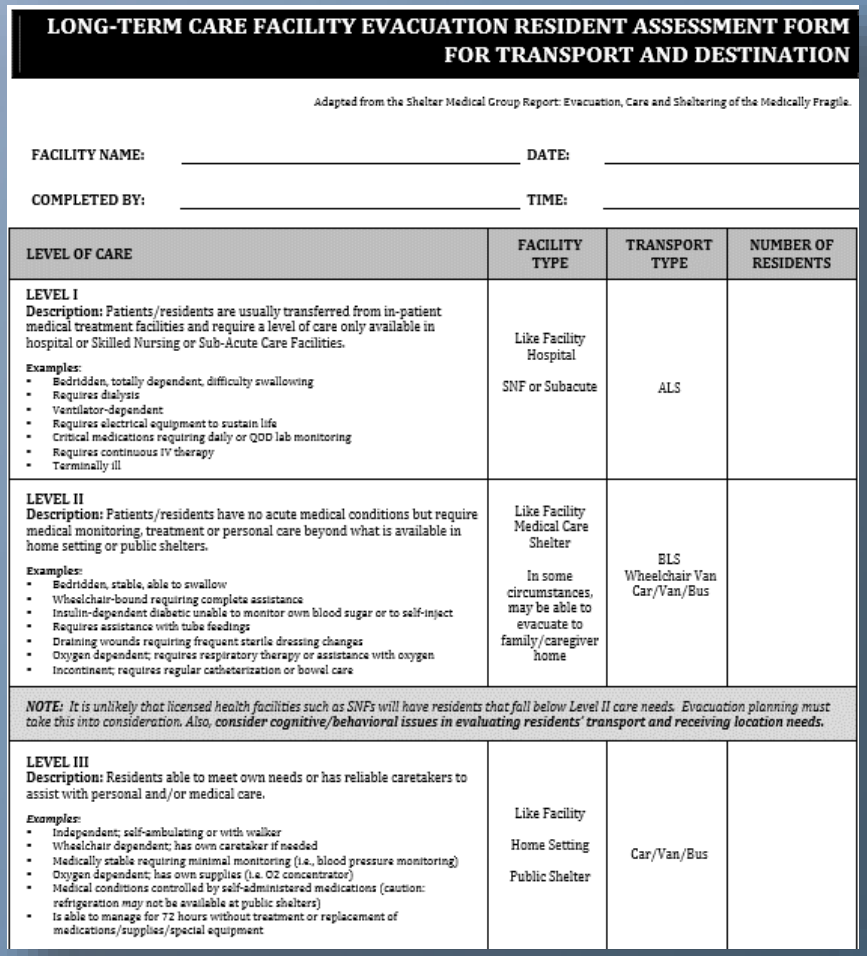
- Hurricane Irma: The strongest Atlantic basin hurricane ever recorded outside the Gulf of Mexico and the Caribbean Sea.
- Two-story skilled nursing facility, licensed for 152.
- Decision of the facility to shelter in place due to the frail condition of the residents and the stress of moving them out of the projected path of storm impact.
- Power knocked out on Sunday. AC not on generator.
- Multiple calls to request power restoration, but no request for evacuation assistance. Portable AC brought in.
- On the following Wednesday concerns led rescuers to facility and they found 40 residents suffering critical heat-related illness.
- A total of 12 heat-related deaths. Homicide charges being considered.

OUR FOCUS TODAY: SAFE EVACUATION

CMS Says this INCLUDES:

- Care and treatment of evacuees
- Staff responsibilities
- Transportation (MOUs)
- Tracking residents and staff
- Evacuation locations (Pre-Arranged)
- Primary and alternate means of communication with external sources of assistance

LTC Evacuation Resident Assessment Form For Transport And Destination



LONG-TERM CARE FACILITY EVACUATION RESIDENT ASSESSMENT FORM FOR TRANSPORT AND DESTINATION

Adapted from the Shelter Medical Group Report: Evacuation, Care and Sheltering of the Medically Fragile.

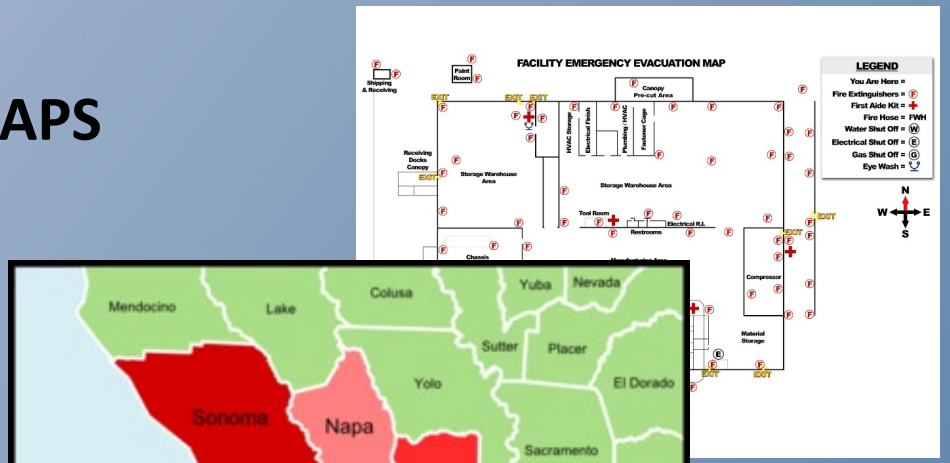
FACILITY NAME: _____ **DATE:** _____

COMPLETED BY: _____ **TIME:** _____

LEVEL OF CARE	FACILITY TYPE	TRANSPORT TYPE	NUMBER OF RESIDENTS
LEVEL I **Description:** Patients/residents are usually transferred from in-patient medical treatment facilities and require a level of care only available in hospital or Skilled Nursing or Sub-Acute Care Facilities. **Examples:** ▪ Bedridden, totally dependent, difficulty swallowing ▪ Requires dialysis ▪ Ventilator-dependent ▪ Requires electrical equipment to sustain life ▪ Critical medications requiring daily or QOD lab monitoring ▪ Requires continuous IV therapy ▪ Terminally ill	Like Facility Hospital SNF or Subacute	ALS	
LEVEL II **Description:** Patients/residents have no acute medical conditions but require medical monitoring, treatment or personal care beyond what is available in home setting or public shelters. **Examples:** ▪ Bedridden, stable, able to swallow ▪ Wheelchair-bound requiring complete assistance ▪ Insulin-dependent diabetic unable to monitor own blood sugar or to self-inject ▪ Requires assistance with tube feedings ▪ Draining wounds requiring frequent sterile dressing changes ▪ Oxygen dependent; requires respiratory therapy or assistance with oxygen ▪ Incontinent; requires regular catheterization or bowel care	Like Facility Medical Care Shelter In some circumstances, may be able to evacuate to family/caregiver home	BLS Wheelchair Van Car/Van/Bus	
NOTE: *It is unlikely that licensed health facilities such as SNFs will have residents that fall below Level II care needs. Evacuation planning must take this into consideration. Also,* ***consider cognitive/behavioral issues in evaluating residents' transport and receiving location needs.***			
LEVEL III **Description:** Residents able to meet own needs or has reliable caretakers to assist with personal and/or medical care. ***Examples:*** ▪ Independent; self-ambulating or with walker ▪ Wheelchair dependent; has own caretaker if needed ▪ Medically stable requiring minimal monitoring (i.e., blood pressure monitoring) ▪ Oxygen dependent; has own supplies (i.e. O2 concentrator) ▪ Medical conditions controlled by self-administered medications (caution: refrigeration may not be available at public shelters) ▪ Is able to manage for 72 hours without treatment or replacement of medications/supplies/special equipment	Like Facility Home Setting Public Shelter	Car/Van/Bus	

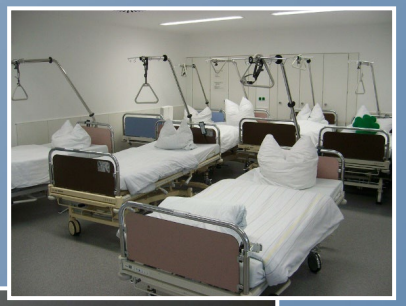
FACILITY EVACUATION AND MAPS

- Definitions
- Agreements for Relocations Sites
- Logistics
  - Transportation
  - What to send
  - Resident ID
  - Tracking
  - Routes



Emergency Admits

- Develop arrangements with other providers to receive residents/clients in the event of limitations or cessation of operations to maintain continuity of services to residents/clients.



ALTERNATE CARE SITES

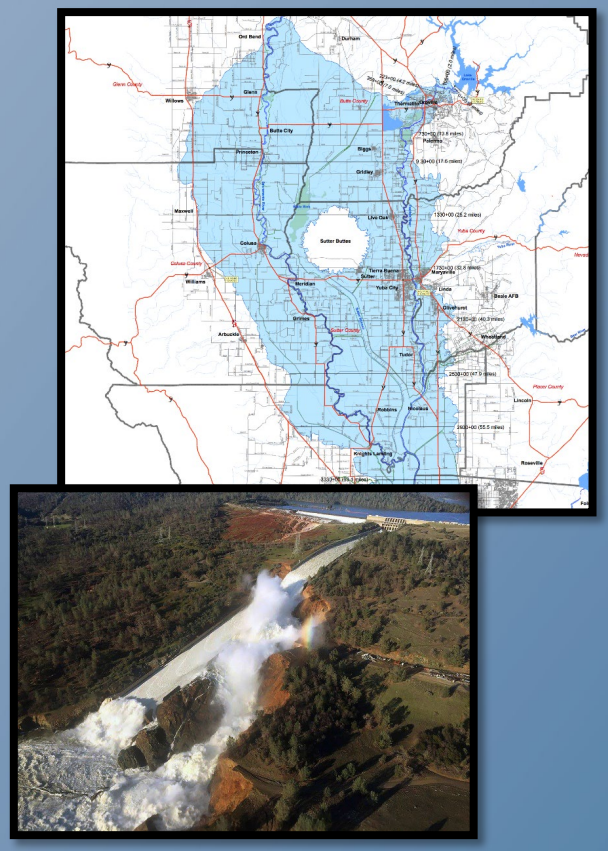
Residents' Unique Needs for Safe Transfer

- In your EOP, do not list hospitals as your alternate care sites, instead pre-determine other "like" facilities.
- Find "like" facilities that can provide the same services as your resident would receive at the home facility—continuity of care.
- "Alternate care site" can also be a specified area in your facility, e.g. when you need to cool your residents in the dining room during a power outage.
- Identify the unique needs (including transportation) of your residents using a resident profile—assign a staff member to keep this resident profile updated periodically.

> **E-0026:** The role of the facility 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.

Lesson Learned: Oroville Dam Overflow, 2017

- Administrator of one Oroville facility was told that a 12 foot wall of water could hit his facility in a couple hours and to get out ASAP.
- Took him several hours to find transportation for his 99 residents, Butte County did not have enough.
- After repopulation, facility was faced with a $70,000 bill for transport from various ambulance companies.
- Administrator said his **number one lesson was knowing the ambulation status of all residents** and updating it regularly so that the staff could order the right transport more efficiently.
- He now updates ambulation status of all residents once a week.
- Know the unique needs of your residents!



ALTERNATE CARE SITES

Memorandums of Understanding / Patient Transfer Agreements

- What are the names of the alternate facilities that have agreed to an MOU or patient transfer agreement?
- Can your alternate care site also serve as your alternate Command Center?
- What will the alternate care site need, listed by essential function, in order to provide continuity of care (sending along staff, DME, meds, etc.)?
- If you have to move residents outside of your immediate area to a facility you can still arrange MOU after the fact for billing and reimbursement purposes.
- CAHF's MOU template: www.cahfdisasterprep.com/mou

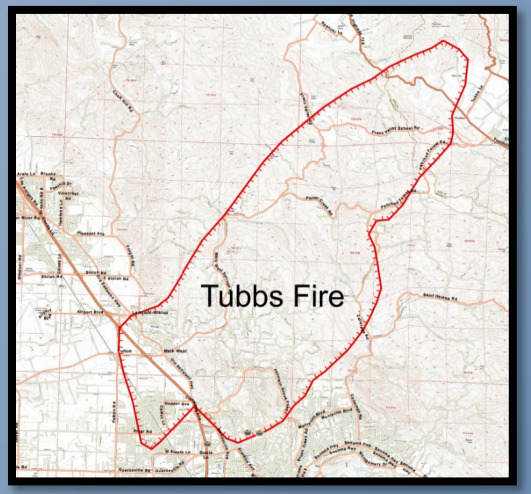
E-0025: The development of arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.

Lesson Learned: Tubbs Fire (2017)

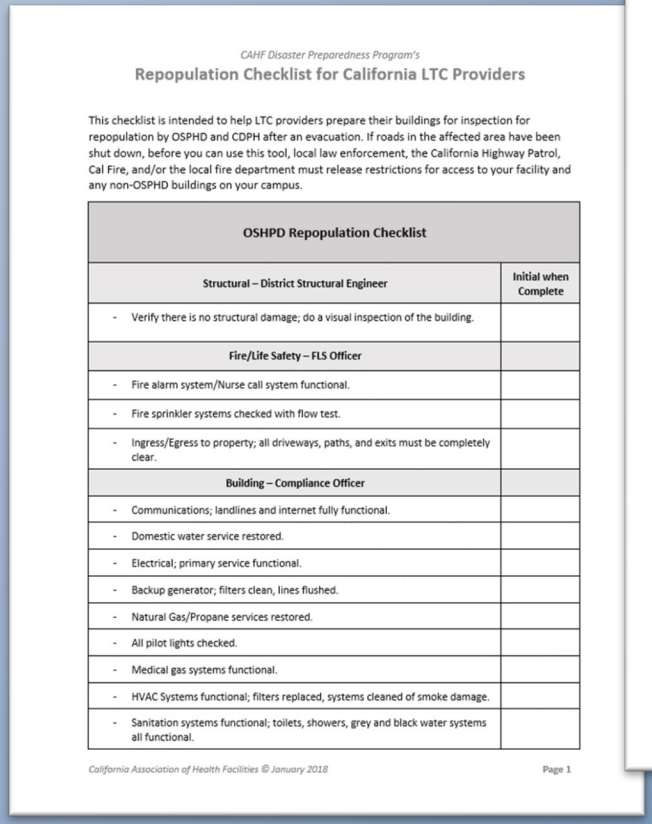
- Veterans Home in Yountville (Sonoma County) was threatened by the Tubbs Fire, at the time the most destructive wildfire in CA. Residents evacuated without medical records to multiple receiving facilities.

- The VA used paper charting, no way to remotely access records after the area was closed off due to wildfire.

- If you paper chart, prioritize taking all your paper charts with you in an evacuation! You do not know when you will be able to return, or if your building will be damaged.



Repopulation after Evacuation

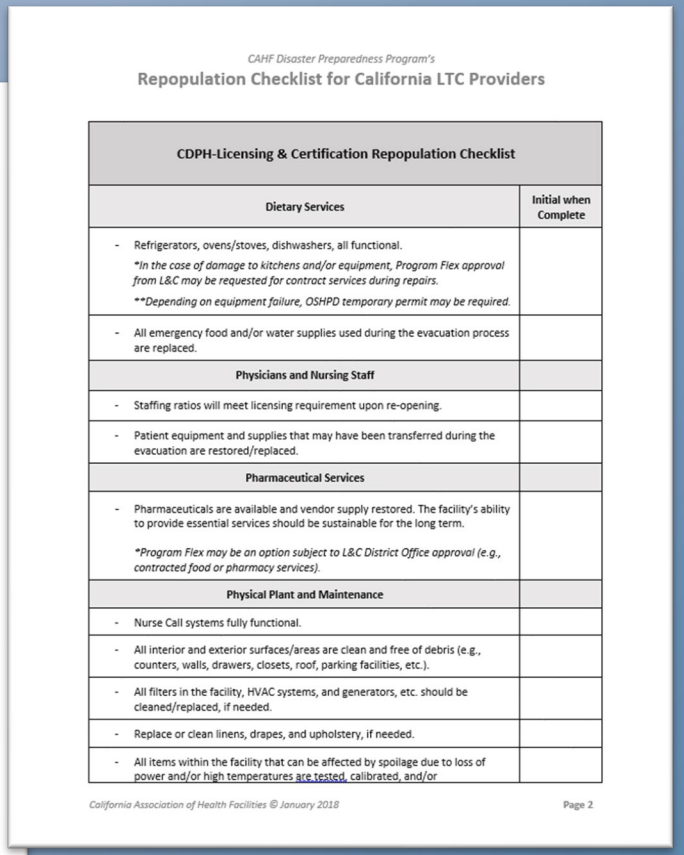


CAHF Disaster Preparedness Program's

Repopulation Checklist for California LTC Providers

This checklist is intended to help LTC providers prepare their buildings for inspection for repopulation by OSPHD and CDPH after an evacuation. If roads in the affected area have been shut down, before you can use this tool, local law enforcement, the California Highway Patrol, Cal Fire, and/or the local fire department must release restrictions for access to your facility and any non-OSPHD buildings on your campus.

OSHPD Repopulation Checklist	
Structural – District Structural Engineer	**Initial when Complete**
- Verify there is no structural damage; do a visual inspection of the building.	
Fire/Life Safety – FLS Officer	
- Fire alarm system/Nurse call system functional.	
- Fire sprinkler systems checked with flow test.	
- Ingress/Egress to property; all driveways, paths, and exits must be completely clear.	
Building – Compliance Officer	
- Communications; landlines and internet fully functional.	
- Domestic water service restored.	
- Electrical; primary service functional.	
- Backup generator; filters clean, lines flushed.	
- Natural Gas/Propane services restored.	
- All pilot lights checked.	
- Medical gas systems functional.	
- HVAC Systems functional; filters replaced, systems cleaned of smoke damage.	
- Sanitation systems functional; toilets, showers, grey and black water systems all functional.	



CAHF Disaster Preparedness Program's

Repopulation Checklist for California LTC Providers

CDPH-Licensing & Certification Repopulation Checklist	
Dietary Services	**Initial when Complete**
- Refrigerators, ovens/stoves, dishwashers, all functional. **In the case of damage to kitchens and/or equipment, Program Flex approval from L&C may be requested for contract services during repairs.* ***Depending on equipment failure, OSHPD temporary permit may be required.*	
- All emergency food and/or water supplies used during the evacuation process are replaced.	
Physicians and Nursing Staff	
- Staffing ratios will meet licensing requirement upon re-opening.	
- Patient equipment and supplies that may have been transferred during the evacuation are restored/replaced.	
Pharmaceutical Services	
- Pharmaceuticals are available and vendor supply restored. The facility's ability to provide essential services should be sustainable for the long term. **Program Flex may be an option subject to L&C District Office approval (e.g., contracted food or pharmacy services).*	
Physical Plant and Maintenance	
- Nurse Call systems fully functional.	
- All interior and exterior surfaces/areas are clean and free of debris (e.g., counters, walls, drawers, closets, roof, parking facilities, etc.).	
- All filters in the facility, HVAC systems, and generators, etc. should be cleaned/replaced, if needed.	
- Replace or clean linens, drapes, and upholstery, if needed.	
- All items within the facility that can be affected by spoilage due to loss of power and/or high temperatures are tested, calibrated, and/or	

We have to be ready to be their “first responders”…

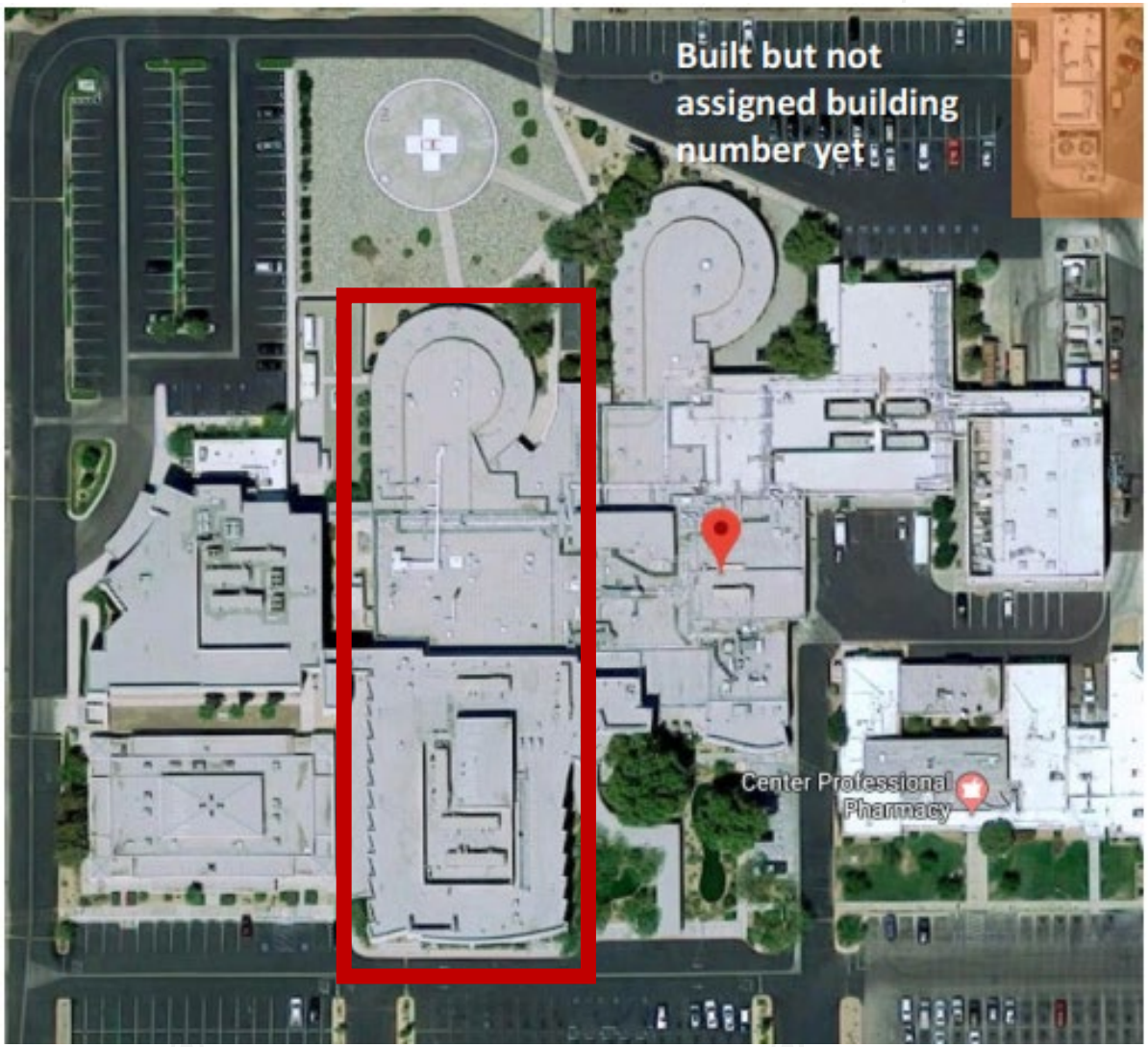
WE ARE THE EXPERTS ON OUR RESIDENTS

Ridgecrest
REGIONAL HOSPITAL

Major Earthquake
Evacuation Lessons Learned
by a Critical Access Hospital

Stephanie Meeks, MBA, CHEP, HACP
Emergency Management & Regulatory Compliance Manager
Ridgecrest Regional Hospital


1011
1081

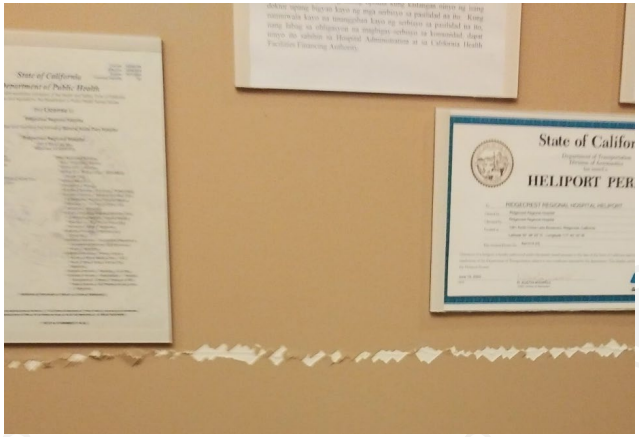

Built but not assigned building number yet
Center Professional Pharmacy

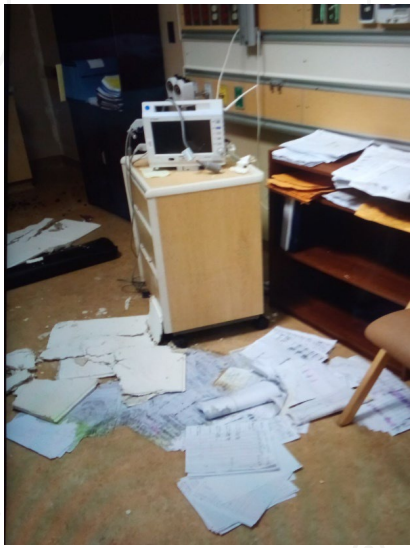
Arrival at Hospital 10:45 a.m.

Initial Physical Assessment

Quick leadership gathering—3 of us at the time had to make quick decisions.

Receiving information from the military base and USGS that a large quake was IMMINENT!





Decision to Evacuate 11:30 a.m.

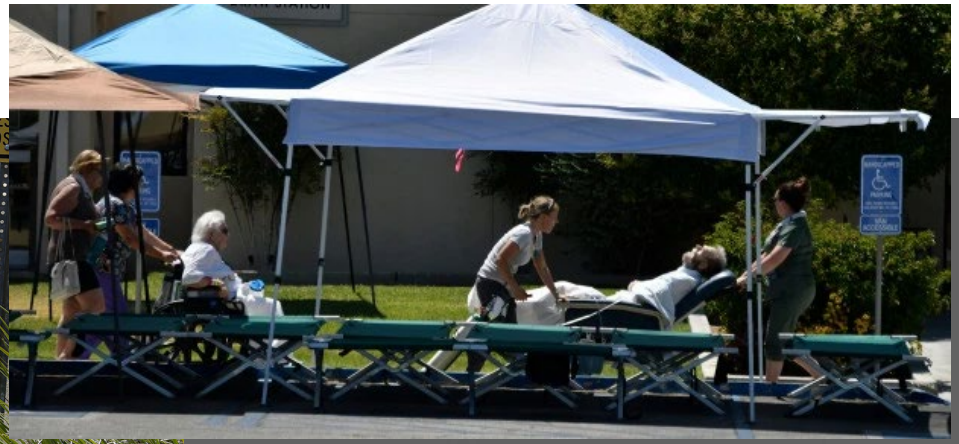
Census

- 15 Med/Surg Patients on 2nd Floor
- 2 ICU Patients on 1st Floor
- 4 Cuplets in Maternal/Child (1964 hospital building)
- 7 Patients in ER—Low/Moderate Acuity
- 12 Residents in Transitional Care Unit (1964 hospital building—Moved to SNF)
- 55 Residents at SNF building adjacted to hopsital—Did not evacuate

Resource Request Pathway

- We used ReddiNet to request 2 strike teams to Ridgecrest to transport patients out, even though we own the only ambulance company in town, we have no control over them in an emergency.

Evacuation



https://www.mcall.com/2019/07/05/update-fires-gas-leaks-injuries-and-cracked-roads-follow-64-magnitude-quake-in-southern-california/

Evacuation—Transport

Transfer of Patients—Our closest neighbor (hospital) is over 100 miles away.

Ambulance strike teams from Bakersfield were deployed to transfer patients out of Ridgecrest.

Request for strike teams–11:30 a.m.
Last patient out–8:20 p.m.

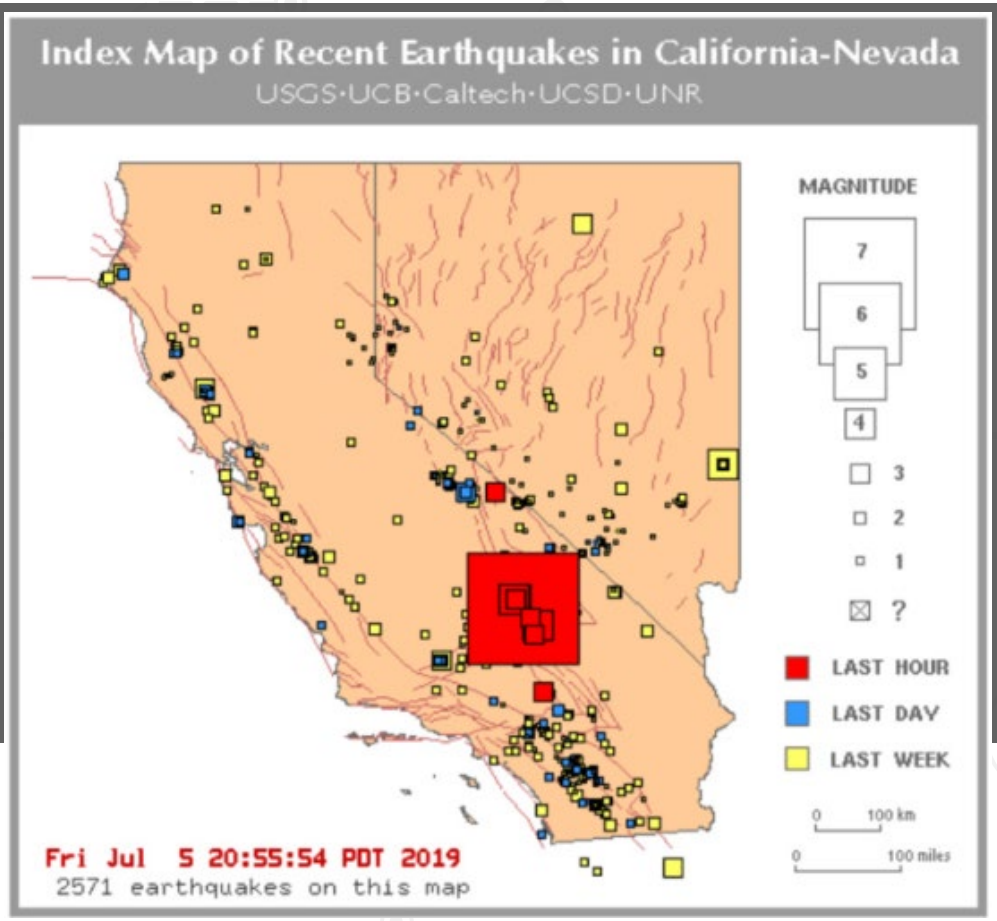
9 Hours…

A Quick Note on our MHOAC

Build that relationship!

KERN COUNTY PUBLIC HEALTH

July 5–7.1 Main Fault Rupture 8:19 p.m.



Luckily, we had already transferred all our patients out on the 4th of July.

However, all but 1 had been discharged and were back in town.

Moving Forward–Planning

Connecting with 3 Healthcare Coalitions not just the county we are in as we transfer patients to multiple counties.

Continue to work with our community to develop MOUs for local alternate care site options.

Know our facility's capabilities to make sure every resource is available to take care of our community without the need to send them out–we would prefer to shelter-in-place and get our patients home if possible due to our remote location.

Moving Forward - Supplies

New military grade field hospital shelters with environmental controls, generators, and additional supplies have been purchased.

Next event, if able, we will shelter in place and discharge if acuity of patients allows.

Goal to be self-sustaining through event rather than relying on external resources and transfers.

Collaboration is KEY – IWV ESC

Four Things to Do by Next Wednesday

- Ensure that Memorandum of Understanding (MoU) are in place for transportation and consider the unique needs of your residents using a resident profile.
- Ensure MoUs are in place for transfer and discharge near and far.
- Ensure medical records are transferable/available for each resident.
- Assign a staff member to keep the resident profiles updated.

Questions?

Thank you!

Jason Belden | jbelden@cahf.org

Ryan Dickerson | ryan.dickerson@providence.org

Stephanie Meeks | stephanie.meeks@rrh.org




Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

HSAG HEALTH SERVICES ADVISORY GROUP

This material was prepared by Health Services Advisory Group (HSAG), a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. QN-12SOW-XC-50162023-02