Overview

- Understanding Facility Requirements for Disaster Preparedness
- Understanding Federal, State and Local Health Officer Powers
- Compliance Issues
- Surge Capacity Planning
- Training and Education
Be Prepared!

Are We Prepared?

Trust for America’s Health Report (Dec. 2006)

- 15 states/2 cities at highest preparedness for emergency vaccines, antidotes and supplies
- 11 states and D.C. lack sufficient capabilities to test for biological threats
- 4 states lack sufficient laboratory tests for anthrax or plague
- 4 states do not test for flu year-round
- 26 states would run out of hospital beds within two weeks of moderately severe pandemic flu
- 12 states and D.C. are not fully compatible with CDC NEDSS to track disease outbreak information
- 40 states and D.C. have a nursing shortage
- 6 states cut their public health budgets between FY 05 and 06; median state funding is $31 per person per year
EMERGENCY PREPAREDNESS PLANS
Hospital Emergency Plans

- JCAHO
- Medicare
- Licensing

Hospital Emergency Plans

JCAHO Requirements

- Standards are regularly updated, with changes in 2006 and 2007
- Hospitals must conduct a hazard vulnerability analysis to identify potential emergencies that could affect the need or provision of its services
- Emergency plan development must include Medical Staff and Administration
- Plan development process must include linkage with community command structure
Disaster Drills (E.C.4.20)
- Required 2x per year, either in response to an actual emergency or in planning drills
- Drills must be conducted at least four months apart and no more than eight months apart
- Hospital must participate in at least one community-wide practice drill a year (where applicable) relevant to the priority emergencies identified in its hazard vulnerability analysis
- Drills must be critiqued to identify deficiencies and opportunities for improvement. The hospital must test the emergency management plan twice a year, either in response to an actual emergency or in planning drills.

Key standards for Hospitals (including CAHs)
- Mitigation, preparedness, response and recovery strategies and actions for each priority emergency
- Process for plan activation, and staff and external notification
- Command structure and personnel assignments
- Management of patient care
- Procedures for decontamination and infection control
- Management of logistics (drugs, food, utilities, supplies, etc.)
- Security
- Communication with news media and patients/families
- Back-up communications and information systems
- Evacuation
- Establishment of alternative care sites
Hospital Emergency Plans
Medicare Requirements

- Medicare COPs for hospitals do not require an emergency preparedness plan; Medicare COPs for skilled nursing facilities require an emergency plan
- Interpretive guidelines for hospitals require an emergency preparedness plan
  - Plan must address likely risks for the area, such as natural disasters, bioterrorism, utilities disruption, nuclear or industrial accidents and other mass casualties
  - Interpretive Guidelines provide a list of issues that “should be considered” in the development of plans

August 2006 Report: OIG reviewed preparedness for nursing facilities in the aftermath of Katrina et al.
- Surveyed facilities met COP standards
- Implementation was inconsistent with plans
- Common problems:
  - Failure of transportation to meet contract commitments
  - Complications in moving medication with patients
  - Lack of preparedness for host facilities
  - Inadequate staffing and supplies (e.g., food, water, drugs)
  - Difficulty in promptly returning patients to facilities
- Report recommended that CMS strengthen federal certification standards for emergency plans
- CMS says it is looking at the issue
Hospital Emergency Plans Licensing Requirements

- Regulations vary from state to state
- E.g., California -- regulations adopted in 1975, and have not been updated in 31 years
**Federal, State & Local Roles**

**Overview: Problems to Consider --**
- Lack of clear roles and coordination between layers of government
- Lack of minimum standards and powers – variations between states and local agencies
- Barriers to coordination between public and private sectors
- Speed and clarity of communication

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**Legal Authorities and Public Health Responses**

- Fed Gov’t authority over public health is limited to its spending authority and activities affecting interstate commerce
  - Feds can implement international quarantine or restrict interstate/air travel to contain communicable diseases
- States have primary responsibility and authority to further public health under its police powers and parens patriae power
- All governments are limited by Constitutional due process rights of individuals
**Federal Role**

- Policy making
- Financing
- Oversight of national disease prevention efforts
- Collection/dissemination of information
- Some capacity building, e.g., Strategic National Stockpile

**State Role**

- Police power to protect the public health
- Public health power -- detection, prevention and promotion (not delivery of health care)
- Federal government has directed states undertake emergency planning, including development of a pandemic flu plan
- Most states have outsourced disaster response to local governments
- Most state and local government can declare states of emergencies
State/ Local Roles

- Primary state/local roles are to detect communicable disease and prevent its spread
- Emergency Orders
  - State of War
  - State of Emergency – by the governor
  - Local Emergency – usually by local governing board
  - Health Emergency – some states permit local health officers to declare local health emergencies, but scope may be limited to certain types of emergency conditions

Powers of Health Officers

Typical Authorized Police Power Actions –
- Quarantines – persons, property and places
- Isolation (derivative of quarantine power)
- Compulsory examination and treatment
- Rationing of materials (but constitutional issues if a “taking”)
- Closure of areas
Powers of Health Officers

- Compliance officers – need to know the scope and extent of health officer powers:
  - Can health officers order a facility to share equipment or supplies with other facilities?
  - How far can health officers go in data-mining of patient health information/records?
  - Can health officers order limitations on individuals who can receive limited vaccines?
  - Can health officers order hospitals to provide services that are not available in the community?

Powers of Health Officers

Do Your State or Local Health Officers Have the Following Powers?

- Rationing of privately-owned resources
- Rationing of privately-provided health care services
- Commandeering of health facilities
- Conscription of health care personnel

What do you do when a health officer exceeds his/her scope of authority?
SPECIFIC HEALTHCARE ISSUES

HIPAA and Confidentiality

- Under HIPAA, covered entity may not use or disclose protected health information (PHI) except as permitted under Privacy Rule
- In emergency, tension between privacy rights and need to share health information to inform families, friends, and public health workers
- State laws - e.g., California law defines several specific reportable conditions, including “when the disclosure is otherwise specifically authorized by law” Civil Code § 56.10 (c)(14)
HIPAA and Confidentiality

Sharing PHI during emergency
- Privacy Rule allows sharing of PHI without authorization to public health authority in response to bioterrorism or public health emergency. 45 CFR Section 164.512(b).
- Privacy Rule allows release of PHI to public health authority without authorization for certain public health activities, such as surveillance, but limited to “minimum necessary” information.

HIPAA and Confidentiality

HIPAA Waivers during Katrina
- Section 1135 Waivers (referencing Social Security Act)
- HHS waived certain privacy requirements in emergency areas affected by Katrina and Rita (i.e., needing to obtain consent to share info with family/friends; notice of privacy practices)

HHS Bulletin Reminders
- Katrina bulletins reminded providers how Privacy Rule allows sharing PHI in disaster relief efforts for treatment purposes and to notify caregivers.
HIPAA and Confidentiality

- **Other Issues**
  - Health information is protected whether person living or dead
  - Release of patient information to media
  - Security and storage of records (offsite storage; electronic records)
  - EHRs – allows record to follow patient

EMTALA Issues

- 2004 Amendments (Project Bioshield Act) permit CMS to temporarily waive or modify the application of EMTALA standards relating to:
  - Transfers of unstabilized emergency patients if required by the circumstances of a declared emergency by a hospital in the emergency area during the period of the emergency; and
  - Directing or relocating patients for medical screening to alternate locations in accordance with the state emergency preparedness plan
EMTALA Issues

- EMTALA continues in force until three conditions are met –
  - The federal government declares a national emergency;
  - HHS issues a waiver that includes one or more of the EMTALA obligations; and
  - The hospital is located in the designated emergency area

Katrina EMTALA Waiver

- Limited to “the redirection of an individual to another location to receive a medical screening examination pursuant to a state emergency preparedness plan or transfer of an individual who has not been stabilized if the redirection or transfer arises out of hurricane related emergency circumstances.”
EMTALA Issues

For hospitals in the Designated Emergency Area, read the waiver –

- Medical screening -- how broad is the waiver? All patients?
- Transfers - is the waiver limited to transfers required by the emergency situation?

For hospitals in the Designated Emergency Area, the waiver authority does not extend to –

- the obligation to accept transfers (which may be a moot issue)
- the private right of patients to bring lawsuits for EMTALA violations (but recovery is less likely if operating in accordance with the waiver)
**EMTALA Issues**

- For hospitals outside the Designated Emergency Area, the waiver authority does not apply –
  - Must comply with EMTALA if influx of patients from the emergency area
  - Must accept transfers (if capacity) from hospitals in the emergency area

**Credentialing**

- Credentialing and Privileging
  - Need for temporary credentialing and relaxation of standards during emergency
  - JCAHO requires hospitals to establish procedure for verifying credentials and granting privileges during and after disaster (HAS Std MS 4.10)
  - HRSA's ESAR-VHP Program assisted with registration, credentialing, and deployment of volunteer professionals to Gulf region by using online systems
Credentialing

Licensing Issues
- Out-of-State Professionals – Uniform Emergency Volunteer Healthcare Practitioners Act (not all states have adopted)
- JCAHO – If hospital’s disaster plan is activated, may implement modified process for determining qualifications and competence of volunteer practitioners (Std HR 1.25 and MS 4.110)
  - Still limited to activities under license
  - Must verify identity and licensure
- Need to address emergency licensing in Med Staff Bylaws

Contracting Issues

Vendor Contracts
- “Force Majeure” (Acts of God or nature) clauses may excuse performance from either side
- Consider renegotiating terms that are specific to “emergency” or pandemic events
- Review indemnification clauses for nonperformance or defective performance
- Review payment obligations – what if cannot transfer funds during emergency period

Danger of Overloaded Commitments by Vendors
- Katrina -- same bus company was contracted for all elderly homes, so no buses left to evacuate
Reimbursement Issues

- 3rd Party Payor Contracts
  - Review prior authorization requirements and if any waiver for public health emergency admissions
  - Any adjustments for disaster response?
    - Medical necessity
    - Covered services
  - Payment for care provided during quarantine or isolation?
  - See AHIP posting of information for coverage during hurricane relief (www.ahip.org/hurricaneresponse/)

Reimbursement Issues

- HHS Response to Katrina and Rita
  - Section 1135 Waivers for certain Medicare, Medicaid, and SCHIP requirements to facilitate healthcare provision to evacuees
    - www.hhs.gov/katrina/ssawaiver.html
  - Providers could be reimbursed for items and services even though not comply with all requirements because of disaster, so long as good faith effort and no fraud or abuse
Reimbursement Issues

- Examples of waived conditions:
  - Professional licensure in state where services provided
  - Bed classification requirement (i.e., use of psych beds for inpatient services during emergency)
  - Some eligibility verification requirements where documentation not readily available

Reimbursement Issues

- CMS relaxed Medicare billing requirements during Katrina and Rita
  - Examples include:
    - Allow filing paper claims
    - Accelerated or advanced payments to emergency providers in region
    - Instructed intermediaries to accelerate payments and relax cost report deadlines
    - Allow use of other data to substantiate payment when hospital's records unavailable or destroyed
  - Full List at:
    www.hhs.gov/katrina/fedpayment.html
  - See HHS Speech at:
    www.hhs.gov/asl/testify/t060126.html
Reimbursement Issues

- Medicaid and SCHIP Section 1115 Waivers
  - Granted temporary eligibility status to evacuees in new state
  - Eased administrative burdens and simplified enrollment
  - Provided temporary uncompensated care pool for state and its providers treating displaced victims from hurricanes
  - Temporarily expanded coverage for services that normally outside standard Medicaid benefits

Insurance Coverage

- Business Interruption Coverage
- Casualty/Loss Coverage
- Liability Coverage
- Review policies as they relate to public health emergency
  - Level of coverage
  - Scope of coverage
  - Cover loss if government authority takes over operations?
  - Triggering events for coverage
Surge Capacity Planning

- “Surge capacity” defined as a rapid, significant increase in patient capacity to meet patient needs
- Involves beds, equipment, staffing, supplies and related logistics
  - Case studies on post-Katrina facilities
  - May consider standards for surge hospitals
Surge Capacity Planning

2006 California Surge Capacity Survey

- Less than 50% of hospitals have documented full-scale surge plans
- 18% of hospital staff have received emergency response training
- Hospital drills focus on evacuation, not influx
- 100 hospitals do not participate in HRSA surge capacity planning

Dec. 2006 -- $5 million contract to PWC to develop a surge capacity plan in six months

Planning - What Does it Require?

- Facilities
- Supplies
- Equipment
- Infection control
- Vaccine/anti-virals

Surge capacity for beds, personnel, morgue
Personnel protective equipment
Ventilators
? Tamiflu
Major isolation plan
Staff education
Develop internal rationing plan

Coordinate with State/County
Planning - What Does it Require?

Services — Imaging, pathology and other ancillaries
Logistics — Food, laundry, security
Admin. — Chain of command
IT Support — Patient registration and tracking; medical records; billing; etc.

Coordinate with State/County

STAFF TRAINING AND EDUCATION
Training - Who and What

- Disaster Policy for Staff
  - Accessible via hardcopy or intranet
  - Telecommuting policy for emergency
  - Voluntary Nat’l Stds for Disaster Preparedness (NFPA 1600) www.nfpa.org
- Identify critical staff and personnel
  - Medical staff
  - Nurses and allied health professionals
  - Patient support
  - Plant operations
  - Vendors

Training - Who and What (cont.)

- Communicating with Staff (before, during, and after)
  - Call-in line or website for further info
  - Public announcement postings
  - Chain of command/Telephone chain
  - Security of communications (passwords)
- Public Health Education for Staff
Training – Who and What (cont.)

- Cross Training Staff for various job functions
  - Understand the job functions that impact an employee’s function
  - Recognize Union issues
  - Conduct the Job Skills inventory and keep it current, including language capability and interpretation

Training – Who and What (cont.)

- Train on Attendance Concerns
  - Consider flex time alternatives for jobs that don’t require presence at hospital
  - “Presenteeism” of sick workers may be problem for spreading disease
  - FMLA issues for prolonged absences
  - Health Officer can order staff to be tested and cleared before returning to work
  - Have contingency plan for high absenteeism
  - Consider temporary housing
Questions and Answers
DISASTER PREPAREDNESS FOR THE COMPLIANCE OFFICER

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