RHC Emergency Preparedness Workshop

SESSION 1: What do the regulations say?

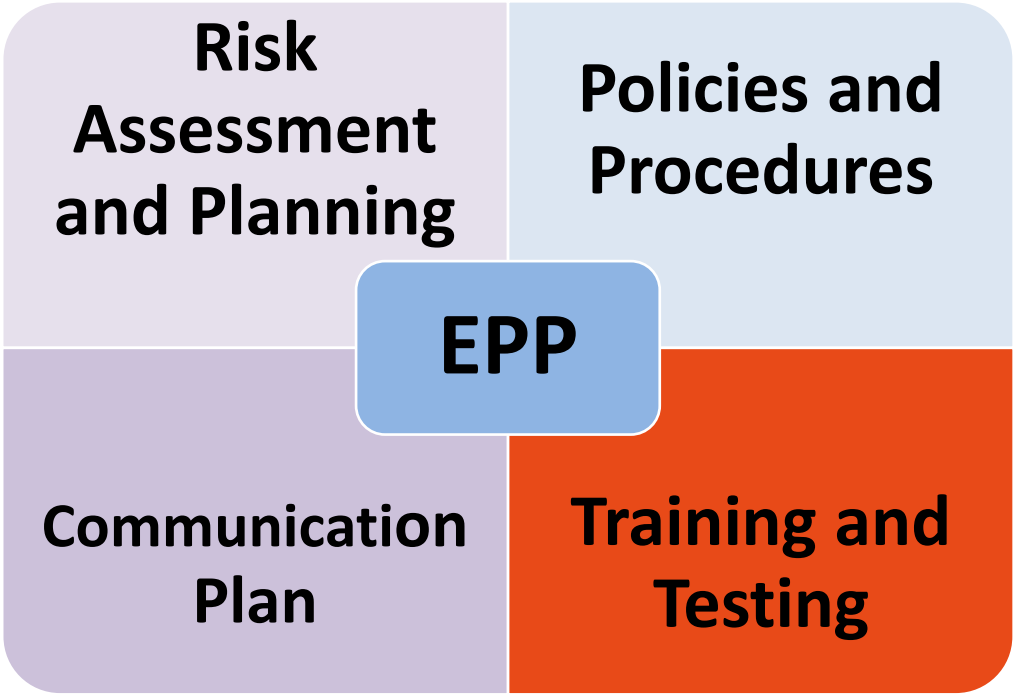
Oregon State Office of Rural Health
January 17, 2023
Presenter: Patty Harper

42 CFR §491.12

EMERGENCY PREPAREDNESS AS A CONDITION OF CERTIFICATION

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-491/subpart-A/section-491.12

Emergency Preparedness Program



§ 491.12 Emergency preparedness.

The Rural Health Clinic/Federally Qualified Health Center (RHC/FQHC) must comply with all applicable Federal,
State, and local emergency preparedness requirements. The RHC/FQHC must establish and maintain an emergency
preparedness program that meets the requirements of this section. The emergency preparedness program must
include, but not be limited to, the following elements:

This content is from the eCFR and is authoritative but unofficial.

(a) *Emergency plan*. The RHC or FQHC must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years. The plan must do all of the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.

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

(3) Address patient population, including, but not limited to, the type of services the RHC/FQHC has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.

What if my RHC is Provider-Based?

- Your RHC must fulfil all of the EPP requirements independently from your parent organization.
- The RHC EPP may be integrated with the organization's master plan; BUT, the hospital's plan and the RHC plan are not the same. The RHC must have all components required in 42 CFR 491.12.
- The RHC's risk assessment and activation plans will be different from those of the hospital or other subcomponents of the parent organization. This will change based on location, physical plant and other risks unique to each setting.
- The hospital requirements are not the same as the RHC requirements in Appendix Z.
- If someone from your clinic participates in a hospital emergency preparedness training or testing activity, then that information then needs to be disseminated to all of the clinic staff in order to count.

Risk Assessments

Community-Based

Facility-Based

Your EPP Begins with Risk Assessment

- Your Emergency Preparedness Program begins with a risk assessment process using an all-hazards approach.

- Without identifying the risks—potential threats and probable emergency events—you cannot create policies and procedures which guide your emergency response to those risks.

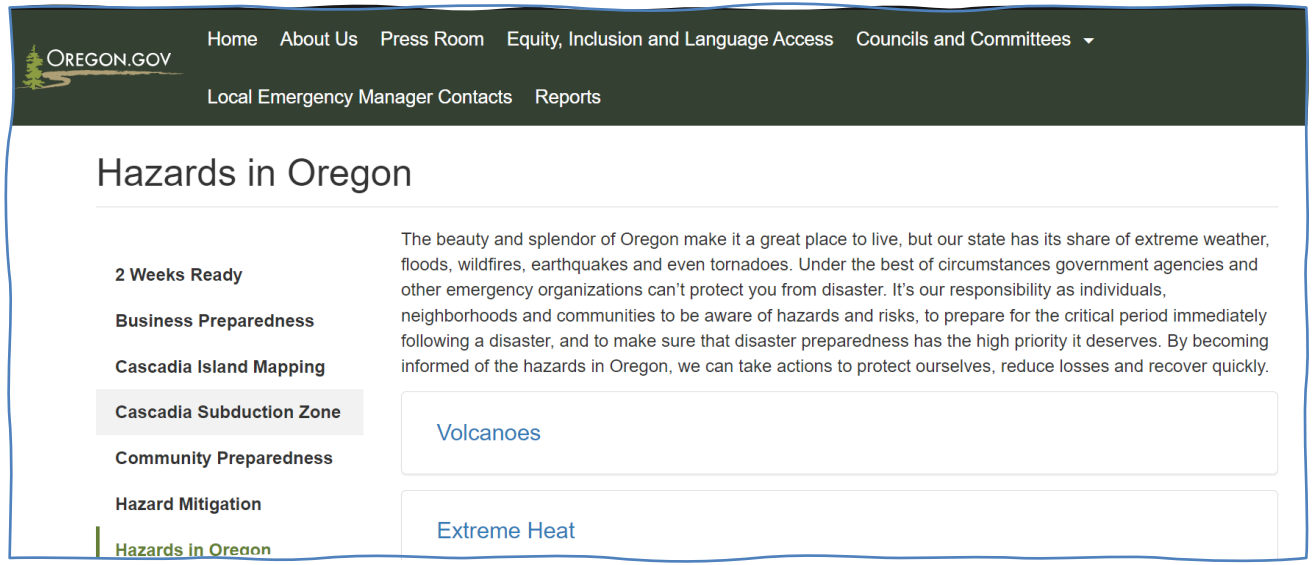
- The risk assessment process must be unique to your facility type (Rural Health Clinic), your geography and other characteristics which apply to your RHC.

- The Emergency Preparedness Program must be reviewed every 2 years which means the assessments are also updated biennially.

- **All healthcare facilities are required to include Emerging Infectious Disease in their risk assessments.**

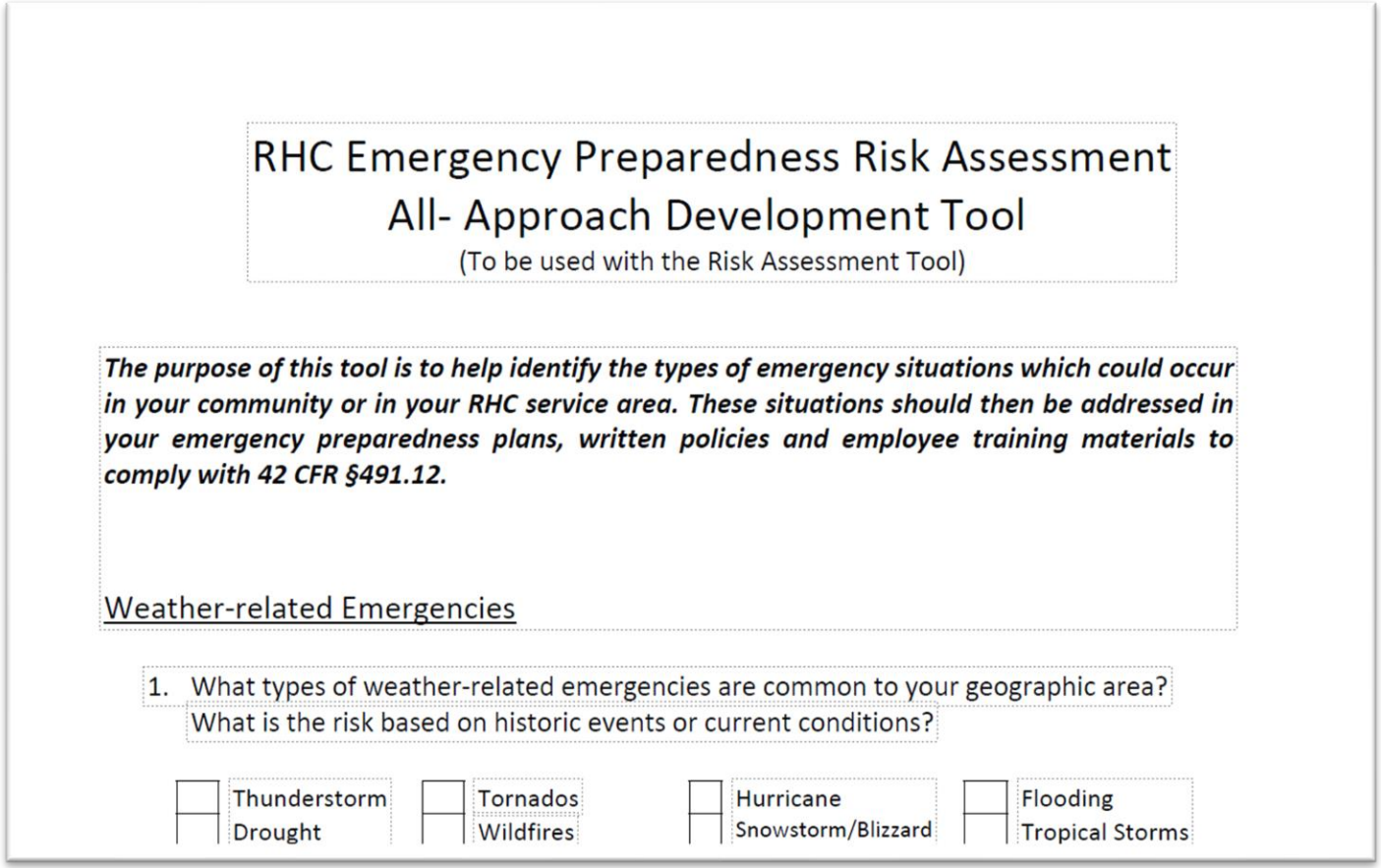
Oregon Hazards

https://www.oregon.gov/oem/hazardsprep/Pages/Hazards-in-Oregon.aspx



If you don't know where to start at all, begin with a brainstorming session to help identify possible threats.

Then, build your risk assessment from the potential hazards identified in the brainstorming session.



RHC Emergency Preparedness Risk Assessment
All- Approach Development Tool
(To be used with the Risk Assessment Tool)

The purpose of this tool is to help identify the types of emergency situations which could occur in your community or in your RHC service area. These situations should then be addressed in your emergency preparedness plans, written policies and employee training materials to comply with 42 CFR §491.12.

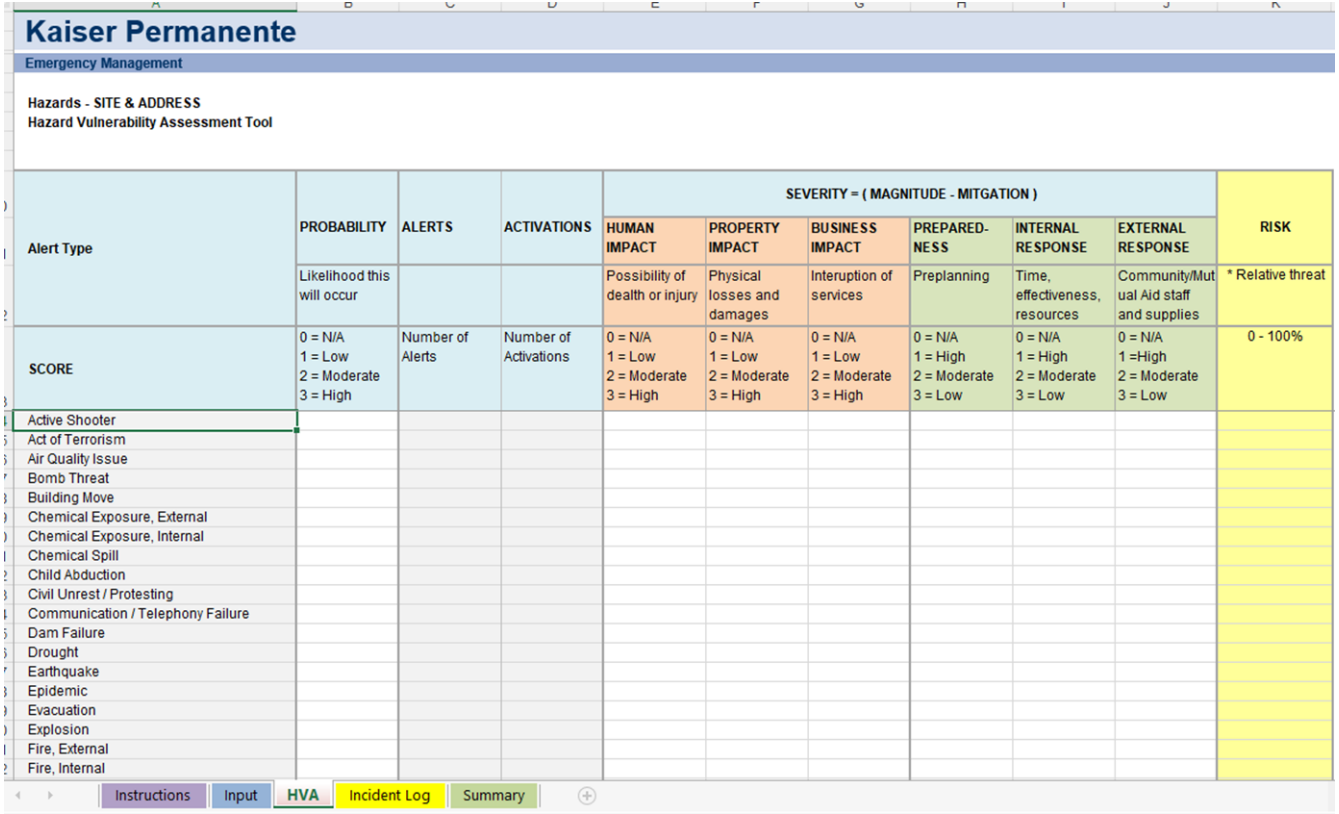
Weather-related Emergencies

1. What types of weather-related emergencies are common to your geographic area? What is the risk based on historic events or current conditions?

☐ Thunderstorm ☐ Tornados ☐ Hurricane ☐ Flooding
☐ Drought ☐ Wildfires ☐ Snowstorm/Blizzard ☐ Tropical Storms

The Kaiser Permanente Tool includes over 60 types of events.

Source: Kaiser Permanente



Kaiser Permanente

Emergency Management

Hazards - SITE & ADDRESS
Hazard Vulnerability Assessment Tool

Alert Type	PROBABILITY	ALERTS	ACTIVATIONS	SEVERITY = (MAGNITUDE - MITGATION)						RISK
				HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur			Possibility of dealth or injury	Physical losses and damages	Interuption of services	Preplanning	Time, effectiveness, resources	Community/Mutual Aid staff and supplies	* Relative threat
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	Number of Alerts	Number of Activations	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 =High 2 = Moderate 3 = Low	0 - 100%
Active Shooter										
Act of Terrorism										
Air Quality Issue										
Bomb Threat										
Building Move										
Chemical Exposure, External										
Chemical Exposure, Internal										
Chemical Spill										
Child Abduction										
Civil Unrest / Protesting										
Communication / Telephony Failure										
Dam Failure										
Drought										
Earthquake										
Epidemic										
Evacuation										
Explosion										
Fire, External										
Fire, Internal										

Instructions | Input | HVA | Incident Log | Summary

https://www.calhospitalprepare.org/post/updated-hva-tool-kaiser-permanente

Rank each potential hazard probability and expected impact with 0-3 with 0 being the lowest and 3 being the highest.
Total Risk score: 0 - 4 = Low; 5 -8 =Moderate; 9 – 12 = High

Name of Facility: _____ Date of Risk Assessment:_____

Type of Risk Assessment:

☐ Facility

☐ Community

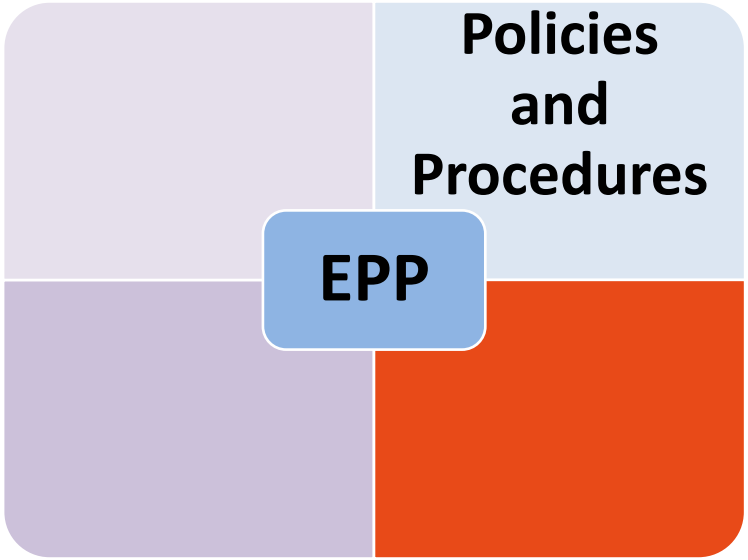
Prepared by: _____

Type of Disaster	Probability	Human Impact	Property Impact	Disruption of Services	Total Pts.	Risk Score	Plan in EPP
Natural Disasters							
Severe Thunderstorms (Wind/Lightening)							
Flooding							
Other Severe Weather							
Rockslides							
Wildfires/External Fire							
Extreme Temperatures							
Earthquake							
Tsunami							
Human Hazards/Events							
Active Shooter							
Violent Patient/Guest							
Mass Casualty Incident							
Community-wide incident							
Unexpected Absence of Provider							
Staffing Shortage due to external event							
Industrial/Agricultural/Biological							
Transportation Accident (rail, highway,other)							
HazMat Accident							
Industrial Accident							
Bio-terrorism							
Emerging Infectious Disease							
Public Health Emergency/Pandemic							

Example of a simple Points-based Risk Assessment Tool. Include all types of hazards.

Remember that you will need two risk assessments-one for your RHC and one for your community.

Policies & Procedures



EPP Policy and Procedure Basics

- You must have written polices and procedures which have been developed from your risk assessment and planning processes. Include all required elements.
- You will need some policies on how the EPP will be developed and reviewed.
- These policies may be separate or part of your EPP Plan Document.
- Remember that the plan document becomes the go-to resource for your RHC whenever an emergency response or an activation of your plan is required.
- The EPP Plan should be easy to find and easy to read. Your staff should be able to easily understand what they should do and who they should call.
- Avoid overly-detailed, wordy documents. You are creating a guidebook, a set of instructions to be used in an emergency situation.

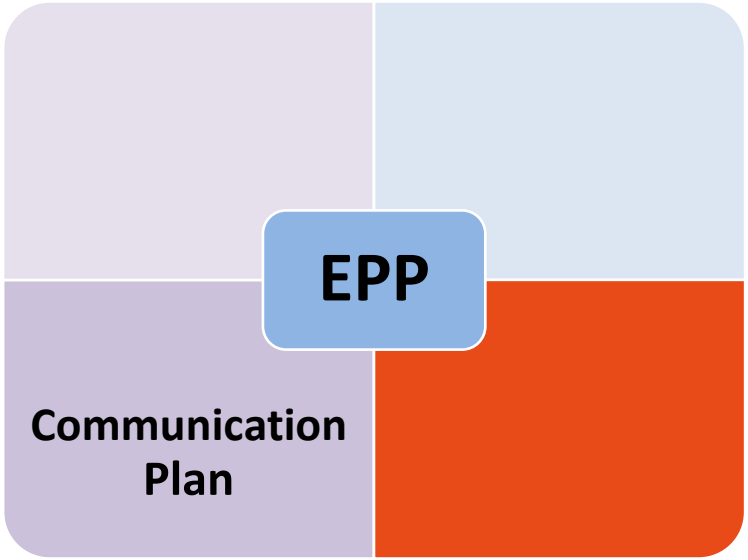
(b) **Policies and procedures.**

The RHC or FQHC must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, **risk assessment** at paragraph (a)(1) of this section, and the **communication plan** at paragraph (c) of this section.

The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:

(1) Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.
(2) A means to shelter in place for patients, staff, and volunteers who remain in the facility.
(3) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.
(4) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

Communication Plan



(c) **Communication plan**.

The RHC or FQHC must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:

(1) Names and contact information for the following:

- (i) Staff.
- (ii) Entities providing services under arrangement.
- (iii) Patients' physicians.
- (iv) Other RHCs/FQHCs.
- (v) Volunteers.

(2) **Contact information** for the following:

(i) Federal, State, tribal, regional, and local emergency preparedness staff.

(ii) Other sources of assistance.

(3) **Primary and alternate means for communicating** with the following:

(i) RHC/FQHC's staff.

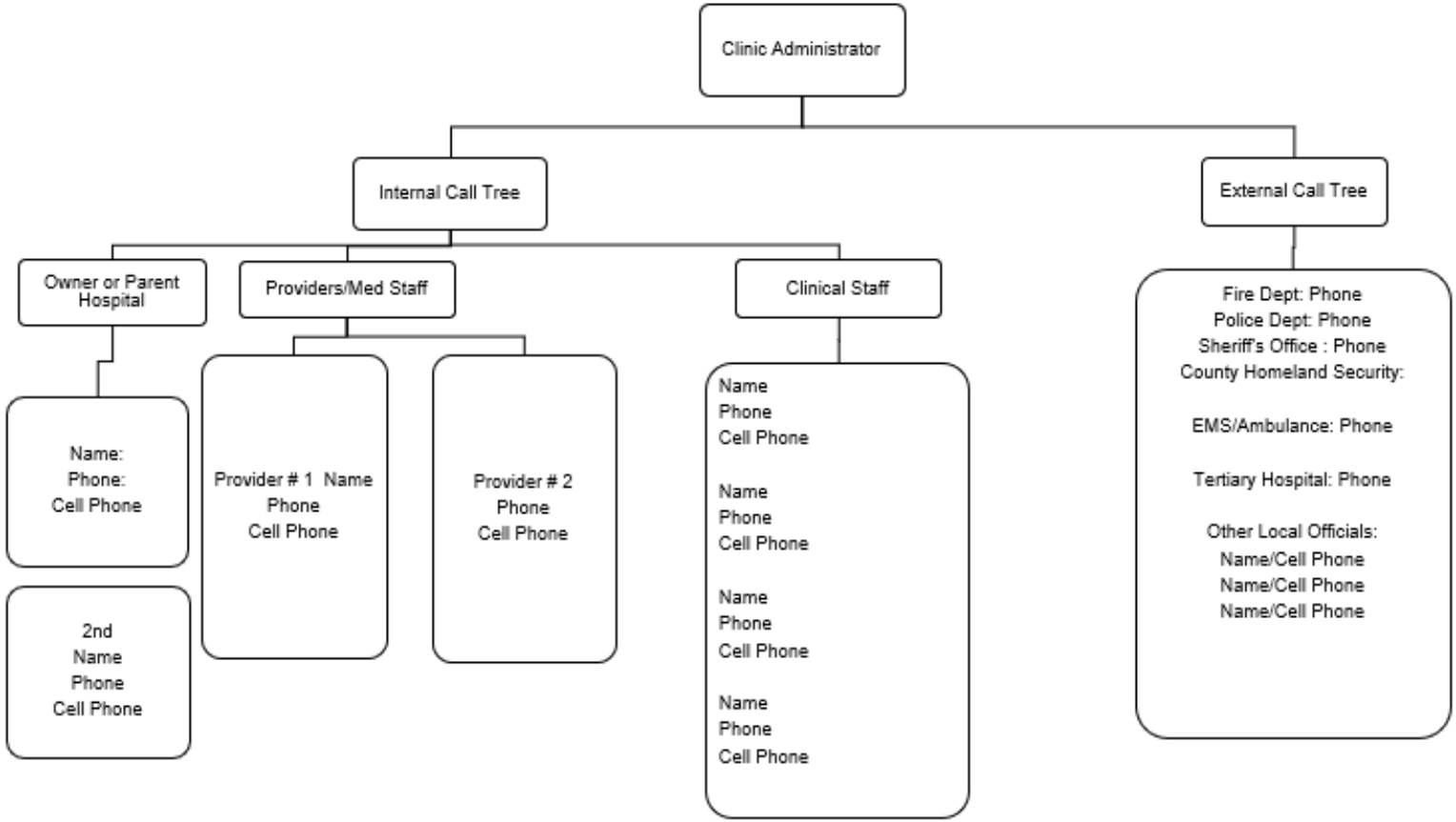
(ii) Federal, State, tribal, regional, and local emergency management agencies

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

(5) **A means of providing information about the RHC/FQHC's needs, and its ability to provide assistance**, to the authority having jurisdiction or the Incident Command Center, or designee.

Who to include in your Communication Plan?

- Clinic Administrator or Hospital Administrator or other Hospital Leadership
- Medical Director
- All RHC Staff (Providers, Clinical and non-clinical staff)
- Local law enforcement and first responders (Sheriff, Police, EMS)
- County law enforcement and emergency preparedness officials
- State emergency preparedness/response officials
- Other information in your plan includes contact information for other regional healthcare facilities (hospital, RHCs, FQHCs and Tribal Authorities).


Clinic Administrator
Internal Call Tree
External Call Tree
Owner or Parent Hospital
Providers/Med Staff
Clinical Staff
Name:
Phone:
Cell Phone
2nd
Name
Phone
Cell Phone
Provider # 1 Name
Phone
Cell Phone
Provider # 2
Phone
Cell Phone
Name
Phone
Cell Phone
Name
Phone
Cell Phone
Name
Phone
Cell Phone
Name
Phone
Cell Phone
Fire Dept: Phone
Police Dept: Phone
Sheriff's Office : Phone
County Homeland Security:
EMS/Ambulance: Phone
Tertiary Hospital: Phone
Other Local Officials:
Name/Cell Phone
Name/Cell Phone
Name/Cell Phone

Oregon Local Emergency Contacts

https://www.oregon.gov/oem/Documents/locals_list.pdf

LOCAL AND TRIBAL EMERGENCY MANAGERS

October 24, 2022

BAKER
Baker County Emergency Management
Baker County Courthouse
1995 3rd Street
Baker City, OR 97814
https://www.bakercounty.org/emergency/emgmt.html

Jason Yencopal, Emergency Program Manager
Office Phone: (541) 523-9669
Office Fax: (541) 523-8201
Email: jyencopal@bakercounty.org

BENTON
Benton County Emergency Management
180 NW 5th St
Corvallis, OR 97330
https://www.co.benton.or.us/preparedness
https://www.co.benton.or.us/sheriff/page/sheriffs-office-special-services

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Office Fax: (541) 766-6011
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https://www.facebook.com/ClackamasDM
Twitter: https://twitter.com/clackamascounty;
https://twitter.com/ClackamasDM
You Tube:
https://www.youtube.com/user/ClackamasCounty

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Office Phone: (503) 650-3381
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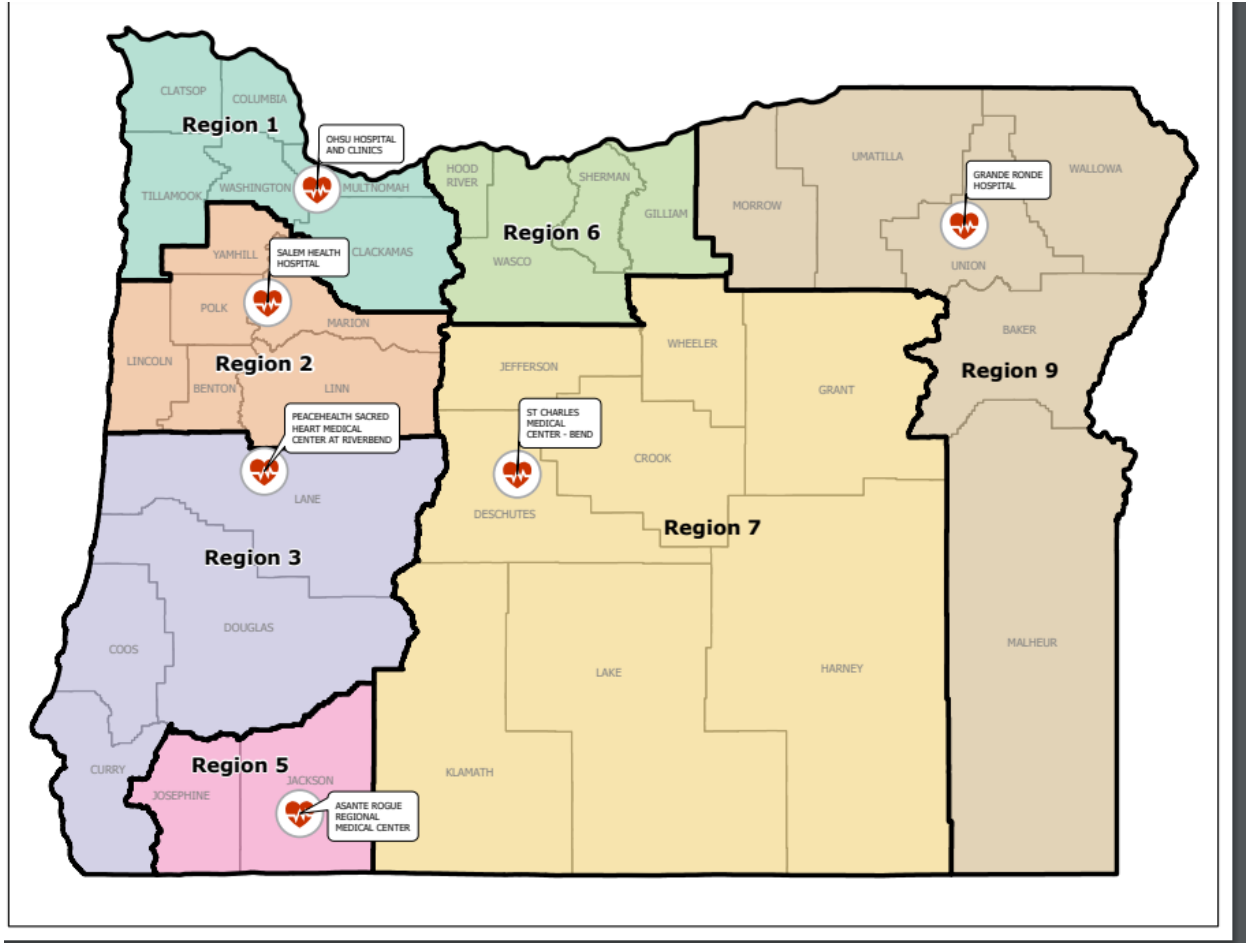
Jamie Poole, Interim Deputy Disaster Manager
Office Phone: (503) 655-8838
Email: jpoole@clackamas.us

Molly Caggiano, Community Planning Coordinator
Cell Phone: (503) 352-2798
Email: mcaggiano@clackamas.us

Emily Murkland, Community Planning Coordinator
Cell Phone: (503) 679-9127
Email: emurkland@clackamas.us


Region 1
CLATSOP
COLUMBIA
TILLAMOOK
WASHINGTON
MULTNOMAH
OHSU HOSPITAL AND CLINICS
Region 2
YAMHILL
CLACKAMAS
SALEM HEALTH HOSPITAL
POLK
MARION
LINCOLN
BENTON
LINN
PEACEHEALTH SACRED HEART MEDICAL CENTER AT RIVERBEND
Region 3
LANE
DOUGLAS
COOS
CURRY
Region 5
JOSEPHINE
JACKSON
ASANTE ROGUE REGIONAL MEDICAL CENTER
Region 6
HOOD RIVER
SHERMAN
GILLIAM
WASCO
Region 7
JEFFERSON
WHEELER
GRANT
ST CHARLES MEDICAL CENTER - BEND
CROOK
DESCHUTES
LAKE
HARNEY
KLAMATH
Region 9
UMATILLA
MORROW
WALLOWA
GRANDE RONDE HOSPITAL
UNION
BAKER
MALHEUR

Training & Testing

(d) **Training and testing**. The RHC or FQHC must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.

(1) Training program. The RHC/FQHC must do all of the following:

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

(ii) Provide emergency preparedness training at least every 2 years.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

(v) If the emergency preparedness policies and procedures are significantly updated, the RHC/FQHC must conduct training on the updated policies and procedures.

Emergency Preparedness Quiz
Clinic Name

Name_____ Date_____

1. All Rural Health Clinics are required to have an Emergency Preparedness Plan.

   TRUE FALSE

2. Our safe room or place where we will go to shelter from severe weather is:
   a. X-ray room
   b. Hallway
   c. Exam room 3
   d. Breakroom

3. The Emergency Preparedness Plan for our RHC is located:
   a. Within InQdocs under Policy #290 and accessible through my log-on
   b. In a _____binder in _____'s office
   c. We do not have a written Emergency Preparedness Plan.
   d. We only receive verbal instructions in an emergency.
   e. Both a and b

7. What does the acronym **RACE** stand for?
   a. Run, Alert, Call, Evacuate
   b. Rescue, Alarm, Contain, Evacuate
   c. Rescue, Alarm, Contain and Extinguish
   d. Rescue, Alarm, Call, Extinguish

8. When using a fire extinguisher, the **PASS** acronym means?
   a. Pull, Aim, Squeeze, Sweep
   b. Push, Aim, Sweep, Squeeze
   c. Pull, Alarm, Stop, Squeeze
   d. Push, Alarm, Sweep, Squeeze

9. The clinic will use the following methods for receiving alerts about severe weather:
   a. Cell phone alerts
   b. Alerts sent from the County Emergency Management agency or local law enforcement.
   c. Other media sources (radio, waiting room tv, internet)
   d. All of the above

EMPLOYEE EPP TRAINING CHECKLIST

Employee Name:_____

Position/Role:_____ Hire Date:_____

✓	Training Description	Date	Supervisor initials
	Employee knows the location of the EPP binder or can access the EPP through InQdocs		
	Employee knows how to access plan on-line or through an application		
	Employee knows how to find a specific emergency response plan in the binder		
	Employee knows where fire extinguishers are located		
	Employee knows RACE and PASS acronyms		
	Employee can identify evacuation routes		
	Employee knows where to find the communication tree and understands how to use it		
	Employee knows any code words or code alerts used in emergency situations		
	Employee knows which room(s) can be used as safe rooms for sheltering in place		
	Employee knows where emergency supplies are kept flashlights, batteries, power packs.		
	Employees know what types of alternative communication are available.		
	Employee understands the concept of delegation of authority.		
✓	**Testing Participation**		
	Employee has participated in a community exercise		
	Employee has participated in a facility wide exercise		
	Employee has participated in a tabletop exercise		
	Employee has participated in an in-service training where training from a community wide or facility wide exercise was disseminated to clinic staff		
	Employee has participated in the activation of a real emergency response plan.		
	Employee has participated in a post-event evaluation or after-action report creation.		
	Employee has attended city, county or state workshops or meetings on EPP		

(2) Testing. The RHC or FQHC must conduct exercises to test the emergency plan at least annually. The RHC or FQHC must do the following:
(i) Participate in a full-scale exercise that is community-based every 2 years; or

(A) When a community-based exercise is not accessible, an individual, facility-based functional exercise every 2 years; or.

(B) If the RHC or FQHC experiences an actual natural or man-made emergency that requires activation of the emergency plan, the RHC or FQHC is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an ***additional exercise every 2 years, opposite the year the full-scale or functional exercise*** under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to following:

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

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

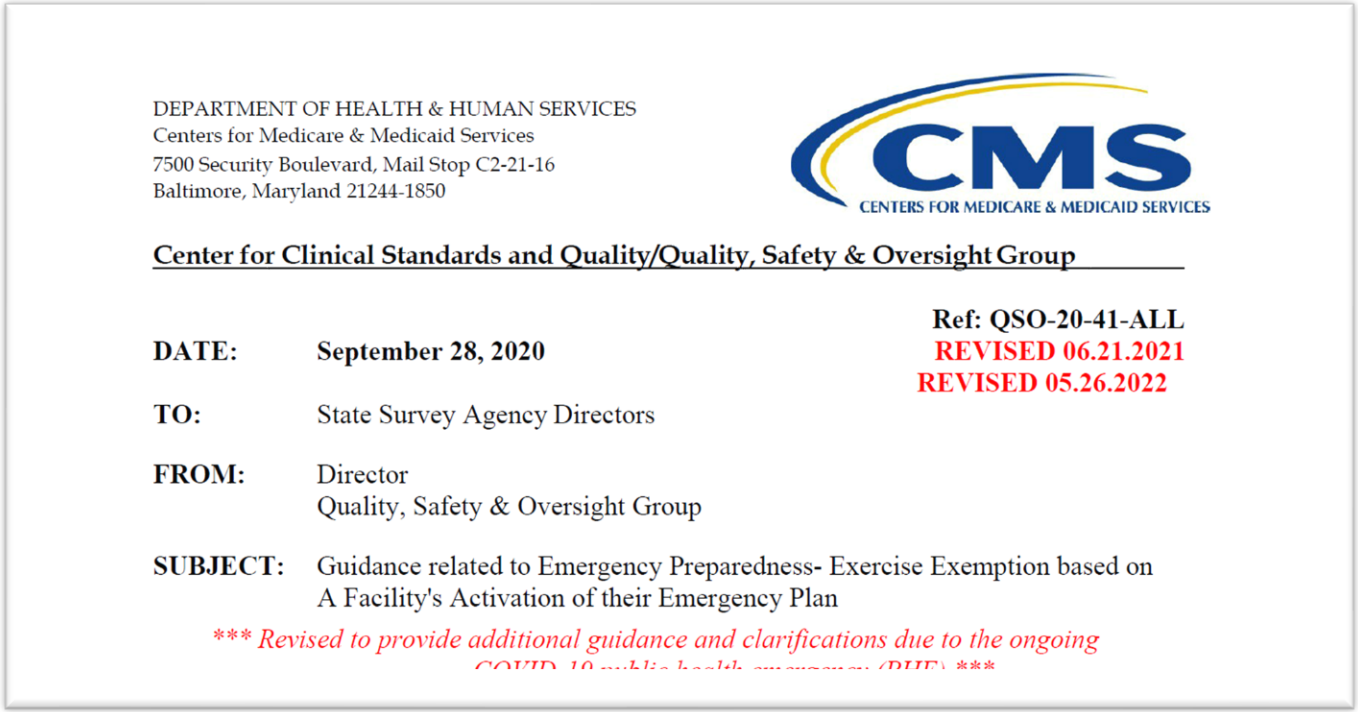
(iii) ***Analyze the RHC or FQHC's response to and maintain documentation*** of all drills, tabletop exercises, and emergency events, and revise the RHC or FQHC's emergency plan, as needed.

(e) Integrated healthcare systems. If a RHC/FQHC is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the RHC/FQHC may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.
(2) Be developed and maintained in a manner that takes into account ***each separately certified facility's unique circumstances***, patient populations, and services offered.

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.
(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include all of the following: (i) A documented community-based risk assessment, utilizing an all-hazards approach. (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.
(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

New CMS Guidance



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-20-41-ALL
REVISED 06.21.2021
REVISED 05.26.2022

DATE: **September 28, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance related to Emergency Preparedness- Exercise Exemption based on A Facility's Activation of their Emergency Plan

**** Revised to provide additional guidance and clarifications due to the ongoing*

https://www.cms.gov/files/document/qso-20-41-all-revised-05262022.pdf

For providers of outpatient services: These providers must continue to test their program annually, by participating in a community-based full-scale exercise (if available) or conduct an individual facility-based functional exercise every other year. In the opposite years off the full-scale exercise, the providers are required to conduct a testing exercise of their choice, which may include either a community-based full-scale exercise (if available), an individual, facility-based functional exercise, a drill, or a table-top exercise or workshop that includes a group discussion led by a facilitator.

Outpatient providers and suppliers include: Ambulatory Surgical Centers (ASCs), freestanding/home-based hospice, Program for the All-Inclusive Care for the Elderly (PACE), Home Health Agencies (HHAs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Organizations (which include Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services), Community Mental Health Clinics (CMHCs), Organ Procurement Organizations (OPOs), **Rural Health Clinics (RHCs),** Federally Qualified Health Centers (FQHCs), and End-Stage Renal Disease (ESRD) facilities.

CMS Testing Definitions

Full-Scale Exercise (FSE): A full scale exercise is an operations-based exercise that typically involves multiple agencies, jurisdictions, and disciplines performing functional (for example, joint field office, emergency operation centers, etc.) and integration of operational elements involved in the response to a disaster event, i.e. "boots on the ground" response activities (for example, hospital staff treating mock patients).

Functional Exercise (FE): "FEs are designed to validate and evaluate capabilities, multiple functions and/or sub-functions, or interdependent groups of functions. FEs are typically focused on exercising plans, policies, procedures, and staff members involved in management, direction, command, and control functions" as defined by DHS's Homeland Security Exercise and Evaluation Program (HSEEP).

Mock Disaster Drill (Exercise of Choice Only): A drill is a coordinated, supervised activity usually employed to validate a specific function or capability in a single agency or organization. Drills are commonly used to provide training on new equipment, validate procedures, or practice and maintain current skills. For example, drills may be appropriate for establishing a community- designated disaster-receiving center or shelter. Drills can also be used to determine if plans can be executed as designed, to assess whether more training is required, or to reinforce best practices. A drill is useful as a stand-alone tool, but a series of drills can be used to prepare several organizations to collaborate in an FSE.

Workshop (Exercise of Choice Only): A workshop, for the purposes of this guidance, is a planning meeting/workshop, which establishes the strategy and structure for an exercise program as defined in HSEEP guidelines.

Table-top Exercise (TTX) (Exercise of Choice Only): A table-top exercise involves key personnel discussing simulated scenarios in an informal setting. TTXs can be used to assess plans, policies, and procedures. A table-top exercise is a discussion-based exercise that involves senior staff, elected or appointed officials, and other key decision making personnel in a group discussion centered on a hypothetical scenario. TTXs can be used to assess plans, policies, and procedures without deploying resources.

Your testing exercise MUST be for an event that is included in your current risk assessment. If the activation of an event is for an emergency not included in your most recent risk assessment, then the risk assessment and the plan should both be revised based on the after-action findings for the activation.

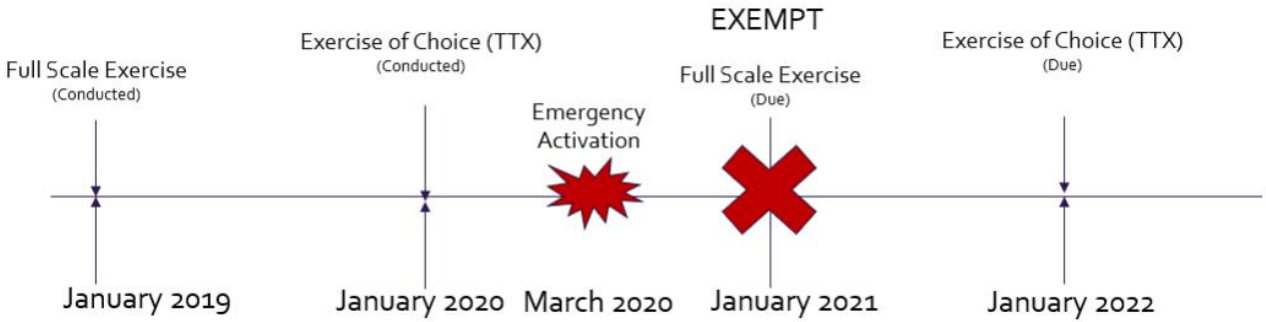
Requirement for Outpatient Providers Requirement & Guidance: Outpatient providers must conduct a full-scale exercise (or individual facility-based exercise when a full-scale is not available) every 2 years pursuant to standard (d)(2) of their respective "Emergency Preparedness" regulation and in opposite years conduct any one of the "exercises of choice," which include another full-scale or individual facility-based functional exercise, tabletop exercise, workshop, or mock drill.

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

What if I you are still under COVID-19 Activation?

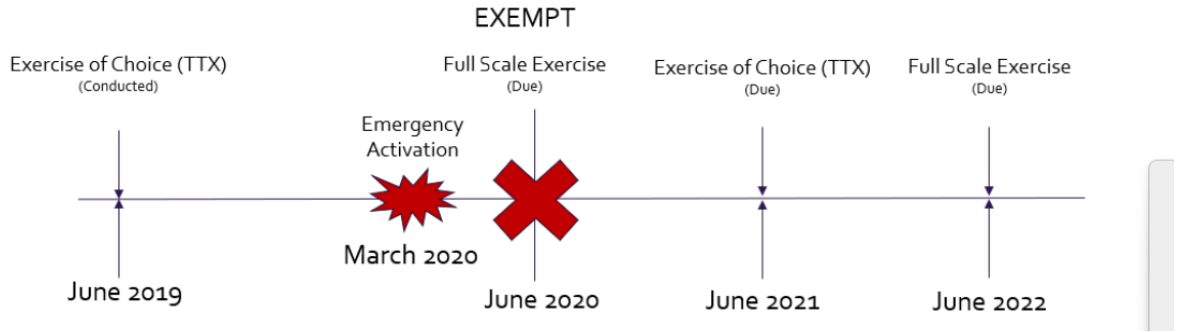
For Outpatient Providers: If the facility claimed the full-scale exercise exemption in 2020 based on its activated emergency plan for COVID-19 response and has since resumed normal operating status, the outpatient provider/supplier is expected to complete its required full-scale exercise in 2022, unless it has reactivated its emergency plan for an actual emergency during its 12-month cycle for 2022. If the facility claimed the full-scale exercise exemption in 2021 based on its activated emergency plan for COVID-19 response and has since resumed normal operating status, the outpatient provider/supplier is expected to complete its required full-scale exercise in 2024.

Scenario #1. Facility X conducted a full-scale exercise in January 2019 and a table-top exercise for January 2020 (opposite year). In March 2020, Facility X activates its emergency preparedness plan 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: The facility is exempt from the next scheduled exercise (January 2021 full-scale exercise). It would then be required to complete their opposite year exercise of choice by January 2022.



Scenario #2. Facility Y conducted a table top exercise in January 2019 as the exercise of choice and conducted a full-scale exercise in January 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? Answer: The facility is exempt from the January 2022 full-scale exercise for that "annual year". However, the facility must conduct its exercise of choice by January 2021, and again in January 2023.

Scenario #3. Facility Z conducted a table-top exercise in June 2019 (based on its annual cycle). It is scheduled to conduct a full-scale exercise in June 2020. In March 2020, Facility Z 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? Answer: The facility is exempt from the June 2020 scheduled full-scale exercise for that "annual year" and is required to complete an exercise of choice in June 2021, and a following full-scale exercise in June 2022. It is exempt from its next required full-scale or individual facility-based exercise which would have been in June 2020.



What evidence is needed to prove to surveyors the exemption clause applies to your RHC?

- Verify documentation evidence that the facility activated its emergency plan (in order to determine whether the testing exemption is acceptable for use). Documentation may include, but is not limited to, the following:
- Notice of activation to staff via electronic systems (alerts);
- Proof of patient transfers and changes in daily operations based on the emergency;
- Initiation of additional safety protocols, for example, mandate for use of personal protective equipment (PPE) for staff, visitors and patients as applicable;
- Coordination with state and local emergency officials;
- Minutes of board/facility meetings; o 1135 Waiver (individual or use of blanket flexibilities); or,
- Incident command system related reports, such as situation reports or incident action plans.

COVID-19 EMERGENCY ACTIVATION PLAN AND RECORD OF DOCUMENTED RESPONSE*

RHC NAME: _____

Located in the County and State of _____

Date Emergency Plan Activated: _____ Date Activation Concluded: _____

Emergence of the Pandemic

Etiology

COVID-19 is caused by a coronavirus. Coronaviruses are a large family of viruses that are common in people and many different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people such as with MERS-CoV, SARS-CoV, and now with this new virus (named SARS-CoV-2).

The SARS-CoV-2 virus is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats. The sequences from U.S. patients are similar to the one that China initially (December 2019) posted, suggesting a likely single, recent emergence of this virus from an animal reservoir.

Early on, many of the patients at the epicenter of the outbreak in Wuhan, Hubei Province, China had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread. Person-to-person spread was subsequently reported outside Hubei and in countries outside China, including in the United States. Some international destinations now have ongoing community spread with the virus that causes COVID-19, as do some parts of the United States. Community spread means some people have been infected and it is not known how or where they became exposed. Learn more about the spread of this newly emerged coronavirus.

A **pandemic** is a global outbreak of disease. Pandemics happen when a new virus emerges to infect people and can spread between people sustainably. Because there is little to no pre-existing immunity against the new virus, it spreads worldwide. The virus that causes COVID-19 is infecting people and spreading easily from person-to-person.

Symptoms and Severity

The complete clinical picture of COVID-19 is not fully known. Reported illnesses have ranged from very mild (including some with no reported symptoms) to severe, including illness resulting in death. While information so far suggests that most COVID-19 illness data out of China suggests serious illness occurs in 16% of cases. Older people and people of all ages with severe chronic medical conditions — like heart disease, lung disease and diabetes, for example. Individuals experiencing severe illness may develop acute respiratory distress and require critical care support including mechanical ventilation.

IV. Patient Screening

The following processes and procedures were implemented as measures to screen patient. (Attach copies of screening protocols implemented during the emergency activation timeline.)

☐ Phone Screening _____ ☐ Questionnaires_____

☐ Temping Patients Prior to Entry_____ ☐ Masking Pts w/S &S _____

☐ Using Dedicated Entries _____ ☐ Using Dedicated Exam Rooms _____

☐ Room Entry Logs ☐ Other: _____

V. Restriction of Visitors

The following restriction of visitors and guests entering the clinic was made as evidenced by the creation of ☐ An addendum to Policy #290 ☐ Internal processes and procedure changes

A summary of those changes includes:

☐ Limiting # of people w/pt. ☐ Restricting non-essential visitors ☐Restricting vendors

☐ Other: _____

_____

_____

_____

VI. Screening of Staff

The following measures were implemented to screen providers and staff.

☐ Temping before entering building ☐ Asking about symptoms ☐ Asking about exposure

☐ Identifying staff at risk ☐ Other: _____

VII. Modification or Restriction of Services

As a result of emergency activation, the following modifications or restrictions in services were implemented. Include cessation of services, relocation of services, reduced services, use of telehealth and e-visits.

_____

_____

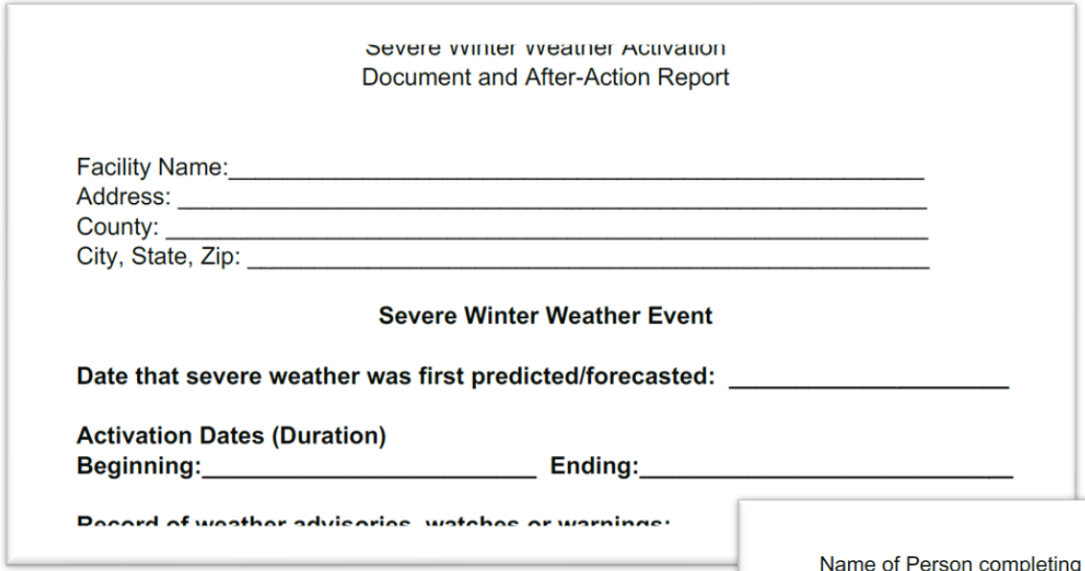
Documenting Exercises or Activations

After Action Report

Revising Risk Assessments and EP Plans

Document at least these things:

- Date and Time of the Exercise or Activation
- How were you notified of the Emergency
- Who was in the RHC when the Activation Occurred
- Who participated in the exercise
- The circumstances leading up to or describing the emergency
- Proof of any alert if available (weather alert, text message, email)
- What happened and when (start/end times, if applicable)
- What was effective and worked?
- What wasn’t right and why?
- What can be improved in our emergency response?
- Signatures on the report!



Severe Winter Weather Activation
Document and After-Action Report

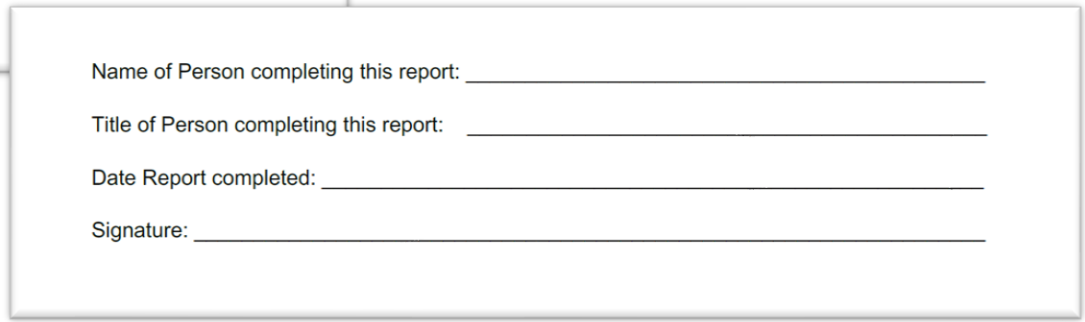
Facility Name:_____
Address: _____
County: _____
City, State, Zip: _____

Severe Winter Weather Event

Date that severe weather was first predicted/forecasted: _____

Activation Dates (Duration)
Beginning:_____ Ending:_____

Record of weather advisories, watches or warnings:



Name of Person completing this report: _____

Title of Person completing this report: _____

Date Report completed: _____

Signature: _____

Document Any Activation and have a signed report.

Then, make any EPP revisions based on the finding.

AFTER ACTION REPORT

Name of Facility:		
Name/Title of Person Completing Report:		
Date:	**Start Time:**	**End Time:**

Drills/Exercises or Incident response: ☐ Drill or Exercise ☐ Actual Event/Incident

○ Fire ○ Power Outage ○ Evacuation ○ Flood ○ Lockdown ○ Extreme Weather

○ Other (specify): _____

Participation: Provide a list of individuals and agencies participating in the event:

Timeline of events: Provide description of events and activities

Discussion and recommendations: Provide any recommendations for improvements or changes to the emergency plan and procedures and how they will be addressed.

Attach any additonal documentation.

Signature of Person Completing the Report: _____

Clinic Name

Educational Sign-in Sheet

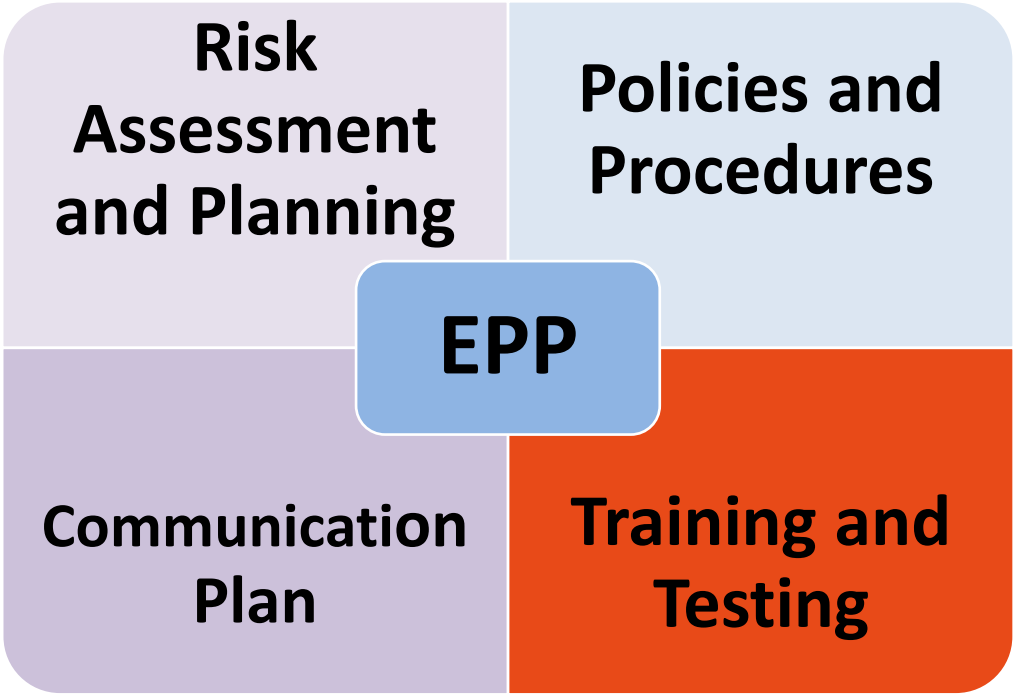
Discussion of Emergency Exercise or Activation

Event: _____ Event Date: _____

Education Date: _____

Printed Name	Title/Role	Signature

Emergency Preparedness Program



Questions?

In Session 2, we will facilitate a workshop testing activity that will help you learn how to conduct your own tabletop testing exercising at your RHC. You will receive sample forms, templates and other resources.

Patty Harper, RHIA, CHTS-PW, CHTS-IM, CHC®

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Patty Harper is CEO of InQuiseek Consulting, a healthcare consulting company based in Louisiana. She has over 24 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration (cum laude) from Louisiana Tech University. She is credentialed through AHIMA as a RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy and has previously been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics., state and national organizations throughout her healthcare career including NARHC, NRHA, AHIMA, MGMA, and HFMA. Patty currently serves on the Board of NARHC and is the RHC Technical Advisor for Texas Association of Rural Health Clinics.