DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

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TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

/S/

FROM: Stuart Wright
Deputy Inspector General
for Evaluation and Inspections

SUBJECT: Memorandum Report: *Supplemental Information Regarding the Centers for Medicare & Medicaid Services' Emergency Preparedness Checklist for Health Care Facilities*, OEI-06-09-00271

To assist the Centers for Medicare & Medicaid Services (CMS) in ensuring that healthcare facilities develop comprehensive emergency plans, this memorandum provides supplemental information regarding our recent study *Gaps Continue to Exist in Nursing Home Emergency Preparedness and Response During Disasters: 2007-2010* (OEI-06-09-00270).[1] Specifically, it suggests additional guidance that CMS can consider including when next revising the CMS *Emergency Preparedness Checklist Recommended Tool for Effective Health Care Facility Planning* ("CMS checklist").

SUMMARY

In 2007, CMS published an emergency preparedness checklist that healthcare facilities, including nursing homes, can use as guidance to develop and update emergency plans. In our recent study of nursing home emergency preparedness, we used this checklist to evaluate the emergency plans for 24 purposively selected Medicare- and Medicaid-certified nursing homes affected by disasters. We found that most of these emergency plans contained gaps in the information they included, and we recommended that CMS take these gaps into account and specify elements that should be required for inclusion in nursing home emergency plans. We also found that most of the selected nursing homes either were not aware of the CMS checklist or had not used it in developing their emergency plans, and we recommended that CMS promote use of the

[1] Department of Health and Human Services (HHS), OIG, *Gaps Continue to Exist in Nursing Home Emergency Preparedness and Response During Disasters: 2007-2010,* OEI-06-09-00270, March 2012.

checklist by making additional outreach efforts and partnering with other entities.[2] During our review of the emergency plans, we also identified the opportunities for CMS to improve its checklist, which we have outlined in this memorandum report.

BACKGROUND

CMS Emergency Preparedness Checklist for Health Care Facilities

In 2007, CMS issued an emergency preparedness checklist for healthcare facilities. The checklist consists of tasks CMS recommends that healthcare facilities, including nursing homes, perform as they develop their emergency plans. CMS issues the checklist as guidance and does not require that facilities perform each task. (See Appendix A for the CMS checklist.)

METHODOLOGY

In our recent study of nursing home emergency preparedness, we compared the emergency plans of 24 purposively selected nursing homes—all certified by Medicare and Medicaid, and all affected by disasters—to the CMS checklist for healthcare facilities. From this comparison, we identified six areas of concern in which the emergency plans of the selected nursing homes did not fully address the guidance provided in the CMS checklist. While reviewing the emergency plans, we also identified areas in which CMS could consider providing additional guidance for healthcare facilities.

Standards

This inspection was conducted in accordance with the *Quality Standards for Inspection and Evaluation* approved by the Council of the Inspectors General on Integrity and Efficiency.

RESULTS

In the next revision of the checklist, CMS could consider adding greater detail and more pointed guidance. Specifically, CMS could add guidance regarding searching for missing patients, determining sufficient quantities of supplies, reviewing recommended emergency response practices, tailoring emergency planning templates, and collaborating in healthcare coalitions.

Missing patients. Among the tasks in the CMS checklist is a task related to tracking individuals during and after a facility evacuation, but there is no task related to searching

[2] HHS, OIG, *Gaps Continue to Exist in Nursing Home Emergency Preparedness and Response During Disasters: 2007-2010*, OEI-06-09-00270, March 2012. We found that, on average, selected nursing homes included items that corresponded to about half of the checklist-recommended tasks in their emergency plans and no plans had corresponding items for all of the tasks. We also found that only 13 of 24 selected nursing homes were aware of the checklist and only 7 of these 13 reported using it in developing their emergency plans. The remaining 6 nursing homes reported using guidance from other sources, such as their corporate offices or local emergency managers.

for missing patients. Emergencies can create particular challenges for healthcare facilities in knowing the whereabouts of patients under their care and may increase the risk of missing patients. Two of the twenty-four selected nursing homes in our study temporarily "lost" residents when evacuating for a disaster, and 12 of the 24 did not include procedures regarding missing residents in their emergency plans.

Undefined quantities of supplies. The CMS checklist includes tasks related to ensuring that healthcare facilities have sufficient supplies (e.g., food, water) to care for individuals when sheltering in place or evacuating during an emergency, but it does not include guidance for determining the amount of supplies needed. For example, in the section regarding sheltering in place, the checklist recommends only that healthcare facilities have an "adequate" supply of water for a minimum of 7 days. Facility administrators may not have the expertise to estimate water supplies for a given time period. In our study, we found that the emergency plans of the 24 selected nursing homes varied greatly regarding water supplies. For example, one plan stated that the nursing home's emergency water would come from water heaters and filled bathtubs, whereas another nursing home's plan instructed staff to fill freezers with containers of water to use during emergencies. Other plans listed the amount of bottled water to store at the facility, but did not specify how many individuals this would supply or the number of days the supply would last.

Recommended emergency response practices. The CMS checklist includes the task of annually reviewing emergency plans, but it does not include guidance for healthcare facilities to update recommended practices from expert entities such as the Federal Emergency Management Agency (FEMA). As such, healthcare facilities may not immediately learn about changes in recommendations for emergency planning. Of the emergency plans for the 24 selected nursing homes in our study, we found that 7 contained inaccurate and potentially dangerous guidance that conflicted with FEMA recommendations for safety during tornados and hurricanes. Specifically, the seven plans included instructions to open doors and windows in response to powerful winds, whereas FEMA recommends closing all doors and windows during a tornado or hurricane to protect individuals from the flying debris that cause most injuries and fatalities during severe storms.[3]

Emergency planning templates. The CMS checklist does not address facility use of emergency planning templates. The templates provide basic, general planning guidance with space for administrators to add facility-specific information. Of the emergency plans for the 24 selected nursing homes in our study, 15 appeared to use emergency planning templates from the facilities' respective corporate offices, vendors, or other sources. However, some of these nursing homes did not use the templates as intended because they did not fill in critical facility-specific information where prompted. For example, one nursing home retained the template's directions to "remove the sample and insert a copy of your own evacuation plan," and did not include evacuation routes and directions to alternate facilities. CMS could add to the checklist a reminder for

[3] FEMA, *Are You Ready? An In-depth Guide to Citizen Preparedness*, 2004, pp. 60, 70–71. Accessed at http://www.fema.gov on December 13, 2010.

healthcare facilities to appropriately complete emergency planning templates and tailor them to their facility-specific needs and geographic locations.

Healthcare coalitions. The CMS checklist includes a task regarding collaboration with "like" facilities in emergency planning and response. However, the checklist does not reference "healthcare coalitions," an HHS effort to facilitate collaboration among healthcare facilities within a geographic area. The Assistant Secretary for Preparedness and Response (ASPR) defines a healthcare coalition as a "single functional entity of healthcare facilities" that includes different types of healthcare providers at the State and local level (e.g., hospitals, nursing homes, hospices, home care, and dialysis centers) and describes it as a key component for effectively responding to "an event-driven medical surge."[4, 5] The Centers for Disease Control and Prevention (CDC) states that the purpose of such coalitions is to integrate plans and activities of healthcare systems into local and State response plans to increase medical response capabilities.[6] Healthcare facility administrators may be unaware of healthcare coalitions. When we interviewed staff from the 24 selected nursing homes in our study, none mentioned collaboration through healthcare coalitions.

CONCLUSION

CMS has created an extensive emergency preparedness planning tool for healthcare facilities, yet our study of nursing home emergency preparedness found that most nursing homes did not know about the CMS checklist and those who were aware of it did not use it in developing facility emergency plans. In our recent report, we recommended that CMS promote use of the checklist. Additionally, we encourage CMS to also consider including the guidance outlined in this memorandum report.

This memorandum report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-06-09-00271 in all correspondence.

[4] ASPR, *From Hospitals to Healthcare Coalitions: Transforming Health Preparedness and Response in Our Communities*, May, 2011. Accessed at http://www.phe.gov on December 1, 2011.
[5] ASPR, *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness*, January, 2012. Accessed at http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf on February 24, 2012.
[6] CDC, *Public Health Emergency Preparedness Cooperative Agreement*, CDC-RFA-TP11-1101CONT11, June 13, 2011. Accessed at http://www.cdc.gov on December 1, 2011.

APPENDIX A

Table A-1. Centers for Medicare & Medicaid Services Emergency Preparedness Checklist

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: - Copies of any state and local emergency planning regulations or requirements - Facility personnel names and contact information - Contact information of local and state emergency managers - A facility organization chart - Building construction and Life Safety systems information - 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: - Specific actions to be taken for the hazard - Identified key staff responsible for executing plan - Staffing requirements and defined staff responsibilities - 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.). - Communication procedures to receive emergency warning/alerts, and for communication with staff, families, individuals receiving care, before, during and after the emergency - 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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Table A-1. Centers for Medicare & Medicaid Services Emergency Preparedness Checklist (Page 2)

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

Survey & Certification
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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: *
			- Procedures to assess whether the facility is strong enough to withstand strong winds, flooding, etc.
			- Measures to secure the building against damage (plywood for windows, sandbags and plastic for flooding, safest areas of the facility identified.
			- Procedures for collaborating with local emergency management agency, fire, police and EMS agencies regarding the decision to shelter-in-place.
			- Sufficient resources are in supply for sheltering-in-place for at least 7 days, including:
			  - Ensuring emergency power, including back-up generators and accounts for maintaining a supply of fuel
			  - An adequate supply of potable water (recommended amounts vary by population and location)
			  - A description of the amounts and types of food in supply
			  - Maintaining extra pharmacy stocks of common medications
			  - Maintaining extra medical supplies and equipment (e.g., oxygen, linens, vital equipment)
			- Identifying and assigning staff who are responsible for each task
			- Description of hosting procedures, with details ensuring 24-hour operations for minimum of 7 days
			- Contract established with multiple vendors for supplies and transportation
			- 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: * - Identification of person responsible for implementing the facility evacuation plan (even if no outside evacuation order is given) - 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. - 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 - Adequate food supply and logistical support for transporting food is described.

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Table A-1. Centers for Medicare & Medicaid Services Emergency Preparedness Checklist (Page 3)

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
			- The amounts of water to be transported and logistical support is described. - The logistics to transport medications is described, including ensuring their protection under the control of a registered nurse. - Procedures for protecting and transporting resident/patient medical records. - The list of items to accompany residents/patients is described. - 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 - Identify staff responsibilities and how individuals will be cared for during evacuation, and the back-up plan if there isn't sufficient staff. - 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). - A description of how other critical supplies and equipment will be transported is included. - Determine a method to account for all individuals during and after the evacuation - Procedures are described to ensure staff accompany evacuating residents. - Procedures are described if a patient/resident becomes ill or dies in route. - Mental health and grief counselors are available at reception points to talk with and counsel evacuees. - It is described whether staff 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). *
			• **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.

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Table A-1. Centers for Medicare & Medicaid Services Emergency Preparedness Checklist (Page 4)

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
			• **Resident Identification:** Determine how residents will be identified in an evacuation; and ensure the following identifying information will be transferred with each resident: - Name - Social security number - Photograph - Medicaid or other health insurer number - Date of birth, diagnosis - Current drug/prescription and diet regimens - Name and contact information for next of kin/responsible person/Power of Attorney) 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: - 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. - 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.
			• **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: - Encourage the resident to talk about expectations, anger, and/or disappointment - Work to develop a level of trust - Present an optimistic, favorable attitude about the relocation - Anticipate that anxiety will occur - Do not argue with the resident - Do not give orders

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Table A-1. Centers for Medicare & Medicaid Services Emergency Preparedness Checklist (Page 5)

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
			- Do not take the resident's behavior personally - Use praise liberally - Include the resident in assessing problems - Encourage staff to introduce themselves to residents - 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: - Regulatory change - New hazards are identified or existing hazards change - After tests, drills, or exercises when problems have been identified - After actual disasters/emergency responses - Infrastructure changes - Funding or budget-level changes
			• **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: - Exercises or drills must be conducted at least semi-annually - 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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