EVHC READY

The Eastern Region's Pulse On Healthcare Emergency Preparedness

Friday
April 16, 2021

In this issue:

Communications

FEMA- Alerting People with Disabilities and Access and Functional Needs

Source: Federal Emergency Management Agency, Executive Order 13407 mandates that the federal government "include in the public alert and warning system the capability to alert and warn all Americans, including those with disabilities and those without an understanding of the English language." The Integrated Public Alert and Warning System office is working endlessly to build a stronger and more inclusive alert and warning system. For more information, please use the following link.

3WTKR- Alerting People with Disabilities and Access and Functional Needs

Source: 3WTKR, The City of Chesapeake said mobile testing with major mobile carriers is complete. This means they are now fully Text to 9-1-1 operational. City officials said residents in Chesapeake that are experiencing emergencies can now send text messages to 9-1-1 if they need help. For more information, please use the following link.

EVHC READY

The Eastern Region's Pulse On Healthcare Emergency Preparedness

Friday
April 16, 2021

Lessons Learned

EVHC- Fire Alarm Breaker

Source: Eastern Virginia Healthcare Coalition, Label at each fire alarm system control unit, system sub-panel or data gathering panel, supplementary notification appliance (SNAC) panel, digital alarm communicator, etc. identifying the panel location, panel name, and breaker number for the 120VAC circuit. Example: Electrical Rm 120, Panel EP1, Circuit 22. For more information, please use the following link.

Inventory and Maintenance

PPE Distribution. PPE supply distribution this past week to support facilities as they continue to combat the pandemic. Total PPE on hand: 755,979, total PPE distributed for the week: 11,480, total PPE distributed to date: 2,847,878.

PAPR Training. The Resource Management Specialist is currently working with representatives from ILC Dover to conduct training on the Sentinel XL PAPR's. Training will be held June 2nd and 3rd, registration will be sent out next week.

Training and Exercise

Upcoming Training

Exercise and Training workgroup meeting: Wednesday, April 21st at 9:00 – if you are interested in participating in the workgroup please email Mary at mmorton@vaems.org

Lunch and Learn: Hurricane Season is here! May 13 from 12:00 to 1:00
https://us02web.zoom.us/j/88545135287?pwd=U3lrN0Q1UW9rdm54Z0o4RTNLdTRKZz09

ICS 400 April 16 and 17 at TEMS Contact LMS Helpdesk #804-897-9995

ICS 300 June 22, 23, and 24 at TEMS Contact 757-963-0632

Emergency Operations Planning

WMJ- What Do Emergency Department Patients and Their Guests Expect From Their Health Care Provider in an Active Shooter Event?

Source: Wisconsin Medical Journal, The public has significant expectations that the health care provider will assist them during active shooter situations. Providing for the security of the health care provider and patient simultaneously is in conflict with common hospital crisis training.

Efforts must be taken to bring patient expectations and provider training into greater alignment. For more information, please use the following link.

Other

NIH- Social vulnerability and disaster: understanding the perspectives of practitioners

Source: National Library of Medicine, This paper seeks to understand how local emergency managers perceive and define social vulnerability. There has been a significant increase recently in the amount of research on social vulnerability, yet little is known about the extent to which that knowledge is being translated into practice. To address this void, the authors conducted semi-structured interviews with a sample of local emergency managers (N=24), asking them to describe what social vulnerability means to them. The analysis identified four primary perspectives on social vulnerability prevalent in the sample, pertaining to: (i) culture and poverty; (ii) a moral imperative; (iii) a lack of security; and (iv) a lack of knowledge and awareness. Although these practitioner viewpoints may not align perfectly with the definitions of social vulnerability predominant in the hazards and disasters literature, the results of this study do suggest a possible narrowing of the gap between research and practice as it relates to social vulnerability. For more information, please use the following link.

Summary of Significant Updates to Appendix Z, Released March 26, 2021

QSO-21-15-ALL

Exercise or "Testing" Frequency and Documentation.

- Incorporates the changes from the burden reduction rule, which reduces the frequency of exercises for non-LTCF providers.
- Inpatient providers are required to have two exercises per year. Therefore, surveyors will review the most recent two years of documentation to determine compliance. For outpatient providers, testing exercises are required annually, alternating full-scale exercises every other year, with the opposite years allowing for the exercise of choice. ***To determine compliance, surveyors will be required to review the past two cycles (generally four years, presumable two for LTCFs) of emergency testing exercises*** (pg. 15).
- Providers are encouraged to diversify the staff members who participate in exercises. For example, if an exercise has a clinical focus one year, consider having a facilities focus the next to include different staff (pg. 81).
- Additional Home Health Agency- specific updates (pg. 94).
- Facilities should ensure that, when participating in a community-based full-scale exercise, the exercised scenario is documented in the facilities risk assessment (pg. 97-98).
- More detailed guidance and examples regarding ***exemptions based on actual emergencies*** (pg. 100-101).

Training Procedures and Frequency

- Reminders that training should be based on the Emergency Plan and Risk Assessment, guidance on continued training, and documentation requirements (pg. 84-87).
- For ease of demonstrating compliance that the facilities have updated its training program at least every two years (annually for SNFs), CMS recommends that facilities retain at a minimum, the past two cycles (generally four years; presumably two for SNFs) of emergency training documentation for both training and exercises for surveyor verification.
- ESRD - specific requirements have been updated (pg. 88-89).

Frequency of Updating Plans, Policies, and Procedures

- Non-LTCF providers are required to review and update their emergency plan every ***two*** years. LTCFs will remain under the on-year requirement. As a reminder, providers are required to document their plan reviews and updates (pg. 18).
- Policies and Procedures related to Emergency Preparedness and Continuity of Operations should be reviewed with documented updates every two years (annually for LTCFs) (pg. 36).
- LTCFs should include their Medicare and Medicaid certification dates in the front of their plan (pg. 39, see "Emergency Power and Temperature Requirements" section of this document for additional details).

Additional Emphasis on Emerging Infections Disease (EID) Planning

- Pre-COVID, CMS added planning requirements specific to EIDs. These have been strengthened further in response to COVID-19 (pg. 15, 19).
- Providers must integrate EID threats into Risk Assessment process (pg. 22). The Coalition Hazards and Vulnerabilities Assessment, which serves as a regional Risk Assessment for Coalition partners, integrates these threats.
- The SOM recommends including information in facilities policies describing how the facility will monitor evolving guidance in an ongoing emergency, such as an EID. For example, designating a specific individual to monitor the CDC and VDH websites for updated Public Health guidance during a Public Health Emergency (pg. 35).
- ESRDs are expected to detail processes specific to their patient population, including disinfecting ESRD stations and discussing transportation concerns with government partners (pg. 35).

Risk Assessment

- EVHC facilitates a regional Risk Assessment annually, which can serve as a useful guide for members (pg. 23), but all are required to conduct facility-based Risk Assessments as well. Surveyors will be looking to see that your Risk Assessments are both facility-based and community-base (pg. 25). Thus, we recommend having a copy of both the regional and facility-based assessments available.

Healthcare Coalition Participation; Reporting Facility Needs

- Participation in the regional Healthcare Coalition is still encouraged (pg. 31, 46, 77, 97). We recommend maintaining documentation of Healthcare Coalition meetings, training, and planning conversations you attend.
- Reminders of the potential need to report facilities needs and the ability to provide assistance (pg. 76-77).

Emergency Power and Temperature Requirements

- For LTC facilities, there are additional requirements for facilities that were initially certified after October 1, 1990, which must maintain a temperature range of 71 (min) to 81 ºF (max). ***Facilities should include their Medicare [and Medicaid, as applicable] certification date[s] in the front of their plan*** (pg. 39).
- Additional information regarding the use of portable generators (pg. 39).
- If used, portable generators must be connected and provide emergency power to a facility's electrical system circuits via a power transfer system as recommended by the generator manufacturer (pg. 40).
- ***Extension cords should not be run from the portable generator outlet receptacles to electrical appliances*** (pg. 39).

Staff and Patient/Resident Tracking and Evacuation

- Updates to Home Health Agency-specific guidance for tracking patient during emergencies (pg. 48).
- Patient safety should be the number one priority, and it is expected that facilities provide care in a safe setting. Therefore, any existing guidance on patient rights and safe setting (e.g., §482.13(c)(2) for hospitals) should be continued. Survey guidance has been updated to include ***"Ask staff to describe how they would handle a situation in which a patient refused to evacuate?"*** (pg. 50).
- Additional details regarding expectation for transfer agreements, specifically for LTCFs and ICF/IID facilities (pg. 60).
- Inclusion of Alternate Care Sites (ACSs) in planning (pg. 60-63).

Surge Planning

- Providers should incorporate surge planning into emergency plans, policies, and procedures. ***(See extensive guidance pg. 56-57).***
- Inclusion of Alternate Care Sites (ACSs) in planning (pg. 60-63).

Home Health Agency Updates

- See pg. 44, 70 for additional updated guidance specific to HHAs.
- See pg. 94 for additional HHA – specific guidance related to Emergency exercises.

ESRD Updates

- See pg. 64-65 for significant updates specifically for ESRD providers.
- See pg. 88-89 for updates on ESRD – specific training requirements.