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Ongoing Compliance Requirements

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Participants will:

- Confirm the biennial program evaluation is complete and accurate
- Distinguish the difference between emergency plan testing and training
- Evaluate areas of improvement at the clinic

Compliance is Ongoing

- Daily
  - Temp logs, cleaning
- Monthly
  - Environmental rounding
  - Emergency equipment logs
- Quarterly
  - Collaborative/Administrative audits
  - Patient Satisfaction/Staff meeting
  - Credit balance reports

Compliance is Ongoing

- Annually
  - Medicare cost report
  - HR audit
  - Equipment inspection
  - Employee training
- Biennially
  - Policy review
  - Emergency plan review
  - Program evaluation

Compliance is Ongoing

- Miscellaneous
  - Control logs
  - Organizational chart
  - CLIA
  - Sample medication logs
  - Controlled medication logs
  - Autoclave

491.11 Program Evaluation

- The clinic or center carries out, or arranges for, a biennial evaluation of its total program.
- The evaluation includes review of:
  - The utilization of clinic or center services, including at least the number of patients served and the volume of services;
  - A representative sample of both active and closed clinical records; and
  - The clinic's or center's health care policies.
- The purpose of the evaluation is to determine whether:
  - The utilization of services was appropriate;
  - The established policies were followed; and
  - Any changes are needed.
- The clinic or center staff considers the findings of the evaluation and takes corrective action if necessary.

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Program Evaluation:

- Written policy
  - Who participates
  - What information is included
  - Timeline (annual/biennial)
- Written report vs. meeting

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Program Evaluation:

- Utilization of services
  - At least patient/visit count
- Chart audits
  - Quality
  - Meet number/frequency defined in policy
  - Active/closed
    - Closed chart = Deceased, inactive, transferred, aged out

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Program Evaluation:

- Policy review:
  - Patient care policies
  - Timeline
  - Approval process
    - Medical Director
    - Advanced Practice Provider
    - Only place “non-staff” member is mentioned

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Program Evaluation:

- Answers to three questions:
  - Was utilization of services appropriate?
  - Were policies followed?
  - What corrective actions are needed?

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Program Evaluation Meeting Agenda

I. Review the mission and purpose of the advisory council
II. Review utilization of services
    A. Volume
        - Top diagnosis codes
        - Number of patients seen in each clinic by insurance
        - Number of patients seen by age
        - Number of patients seen by gender
        - Number of in house lab services performed
        - Number of in house x-ray performed (if applicable)
        - Number of diagnostic referrals
    B. Care of acute and chronic conditions
    C. Patient safety
    D. Coordination of care
    E. Convenience and timeliness of available services
    F. Patient satisfaction
III. Review Performance Improvement projects
    A. What project is the clinic reviewing
    B. How is the project going
    C. What is the clinic's next area of focus
IV. Updates to overall program:
    A. Review what went well
    B. Review changes that have been implemented
    C. Review improvements needed
    D. Review clinic hours of operations
    E. Review staffing levels
V. Medical record review
    A. Review audit analysis
VI. Review policies and procedures and emergency plan
    A. Review change recommendations
    B. Give final approval
    C. Timeline for implementation
    D. Determine if policies were followed
VII. Conclusion
    A. Set future clinic goals
    B. Next steps
    C. Set date for next meeting

491.12 Emergency Preparedness

- 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:
  - Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
  - Include strategies for addressing emergency events identified by the risk assessment.
  - 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.
  - 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.

491.12 Emergency Preparedness

- 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:
  - Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.
  - A means to shelter in place for patients, staff, and volunteers who remain in the facility.
  - A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.
  - 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.

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491.12 Emergency Preparedness

- 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:
  - Names and contact information for the following:
    - Staff, Entities providing services under arrangement, Patients' physicians, Other RHCs/FQHCs, Volunteers.
  - Contact information for the following:
    - Federal, State, tribal, regional, and local emergency preparedness staff, Other sources of assistance.

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491.12 Emergency Preparedness

- Primary and alternate means for communicating with the following:
  - RHC/FQHC's staff, (ii) Federal, State, tribal, regional, and local emergency management agencies.
- 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).
- 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.

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491.12 Emergency Preparedness

- 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.

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491.12 Emergency Preparedness

- Training program. The RHC/FQHC must do all of the following:
  - 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, Provide emergency preparedness training at least every 2 years.
  - Maintain documentation of the training. Demonstrate staff knowledge of emergency procedures. If the emergency preparedness policies and procedures are significantly updated, the RHC/FQHC must conduct training on the updated policies and procedures.

491.12 Emergency Preparedness

- Testing. The RHC or FQHC must conduct exercises to test the emergency plan at least annually. The RHC or FQHC must do the following:
  - Participate in a full-scale exercise that is community-based every 2 years; or
    - When a community-based exercise is not accessible, an individual, facility-based functional exercise every 2 years; or.
    - 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.

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491.12 Emergency Preparedness

- 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 second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
  - A mock disaster drill; or
  - 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.

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491.12 Emergency Preparedness

- 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.

491.12 Emergency Preparedness

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

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491.12 Emergency Preparedness

- 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:
  - A documented community-based risk assessment, utilizing an all-hazards approach.
  - A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.
- 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.

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Training Vs. Testing

- Staff training
  - Explains what the plan says
  - Education
  - Proactive
  - Documentation – Report or Staff Sign-In Sheet with supporting educational documentation
- Testing
  - Determines if the plan works
  - Analysis
  - Reactive
  - Documentation – After action report

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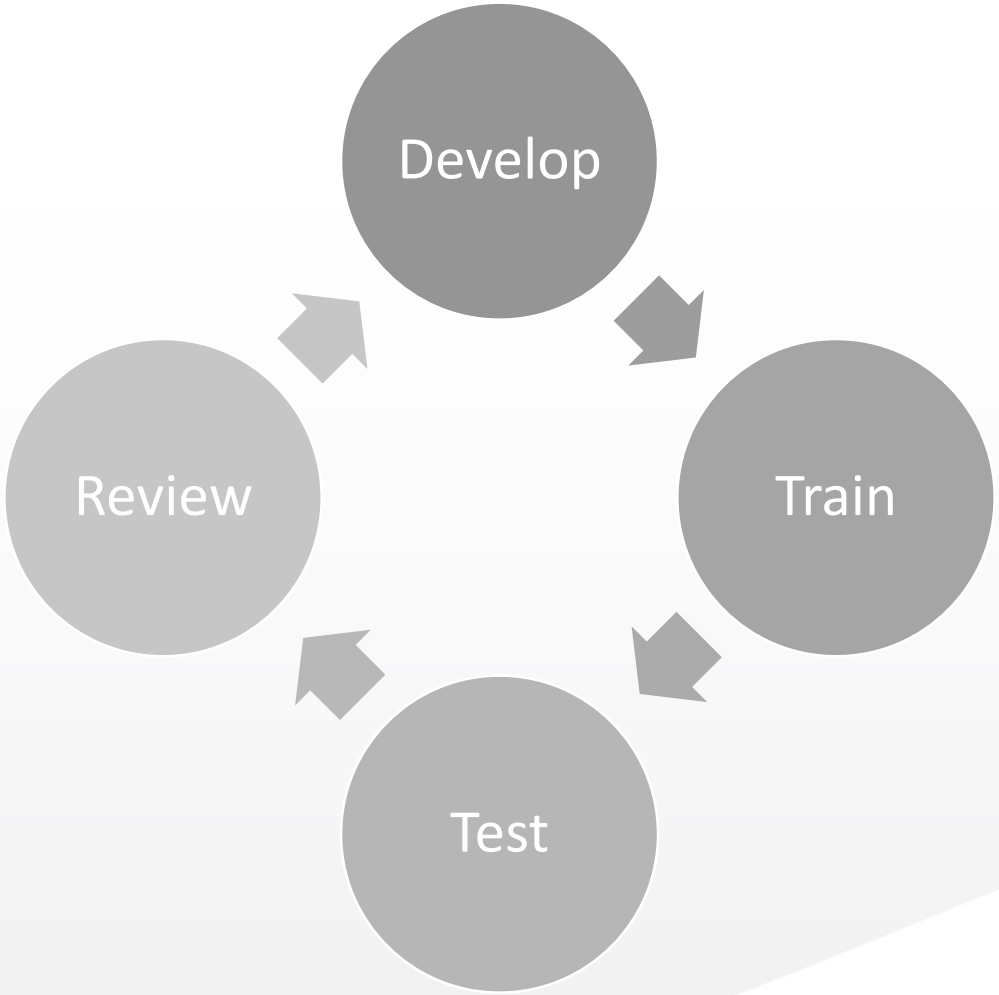
4 Categories of Emergency Planning

- Risk Assessment
- Policies
- Communication Plan
- Training/Testing Program



Tab 1:

- Emergency Operation Plan
  - Introduction (scope, demographics, descriptions)
  - Planning (risks, delegations of authority, incident command, succession, receiving facilities)
  - Policies (shelter, evacuation, documentation, volunteers, lock down, suspension, medications, infectious diseases, surge)
  - Communication (internal, external, communication systems, patients/visitors, requesting assistance)
  - Training/testing programs (timelines, documentation required)
- Copy of Hospital Plan (if applicable)

Tab 2:

- Situational Policies
  - At least top 5 risks
    - AKA: Codes, Action Plans

Tab 3:

- Appendix
  - Facility map
  - Floor plan
  - Organizational chart
  - Risk assessment
  - Contact lists (internal/external)

Tab 4:

- ALL Staff training * Don’t forget providers/PRN staff
  - Documentation of training module (what information is covered)
    - Top risks
    - Roles/responsibilities
    - Meeting points
    - Action plans
  - Documentation to prove staff participation (sign-in/report)

Tab 5:

- Testing/Exercises
  - Drill Schedule
  - After action reports (at least 4 years)

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Resources:

- Appendix G
- Sample Program Evaluation Agenda
- PDSA Tool
- Appendix Z
- After action report template

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