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# Compliance in Crisis: The Compliance Professional's Role in Emergency Preparedness and Implementation

## Four Areas of Preparation That Will Help Your Facility Avoid Costly Compliance Mistakes

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Think emergency preparedness is outside your realm of responsibility as the chief compliance officer? Think again. You serve a vital role in preparing for a crisis. Preparation will be critical to your facility staying in compliance while dealing with extraordinary adverse circumstances.

While the emergency preparedness professionals are organizing food, shelter, and medical care logistics, the compliance professional needs to anticipate the alternative ways that care will be delivered, the unusual patient and non-patient situations that will be encountered, and the resulting compliance and billing issues that should be addressed to avoid possible noncompliance in the heat of the moment. The gist of the federal emergency preparedness requirements that apply to varied types of providers is to develop a well thought-out plan and to practice implementation of that plan so the first attempt is not in crisis but after refinement through practice.[1] These same essential elements apply to the compliance professional's role in preparing for and helping her organization execute compliant operations during stressful unusual circumstances.

This article is intended to help the compliance professional identify potential issues that will arise and develop practical tools to assist in accomplishing compliance during crisis. Using recent scenarios from hurricanes Michael and Florence, this article will discuss four areas of preparation that can help your facility avoid costly compliance mistakes. Effective preparation involves coordination with emergency preparedness professionals and counsel to anticipate potential situations and create procedures and tools so all of you can respond rapidly

in the moment. Thoughtful preparation will also better position your facility to receive reimbursement and enable you to respond to government inquiries after the event.

## Evacuation

Before recent hurricanes, leaders of many facilities found themselves avidly watching every emergency forecast to judge whether they were in the storm's path and when to trigger evacuation efforts. While waiting for an evacuation decision, compliance officers should review their preparation and make any adjustments needed for the potential evacuation scenarios. Keep in mind that normal transport routes may not be available and time of transport could be much longer than anticipated, which could necessitate provision of care enroute. Some skilled nursing facilities evacuating from hurricane areas reported six plus hour bus rides due to flooded or blocked roads. Consider the questions below (in the left-hand column) and corresponding tools (in the right-hand column) when working on emergency preparedness with your operational, emergency preparedness, and billing colleagues.

1. Who is keeping visibility to the path and proximity of the storm to establish the basis for and timing of a full or partial evacuation decision?
2. Are transfer agreements in place with the potential receiving facilities? Suppose the usual transfer partners are not available because of the storm's path. Are alternate transfer agreements in place or templates available to quickly create new agreements?
3. Do transfer agreements cover possible transfer of large numbers and categories of patients?
4. Do receiving facilities have in-network agreements with the same payers so your patients are not adversely affected financially? Do your or the receiving facility's payer agreements allow emergency exceptions?
5. For long-term care, do transfer agreements commit receiving facilities to patients' return once the storm has passed and your facility is able to resume operations?
6. What will you do if any patients refuse to leave? Are you ready with documentation that will justify transfer against their wishes on the basis that the facility cannot meet the patients' needs due to the impending hurricane?

| Evacuation Compliance Tools |
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| 1. Create an event tracker with links to weather sources to justify the decision to fully or partially evacuate and to document lack of capability for EMTALA purposes. |
| 2. Develop transfer agreement templates for different scenarios. Work with counsel to include all needed provisions. Periodically review agreements for appropriate updates or different agreements needed due to changes in transportation routes or receiving facility capabilities and document such reviews. |
| 3. Be sure transfer agreements specifically mention willingness to accept larger numbers of patients and categories of capability, such as ICU, neonatal, etc. |
| 4. Verify receiving facilities have in-network agreements with the same payers and require notification if payment arrangements change. Negotiate provisions with your payers for out-of-network waivers when patients are transferred due to an emergency. |
| 5. If treating long-term patients, consider getting patient written consent for transfer and return. Include commitment in transfer agreements to return patients when your facility resumes operations. Patient choice must still control unless the receiving facility cannot meet patient's needs. |
| 6. Create discharge notice templates that document the facility cannot meet patients' needs and arrangements for transfer. Be sure staff know the regulatory requirements for transfer documentation for different types of patients. Create checklists for each department. |

7. How will patients be transported? Remember to assume that normal transport methods and routes may not be available. Will documentation demonstrate medical necessity for and appropriateness of the transport method and transfer location to justify billing?
8. How will patients' health care needs be met and documented for reimbursement if transport takes extended time due to storm conditions? Will staffing types and numbers satisfy required ratios?
9. Will requirements to bill a hospital or nursing home day of care be satisfied if the patient is in a bus or ambulance a number of hours and spends the night in another facility? When should the time of discharge be recorded if care is provided during transport? Who will bill for care rendered at the receiving facility?
10. If non-traditional transport is used, how will medication administration be accomplished and documented during transport to avoid medication errors or diversion and to justify billing? How many days of medication and supplies should accompany the patient to avoid licensure or other violations?
11. How will staff accompanying patients during transport be able to communicate with other care disciplines if needed? Will the communication methods be confidential and secure under HIPAA?[2]
12. Will staff accompanying patients know whether and how to respond to family, media, or government official inquiries during transport?
13. How will staff's work hours be tracked and documented? Are there any grounds for suspending normal overtime rules, or do overtime hours need to be distinguished for payment purposes?
14. Will staff stay at the receiving facility? Are they already credentialed to provide care at the receiving facility, or do you have a staffing agreement in place to provide staff under contract to the receiving facility? Who will pay for staff services rendered at the receiving facility?

7. Learn ambulance billing rules and whether any waivers are available. Create tools to document patient conditions that justify type of transport and staffing. Investigate whether there are any in-network or approved provider considerations that impact transport options.

8. Negotiate vendor agreements for large-scale emergency transport. Include provisions regarding timing of and payment for possible needed rest/food stops if conditions require alternate longer routes. Create checklists for staffing complements and ratios. Devise tools to document staffing enroute and circumstances justifying variation from requirements.

9. Know time minimums to bill a day of care. Determine how times of departure and acceptance will be documented and coordinated with billing staff and receiving facility. Consider whether care can be provided and documented enroute to qualify as a continued stay. Include in transfer agreement how to coordinate which or both facilities bill.

10. Work with hospital operations teams to create medication security, tracking, and administration tools to use enroute.

11. Educate staff on HIPAA-compliant communication when methods may not be familiar. Consider whether staff cell phones can be used securely or facility technology should be used. Assess communication options if cell networks are not functioning. Work with other facility colleagues to understand and document available security options.

12. Train staff on emergency communication contacts and processes. Anticipate normal contacts may not be available and staff with patients may become points of contact and need to know HIPAA requirements.

13. Coordinate with HR to satisfy overtime rules.

14. Anticipate staffing scenarios, accomplish reciprocal emergency credentialing, and have template staffing agreements prepared.

15. Do belongings need to be returned to the patient at the receiving facility? Is there an agreement in place that requires the patient or his family to retrieve belongings or pay for shipment?
16. If a partial evacuation occurs, how will the facility demonstrate under EMTALA lack of capacity or capability to meet certain patients' needs to justify diversion or transfer from the emergency department?
17. What notices are needed to vendors, government agencies, or referral sources of hospital or nursing home evacuation?

15. Address handling of patient belongings in facility admission agreements and transfer consents.
16. Capture information to document storm path, limited power, staff, and supply resources that warrant temporarily closing units when entire facility operations are not suspended. Establish communication, coordination, and documentation processes to be followed by units and ED.
17. Develop template evacuation notices for suspension and resumption of operations.

The above are some examples that illustrate the compliance officer's role in coordinating preparation to effect compliant operations, transfers, and billing in emergent circumstances. The issues will vary to some degree depending upon the types of services offered at your facility, your geographic location in relation to possible receiving facilities, potential circumstances that could trigger the need to evacuate, and your facility's existing partnerships with other community services and facilities offering comparable services. Effective planning involves identifying possible variations from normal operations in services and billing, determining whether different rules may apply, and developing template tools that can be used quickly to capture in the moment needed documentation to demonstrate compliance with or qualification for waiver of requirements.

## Facility as Place of Refuge

Suppose your facility stays in operation during the storm and does not evacuate. Compliance considerations still arise, and compliance professionals still play an important role in managing emergent circumstances. Since requirements dictate use of emergency generators when normal power sources are not available, health care facilities often become places of refuge for others in the community that do not have power. Compliance professionals need to coordinate with other facility functions to prepare for these circumstances. Potential risks should be identified and advance measures undertaken to minimize such risks. Consider various potential community refuge needs and which implicate compliance considerations.

1. Will those seeking shelter be considered presenting for care under EMTALA? Determine how to prove non-patient status and a communication process to seek care if the need arises. Anticipate whether your facility will ask for payment for meals or track free meals numbers served and circumstances to justify treating expense as "community benefits" provided by a

**Refuge Compliance Tools**

1. Create template signs to designate areas for shelter and areas for homebound patients needing care and corresponding notices of expectations for each. Establish check-in process and documentation to notify and capture acknowledgment of non-patient status, commitment to abide by shelter rules, assumption of risk, and how individuals must initiate care. Track free services, food, and supplies provided.

non-profit entity or to establish qualification for government or other community funding.

2. Is there a need to track who is present for shelter? Suppose there is a request to respond to inquiries from families, the media, or government agencies concerning who is present. Will you have the information and needed permission to do so?
3. Will homebound patients come to the facility for power or care if home health staff cannot reach them?
4. Will your facility make arrangements with home care agencies to provide services in facility provided shelter space? Alternatively, will your facility register as patients, obtain consents to treatment, assume responsibility for care, and bill for any services provided? How will your facility obtain necessary physician orders and document that billing requirements were satisfied?
5. If by necessity care will be provided to homebound patients in a group setting, what measures can be undertaken to afford some privacy? How will you document such measures were implemented? What signs should be posted and what commitment should be included in patient consent forms to abide by patient confidentiality, not post on social media, and not share details with the press? What process will your facility establish to monitor and enforce confidentiality commitments?
6. How will compliant documentation be accomplished if usual computer systems are not available? Have staff been trained on alternate documentation procedures?
7. Is there a plan to address "dropped off" elderly, disabled, or minor individuals whose family members or friends do not return? Will caregivers be required to stay, and how will you identify these possible circumstances at the outset? Consider need for sign or other language interpreters in shelter area to meet federal requirements.
8. Plan for possibility that staff and their families may become boarders as part of facility efforts to assure adequate staffing.

2. Create process so there is some accounting of who is present. Consider obtaining contact information and permission for next of kin or other persons that can be notified if the community member experiences an immediate health need or there are inquiries concerning whether the person is missing or deceased.

3. Anticipate need for medical shelter respite area and how to designate. Consider ways to efficiently provide power such as an "oxygen bar," area for ventilator dependent patients, and whether home dialysis patients can be accommodated or can be admitted and billed as inpatients to receive dialysis.

4. Prepare template agreements with home care agencies to address their delivery of services in shelter space or for the facility to provide and document services. Address process for physician orders, medical necessity documentation, and billing and payment responsibilities.

5. Evaluate options to accomplish privacy in designated shelter spaces. Develop template signs that communicate privacy expectations. Take photos of privacy partitions. Create patient consent forms that include commitments to abide by privacy rules and not post on social media.

6. Have alternative plans to create needed documentation electronically or by hard copy if systems are not available or energy must be conserved. Establish secure location to preserve the security and integrity of documentation. Determine identity of those with permitted access to and authority to make entries in documentation.

7. Consider coordination needed with social services if individuals are abandoned. Formulate plans to address individuals with possible accommodation needs. Assess legal requirements and how to satisfy.

8. Evaluate whether and how to create separate spaces for staff and their families to rest so as to avoid staff feeling they are still "on duty" and should respond to needs of other boarders. Document non-patient status and shelter expectations for staff and family boarders.

## Volunteers and Donation Management

Many dedicated individuals will present willing to help address crisis needs. Retired medical professionals may offer their services. People with access to transportation that functions in an emergency may appear and immediately begin to render assistance in shelter areas, parking lots, or patient care areas. Unrequested food and supplies may be delivered.

The challenge for compliance professionals is how to manage such offers in a way that expresses gratitude but still satisfies any applicable requirements and protects against risk. Comparable considerations arise in managing in-kind and monetary donations. Determine in advance whether Volunteer Services and Foundation personnel will address these efforts and whether the Compliance Office should be involved in educating these colleagues on any applicable compliance requirements and planning implementation strategies.

1. How will your facility screen medical volunteers and assess their qualifications? Do applicable federal or state rules require screening other types of volunteers? Are waivers available in an emergency? What is needed to obtain a waiver?
2. What education of medical volunteers will be needed, how can it be offered briefly and quickly, what topics are essential, and who will provide such training?
3. What signed acknowledgments and commitments are needed from medical and non-medical volunteers? How will your facility be able to prove that volunteers were not employees and not due compensation?
4. How will your facility determine areas of the facility that volunteers can access and those that will be "off-limits?" How will volunteers know which areas are off-limits?
5. Will in-kind donations be accepted or be limited to certain items, and how will needs be communicated to the media?
6. What process will be established to screen acceptability of in-kind donations and to generate tax records and receipts for donors?

| Volunteers and Donation Management |
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| 1. Determine volunteer compliance requirements in an emergency. Consider whether expedited screening can be accomplished or necessary waiver obtained. Assess whether screening required if volunteers are not working with patients. Prepare template volunteer information sheet and waiver request form. |
| 2. Work with educators to develop abbreviated training tailored to different roles. |
| 3. Obtain signed acknowledgment of volunteer status, no expectation of payment, commitment to abide by facility rules, and volunteer assumption of any risk. |
| 4. Evaluate whether best not to allow volunteers in certain roles. Consider use of paper floor plan and facility maps with permitted and restricted areas marked. Assess whether possible to issue any form of temporary identification to volunteers. |
| 5. Assess whether any legal or compliance risks associated with certain types of in-kind donations. Consider only accepting certain categories of items in sealed containers. Work with communications to announce donation needs and details. |
| 6. Develop donation intake process with stated criteria and documentation tools. Consider how to handle rejected in-kind donations. Seek from financial department compliant tax record and receipt donation procedure. |

7. Where will in-kind donations be stored, and what criteria and process will be used to distribute donations within your facility or to the community?
8. How will financial donations be managed and targeted to the areas of most significant need? Will the facility be able to satisfy any non-discrimination rules or other requirements?
9. How will your facility adjust and communicate revised donation needs or the availability of donated supplies or services?

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| 7. Work with the emergency preparedness team and facilities staff to identify accessible and safe storage areas and criteria and process for use or distribution. Consider life safety requirements that may limit areas permissible for storage use. Evaluate documentation or waivers needed if life safety requirements cannot be observed due to emergency circumstances. |
| 8. Work with financial departments to establish system to secure and track cash, check, and other donations and generate real-time receipts. |
| 9. Coordinate with communications department to address plan for changing donation needs. |

## Preparing for Government Inquiries

After the crisis has passed and much hard work has been done, can the compliance professional put emergency preparedness on the back burner and return to her typical compliance functions? The increase in the incidence of national emergencies—both man-made and natural occurrences—has also resulted in increased attention and scrutiny by various levels of federal and state governments of facilities' preparedness for and response to emergent circumstances. Some attention can be complimentary and education focused, but other scrutiny will examine whether the facility complied with myriad government requirements. Any public complaints about the facility's emergency response are likely to generate hindsight evaluations and could result in negative government assessments and consequent adverse publicity.

As a result, it would behoove compliance professionals to work together with the emergency preparedness team to reassess the effectiveness of emergency plans, drills, and efforts, document lessons learned, and revise any plans that could be improved.[3] After an emergency response, compliance professionals also should consider the need to assess whether applicable licensure and certification requirements were satisfied, any waivers may be retroactively obtained, HIPAA privacy and security requirements were met, and medical documentation supports billing for services provided during the crisis. All self-evaluations should be documented and any deficiencies addressed. When the compliance professional's facility is fortunate not to have lived through a crisis, it is beneficial to attend conferences where others share their practical experience or contact colleagues to learn their suggestions learned through real life preparation and response efforts.

Emergency preparedness compliance is a team effort, and the facility compliance staff serve a valuable role with others on the team in preparing for and responding to crisis. Make sure you include emergency preparedness responsibilities in your role so you can assure compliance is accomplished in crisis and lack of planning does not create new crisis after the storm has passed.

### Endnotes

1. Federal emergency preparedness regulations apply to varied provider types and suppliers such as hospitals, 42 C.F.R. § 482.15 et. seq.; rural health clinics, 42 C.F.R. §; 491.12 et. seq.; skilled nursing facilities, 42 C.F.R. § 483.15 et. seq.; religious nonmedical health care institutions, 42 C.F.R. § 403.748 et. seq.; ambulatory surgical centers, 42 C.F.R. § 416.54 et. seq.; hospices 42 C.F.R. § 418.113

et. seq.; psychiatric residential treatment facilities, 42 C.F.R. § 441.184 et. seq.; PACE programs, 42 C.F.R. § 460.84 et. seq.; intermediate care facilities for individuals with intellectual disabilities, 42 C.F.R. § 483.475 et. seq.; home health agencies, 42 C.F.R. § 484.22 et. seq.; comprehensive outpatient rehabilitation facilities, 42 C.F.R. § 485.68 et. seq.; critical access hospitals, 42 C.F.R. § 485.625 et. seq.; certain outpatient physical and speech therapy organizations, 42 C.F.R. § 485.727 et. seq.; community mental health centers, 42 C.F.R. § 485.920 et. seq.; organ procurement organizations, 42 C.F.R. § 486.360 et. seq.; and end-stage renal disease facilities, 42 C.F.R. § 494.62 et. seq.

2. HIPAA communication requirements in an emergency were the subject of questions and answers on the Office for Civili Rights (OCR) Web site at *www.hhs.gove/hipaa/forprofessionals/faq/1068/is-hipaa-suspended-during-a-national-emergency*; *www.hhs.gov/hipaa/forprofessionals/faq/960/can-health-care-information-be-shared*; and *www.hhs.gov/hipaa/forprofessionals/faq/2023/film-and-media/index.html*. Earlier Health Care Compliance Association (HCCA) articles have also addressed these requirements in detail such as: "Maintaining Patient Privacy in an Emergency" in *Compliance Today*, May 2018.
3. Helpful resources include: Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers**,** *www.federalregister.gov/documents/2013/12/27/2013-30724/medicare-and-medicaid-programs-emergency-preparedness-requirements-for-medicare-and-medicaid*; Emergency Preparedness and Response, *www.osha.gov/SLTC/emergencypreparedness*; and Emergency Preparedness and Response, *www.cdc.gov/niosh/topics/emergency.html*.

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