Q3 ASHE Advocacy Liaison Webinar
9/21/16
ASHE Advocacy Team

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Housekeeping

• Please mute your line to reduce background noise.
• Do not put us on hold if you have background music on your hold line.
• We will unmute for the interactive discussion.
• This session will be recorded. The slides will be distributed after the meeting.
Chapter Attendance Poll

• Please enter your name and chapter name in the text box
• Contact Avis Gordon agordon@aha.org with updates or changes to your Chapter’s advocacy liaison appointment
1. CMS emergency management requirements
2. State adoption strategies for the *Life Safety Code*
3. 2018 NFPA 101 and NFPA 99 code cycle
4. ASHRAE 170
5. Focus on Compliance
6. Local or regional activities
CMS Emergency Preparedness Requirements

• Effective date is November 15, 2016
• Implementation date is November 15, 2017
CMS Emergency Preparedness Rule

• Applies to 17 provider types
• Covers 5 key elements
  1. Emergency planning and risk assessment
  2. Policies and procedures
  3. Communication plan
  4. Training and testing
  5. Emergency standby power system
ASHE News

ASHE resource outlines implications of CMS emergency preparedness rule

Published: September 20 2016

Subject Matter: Article | Topics: Codes and standards

ASHE has developed a new resource outlining the implications of the new emergency preparedness rules adopted by the Centers for Medicare & Medicaid Services (CMS). ASHE’s chart shows members each requirement of the new CMS rule; a summary of CMS’s reasoning behind the requirement; and ASHE’s summary of what hospitals will need to do to comply with the new requirement. Many hospitals and health care facilities already comply with Joint Commission standards or NFPA 99 emergency preparedness standards, and may need to make a few minor modifications to comply with CMS regulations.

ACCESS THE NEW ASHE RESOURCE (MEMBERS ONLY) >>

CMS released its final emergency preparedness rule earlier this month. The regulations have an effective of November 15, 2016, but the implementation date is November 15, 2017, allowing organizations time to implement the necessary changes to their emergency preparedness programs. The rule, which applies to 17 different provider types, including hospitals, critical access hospitals, ambulatory surgical centers, long-term care facilities, intermediate care facilities, and rural health clinics, covers four key elements of emergency preparedness:
<table>
<thead>
<tr>
<th>CMS EMERGENCY PREPAREDNESS RULE TEXT</th>
<th>CMS INTENTION (excerpted from CMS final rule)</th>
<th>IMPLICATIONS FOR HEALTH CARE FACILITIES (ASHE interpretation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>§ 482.15 Condition of participation: Emergency preparedness. The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements.</td>
<td>While we agree that the responsibility for ensuring a community-wide coordinated disaster preparedness response is under the state and local emergency authorities, healthcare facilities will still be required to perform a risk assessment, develop an emergency plan, policies and procedures, communication plan, and train and test all staff to comply with the requirements in this final rule. These new requirements will require a coordinated and collaborative relationship with state and local governments during a disaster.</td>
<td>Organizations that are compliant with either the 2012 edition of NFPA 99 or current Joint Commission emergency management requirements will have addressed community involvement within their emergency operations plan, but will need to evaluate the detail to which this cooperative effort is documented and ensure that it indicates how a collaborative relationship with state and local governments is to be coordinated.</td>
</tr>
<tr>
<td>§ 482.15 Condition of participation: Emergency preparedness. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</td>
<td>An all hazards planning approach is considered &quot;a more efficient and effective way to prepare for emergencies. Rather than managing planning initiatives for a multitude of threat scenarios, all hazards planning focuses on developing capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters.&quot; Thus, all-hazards planning does not specifically address every possible threat but ensures that hospitals and all other providers will have the capacity to address a broad range of related emergencies. The providers and suppliers discussed in this regulation should utilize an all-hazards approach to perform a &quot;hazard vulnerability risk assessment.&quot; This final rule will require each of the Medicare- and Medicaid-participating providers and suppliers to perform a risk analysis; establish an emergency preparedness plan, emergency preparedness policies and procedures, and an emergency preparedness communication plan; train staff in emergency preparedness, and test the emergency plan.</td>
<td>Organizations that are compliant with either the 2012 edition of NFPA 99 or current Joint Commission emergency management requirements will have completed a detailed hazard vulnerability assessment (HVA), but will need to evaluate the HVA process to ensure that this documentation includes an all hazards approach.</td>
</tr>
</tbody>
</table>
Major implications

If you are Joint Commission accredited or comply with NFPA 99 EM requirements:

• 28% of CMS requirements are met
• 35% of CMS requirements – evaluate your policies and plans to be sure of compliance
• 37% of CMS requirements could require relocating existing information or adding new
State adoption of NFPA 101 and 99
CMS Adoption of the 2012 *Life Safety Code®* and *Health Facilities Code*,

Video produced by ASHE

2018 Edition NFPA 99 and 101

• Public Input Closing Date: 7/6/2015
• First Draft Report Posting Date: 2/25/2016
• Public Comment Closing Date: 5/16/2016
• Second Draft Report Posting Date: 1/16/2017
• NITMAM Closing Date: 2/20/2017
• NITMAM Posting Date: 4/17/2017
• NFPA Technical Meeting 6/7-6/8, 2017
  Boston MA
ASHRAE 170

- Follows the FGI Guidelines move to separate hospital, outpatient and residential requirements
- Outpatient section is available for comment
- 45-day public review from September 16, 2016 to October 31, 2016
- The intent is not to create new outpatient requirements

http://www.ashrae.org/standards-research--technology/public-review-drafts
• Utility systems (EC.02.05.01) (posted on focus site)
• Means of egress (LS.02.01.20) (posted on focus site)
• Built environment (EC.02.06.01) (posted on focus site)
• Fire protection (EC.02.03.05) (posted on focus site)
• Building and Fire Protection Features (LS.02.01.10)
• Life safety protection (LS.02.01.30)
• Automated suppression systems (LS.02.01.35) (Aug./Sept.)
• Hazardous materials and waste management (EC.02.02.01) (Oct./Nov. 2016)

http://www.ashe.org/compliance
Recent Webinars

August 10, 2016

Chapter 43 of NFPA 101 and Its Impact on Health Care Facilities – Presented by Bill Koffel

http://www.ashe.org/compliance
Questions
Mark Your Calendars

The next Advocacy Liaison webinar will be held Wednesday, 12/7/16 at 12:00 Central Time
2017 ASHE Advocacy Liaison webinars

Q1 – 3/1/17
Q2 – 6/21/17
Q3 – 9/20/17
Q4 – 12/6/17

All webinars are at 12:00 pm Central Time