Emergency Preparedness and Nondiscrimination Rules

Rural Health Clinic Technical Assistance Series Webinar
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2:00 – 3:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time, all participants will be on listen only until the question and answer session of today's conference at which time you may press Star one to ask a question. Today's conference is being recorded. If you have any objections, please disconnect at this time. I would now like to turn the meeting over to your host, Mr. Nathan Baugh. Sir you may begin.

Nathan Baugh: Thank you operator and I want to welcome all of our participants. My name is Nathan Baugh and I am the Director of Government Affairs for the National Association of Rural Health Clinics and the moderator for today's call. Today's topic is emergency preparedness and nondiscrimination rules. This is a series sponsored by HRSA's Federal Office of Rural Health Policy and is done in conjunction with National Association of Rural Health Clinics. We're supported by a cooperative agreement, as you can see on your screen, through the Federal Office of Rural Health Policy which allows us to bring these calls free of charge.

The purpose of the series is to provide RHC staff with viable technical assistance and RHC specific information. Today's calls are 76 in the series which began in late 2004 and during that time there have been over 20,000 combined participants on the RHC national teleconference calls, now also being done as webinars. As you know, there's no charge to participate in the call series. We only encourage you to refer others who might benefit from this information to sign up to receive announcements regarding date topics and speaker presentations at HRSA.gov/ruralhealth/policy/conference.
calls/index. We have the link posted later in the - apologies for the phone. We have the link posted later in the slides.

During the Q&A period, we request that callers please provide their name, city and state location before asking their questions or you can type your question in on the chat box which we will pull up during the Q&A section. In the future, email questions to info@narhc.org and put REC TA question in the subject line. All questions and answers will be posted on the Office of Rural Health Policy conference call series Web site which we also have the link to that there in the slides.

So with the formalities out of the way, we're going to begin our webinar today on emergency preparedness rules and the nondiscrimination rules. So we're going to start with the emergency preparedness and then we'll get to nondiscrimination second. And that's my contact information. If anyone wants to follow up with a question or a call via email or phone, feel free to use that info.

So these are the - of course I don't expect anyone to be able to read anything on this page. The point of this slide is just to show you where we were well currently if you were to get surveyed today. You would only have to follow those three little bullet points on the left. Starting November 15 of this year, you have to comply with all of that rules and regulations that I have listed on the right. So the only point I’m trying to make on this slide is that it's a lot more, right. What we're doing now is a lot less than what we have to do starting November 15. And I’m going to go over everything that's in the new rules.

So as I mentioned, the implementation date is November 15. However, these rules have already been finalized. It's a little confusing because the rules were finalized on November 15 of 2016 but they're not being enforced until
November 15 of this year. So that is an important note to make. The old regime, those three bullet points that I had listed, it was trained - the - it just said to train staff in handling emergencies, we had to place exit signs in appropriate locations and taking - and you had to take other appropriate measures consistent with the conditions of the area where your rural health clinic was located.

Now that was the old regimes and new regime is a new entirely expanded section in the code of federal regulations and it's section 491.12. So if you want the full rules and regulations, it's 491.12. And there's 491.12A, B, C, D and E and we're going to go through each letter subsection slide by slide. 4912A was the first part is effectively an emergency preparedness plan. The emergency preparedness plan must be created and updated every year. So if you don't have a plan, you have to create one. Now it's a bit vague but CMS purposely designed it that way. They're giving RHCs kind of latitude to design how exactly this plan is, you know, can be put together.

There's a few key things that the plan must do, though. It has to have a strategy to address all the various emergency events that your clinic is at risk for. So if you're in the plain states that includes tornados, maybe not hurricanes if you don't get hurricanes, maybe not earthquakes if your area gets earthquakes. But you want to think okay fire am I - is my clinic at risk for a fire? Is my clinic at risk for X, Y, or Z natural disaster? And you have to have a plan to address each specific event. These events also include things like an epidemic, a disease epidemic or even a active shooter in your area or some sort of terrorist event.

You have to analyze in the plan. You have to analyze your capability to help during the emergency and you have to have an authority succession. So similar to how we have a line of authority. If the president dies, the vice president becomes president. If the vice president dies, the speaker of the
house becomes president. You have to have a similar delegation of authority and succession plan for your rural health clinic during an emergency. The other thing it has to have in the plan is a process to cooperate with the broader community on emergency preparedness. And some - if some of this gets repetitive it's because the rules are a little bit repetitive and it kind of elaborates on what that means to cooperate with the broader community on emergency preparedness in later subsections.

And I will say one thing. Pretty much everything else about your plan, so all the other subsections that it'll ask you to do certain things, all of that goes into one plan. You don't have to have a separate document for each of these subsections. Everything can be folded up into one emergency preparedness plan, which is something they clarified in one of the FAQs. And before I go any further, I'm going to point out that the CMS has not yet released the interpretive guidelines for emergency preparedness. So some of the vagueness is designed to provide flexibility and some things we might need further clarification on that we'll get in the interpretive guidelines that are supposed to be released before the summer. So we'll definitely keep everyone informed of those changes on the listserv but it's something to look forward to really kind of getting those refinements as to if something means X, Y, or Z.

All right so the second part here, 491.12B is policies and procedures. Now you have to have a policy and procedure and this can be a part of your emergency preparedness plan and you have to review them and update them annually. So when you have a survey or a comm and they are asking for your policies and your procedures, you have to show them that you've reviewed them and you've updated them within the last year.

Similar to the old regime, you have to have exit signs but now you also have to have an evacuation policy and you have to have staff responsibility during that evacuation. Okay? And I'll get into staff training later but the staff really needs to understand what their role is during an evacuation. Furthermore, you
have to have a means to shelter and place. I'm assuming most rural health clinics have that especially if they're in a tornado risk area. But you have to have a means to shelter and place in case you cannot escape the rural health clinic.

And you also have to have a system of medical documentation that preserves patient info. So I got a question about this once. Someone asked me they said well we keep all our medical documentation in our file cabinet. And I asked her well if your clinic were to, you know, burn down would you be able to preserve that patient info. And she said no. Clearly that would not work for these rules. Now someone then asked well what if it's a fireproof file cabinet. Would that qualify? And I’m not sure. That's something that I would look for the interpretive guidelines to, but I think most rural health clinics will satisfy this requirement, the backing up to the cloud or backing their information up to a server or having some sort of system that if it's a fire or tornado or a hurricane, they're not going to lose all their patient records.

Another thing that must be in your policies and procedures is how you would use volunteers to address surge needs. Now the way - the thing that I've thought of how you could use volunteers is something like if you have rubble blocking your entrance or blocking access to parts of your building, you could use volunteers to help clear the area. You might also use volunteers to donate blood, things like that.

All right 491.12C is the communication plan. Again, this is not a separate plan. This can be a part of your emergency preparedness plan. It also must be updated annually. It has to include contact info for all your staff, any contractors you have, your patient's physicians, other rural health clinics and FQHCs, volunteers, as well as all government emergency preparedness staff. So it has to have at least phone numbers and other contact information for
those individuals. You have to have a primary and an alternate means of communication with RHC staff and governmental agencies.

Now this is something that again I’m looking for the - to the interpretive guidelines to clarify. I know that, for example, like a - your primary means of communication could be like a cell phone, cell network. I know that some rural health clinics have satisfied the alternate means of communication requirement through some sort of radio or something like that. I don't know if you would consider over the internet a separate means of communication as opposed to like a cell service. So this is something that I’m looking towards CMS to clarify exactly what they mean by the alternate means of communication. If you have AT&T and Verizon since that's two different networks would that qualify? I'm not sure. Or do you need like a satellite phone or something like that?

A way to provide - the other thing that your communication plan must do is you have to have a way to provide info about the condition of your rural health clinic and a location of your patients. So, for example, you had - if you were to evacuate, you would obviously need to inform the government emergency preparedness staff where you located or where you evacuated your patients to in an emergency. Or if they were sheltering in place, you would need to know where within the clinic that the patients in your staff were sheltering in place.

You also need to have a way to communicate to authorities about the ability of your RHC to provide assistance. So basically just have a way to assess okay our rural health clinic is up and functioning. We can take patients. We can assist in these ways. You just have to be able to communicate that to the government emergency preparedness authorities in your area.
Training and testing, so this is probably the most burdensome or most difficult part of the new rules to comply with. Rural health clinics are required to train all staff and contractors consistent with their expected roles. And this is one of the things they clarified in the CMS call on emergency preparedness last week. Surveyors will ask your staff what their roles are during an evacuation, what their roles are during an emergency. And your staff needs to be generally competent on what their job is to do in an evacuation or any sort of emergency scenario. So that's going to be something that you've really got to make sure that your staff knows what they're supposed to do, knows how they're supposed to evacuate, etcetera.

You have to have one documented training a year for all staff and again the staff must demonstrate understanding of the emergency procedures. So this is something that the CMS has said that they're going to come out with resources to help you train your staff. It'll be I think a webinar. So they're going to be coming out with resources in hopefully a few months that will help you train your staff. But those are not yet fully developed. The rural health clinics also must participate in one full scale community based exercise annually. And you can check your state HHS Web site for more info. There's - I'll have a link to that later where you can find what the emergency preparedness kind of local group is for you. They should all be listed on your state HHS Web site. There has to be a - so in addition to the first full scale community based exercise, you have to have a second full scale exercise or a tabletop exercise every year. So you can do two full scale community based exercises or one full scale community based exercise and one tabletop exercise. RHCs you have to document your that you did these drills and you have to analyze your performance during the tabletop exercise, during the community based exercise. A lot of people are aware what full scale community based exercise is. At least when I have spoke on this topic before, people seemed to know what it was.
Similarly, they seemed to know what a tabletop exercise was. There's no sort of training that needs to be acquired for the person who's sort of walking everyone through the tabletop exercise. It can kind of be anyone. So again you have to do two of those per year or one full scale community based and one tabletop exercise per year. These have to be done before November 15. So even though we're not the - these rules are not being enforced today, on November 16 if a surveyor shows up at your rural health clinic they're going to expect that in the last year you've done those drills. So if you haven't done two community based exercises, you have this past year then you need to get on that before November 15. So that is something that they clarified as well in last week's webinar.

And so I get a lot of questions about this as well. I know a lot of rural health clinics are a part of a larger integrated healthcare system. And it is absolutely true that if you are part of a larger healthcare system, you can participate in that system's coordinated emergency preparedness program. But you need to make sure it does the following things. One is that it demonstrates that each separate facility actively participated in the program. So, for example, let's say you are in a network of five other rural health clinics and you have maybe one or two CAHs, critical access hospitals. If one of those facilities didn't participate in the drills and the larger emergency preparedness program, then everyone in that healthcare system is out of compliance. So you're really trusting the entire healthcare system every single entity to, you know, be responsible and make sure that they're compliant.

You also need to make sure that the integrated healthcare system plan has taken into account each facility's unique circumstances. In my view, this means that you can't just have a policy for the cause or the hospitals and then one other policy for all rural health clinics. I interpret that to meant that each individual rural health clinic has to take into account some sort of unique circumstance about that rural health clinic for it to meet these requirements.
And as I said here, each separate facility must be in compliance. If one facility is out of compliance, I believe the entire healthcare system is out of compliance, so.

So that is kind of my abbreviated version of the rules and regulations. Again all of this is 491.12, code of federal regulations 491.12. If you Google it, you'll see the pretty much exactly what I just laid out. I have a bunch of links here for more information. This first email here scgemergencyprep@cms.hhs.gov. That was the email that they gave out last week in their webinar. It stands for survey and certification group emergency prep. If you have questions, you can email them.

This second link is a really good link that I've used. It has a bunch of FAQs. I think there's five FAQs that go over all sorts of various questions that people have had about emergency preparedness. I believe the interpretive guideline - guidance when it gets finalized will also be posted at this link. And I mentioned the healthcare - the state healthcare coalition that you have to coordinate your community based exercise with. Those there's a link to all the various healthcare coalitions at the link here as well.

And then the ASPR TRACIE link is also a great resource for healthcare providers. It stands for assistant secretary for preparedness response technical resources assistance center and information exchange, ASPR TRACIE. I believe when the training comes out that CMS is developing on how to train your staff and also training for surveyors will be posted at that ASPR TRACIE Web site. So I'm going to move onto nondiscrimination rules and if people have questions about emergency preparedness we'll have time at the end to answer those.

So the nondiscrimination rules were actually a part of the Affordable Care Act. And it was section 1557 of the Affordable Care Act. And effectively it
said that rural health clinics are not allowed to discriminate on basis of race, color, national origin, sex, age or disability and activities. That's, you know, kind of a standard nondiscrimination policy that applies to all businesses. However they do have a couple of extra things that are sort of new for rural health clinics and for healthcare.

We already had the requirement I believe to provide services - language services and sign language services free of charge to individuals with disabilities or individuals that don't speak English. Now these services were already free of charge. Now, however, they're going - they have a lot more requirements of kind of these taglines and I'll get into that in a second. I do want to make the point here, though that covered entities, aka rural health clinics, we are a covered entity. If you have more than 15 employees, you have a few extra requirements to comply with on nondiscrimination.

You have to have kind of a point person, one employee responsible for kind of overseeing the nondiscrimination policies. And you have to have some sort of grievance procedures that allow for prompt resolution of any sort of violation, discrimination violation. I will note that rural health clinics must have in multiple languages a notice informing the individual of the nondiscrimination rule including how to file a complaint.

So it's a bit of an awkward situation but if someone wanted to file a complaint against your rural health clinic for discriminating, you would need to have a notice informing them how they might be able to file that complaint in their native language. And you don't have to have those posted but you have to have those available. So again in reality in my mind it's kind of an awkward situation. I guess the patient would be demanding that you give them documentation that will allow them to then file a complaint against you. But you must have those notices on hand.
The bottom two links here have - are really good links for this. You have the first one is the general link that links to the final rule and it links to some FAQs. And then the second link there is where you can get all your translations. They have - they've translated everything that you've needed translated in every single language that you need it translated into. They have all of that - those resources at that second link.

Okay so the nondiscrimination taglines. Effectively the phrase is language assistance services are available free of charge. That's what it is in English. You have to have that tagline posted in the top 15 languages in your state for all communications that they - that you deem significant and not small. So you basically anything that any communication that you have you have to do two things. One, you have to decide is this significant. Two, you have to decide is this small or is this not small sized. All right? If it's significant and it's also not small then you have to post these taglines in the top 15 languages. So I have some examples here and I pulled these from the link that I gave you in the last slide. I have Spanish. We have Chinese. I believe the next one is Russian and I have French and Arabic. That's just some examples. So as I mentioned top 15 languages, you have to post those taglines. It has to be significant and anything that is not small. You also have to have those taglines posted in a conspicuous physical location. So I think for most of us that translates into your lobby. So if you don't have those top - that tagline posted in the top 15 languages in your state right now in your lobby, you need to go do that. As soon as this webinar is over, go post. Go find the top 15 languages in your state and go post that tagline.

Now I know there's a lot of questions out there. Well what is considered significant? And this is verbatim from the CMS answer on - in the CMS FAQ. Covered entities, aka rural health clinics, are in the best position to determine within reason which of their communications and publications are significant in the context of their own health programs and activities. So it is
a bit vague but they're basically leaving it up to you, the rural health clinic, to
determine what is significant and what publications are not significant,
although they do give some examples of things that they would consider not
significant later. And I have those.

So the last place I spoke about this was Iowa. And so this is my example. But
they have the top 15 languages online for every single state. So you don't
have to guess or do some research. They - for every single state, they list the
top 15 foreign languages. And it'll - and it's a list that looks something like
this, right. And they even estimate the number of foreign speakers in each
state.

Furthermore, so you have the top 15 rules. You also have top two language
rules. So this one remember I said everything you send out you have to do
two things. Is it significant? Is it small? If it's significant but it's small, then
you have to post the tagline in the - just the top two languages and the top two
foreign languages in your state. Right? Furthermore if it's significant and
large, then you have to post a longer nondiscrimination statement. So it's
more than just we offer free languages services. It's a longer statement which
I have next.

So the statement is name of your rural health clinic complies with applicable
federal civil rights laws and does not discriminate on the basis of race, color,
national origin, age, disability or sex. Okay, so again this is the top two
foreign languages in your state. If it's a significant publication, that full
statement in the top two foreign languages needs to go on that publication.
Again you can find the translations on that link that I had a few slides back.

I have the link to the FAQ which has a lot of great information right there.
I've pulled out a - two of the questions that I think are relevant and that I think
are informative. Like I said, here are some examples of things that CMS
would consider not significant. So you wouldn't have to put any of the language stuff on these. Radio or television ad, I.D. cards -- obviously those are really small -- appointment cards, business cards, banners, envelopes and outdoor advertising. So those are things that you definitely don't have to worry about putting any sort of taglines or foreign languages statements on.

Some example of - some examples of things that are considered small size is the postcards, tri-folded brochures and pamphlets. So remember if it's significant but small, then you have to post the taglines in the top two foreign languages. So it's probably Spanish in most states and at least in the example I gave of Iowa it would be Chinese. So Spanish and Chinese even on things that are considered small such as postcards, tri-fold brochures, pamphlets, etcetera. Notably I will - that they say that anything that's on an 8 1/2 by 11 inch piece of paper, so basically computer paper, that is not considered small size. So you - if you only have top two taglines on something that's on computer paper, that would not - you would be out of compliance with these rules.

All right and so of course I would be remiss to go over all these new rules and not talk about a few executive orders that may or may not apply. On his first day in office, President Trump issued a presidential memorandum basically suspending all pending regulation until someone from the Trump team could basically approve of it. So the first thing that popped into my mind when I read that executive order was does it affect emergency preparedness rules because they're finalized in November but they're not yet being implemented until November 2017. So does that make that regulation pending? We've asked for clarification. All signs indicate that this is not something that was affected by this presidential memorandum even though seemingly it is.

There's two other executive orders that I'm going to talk about before we get to the questions. The first was an order that was supposed to minimize the
burden of the Affordable Care Act and I quoted the relevant section in there. It basically directs all of the HH or all of the department heads to use all the authority and discretion available to them to waive deferred grant exemptions from or delay the implementation of any provision of the Affordable Care Act that would impose a fiscal burden on a state, etcetera, etcetera and then you’ll see healthcare providers as one of the entities that if a rule imposes a fiscal burden on a healthcare provider, the department heads are supposed to find a way to grant exceptions or delay the implementations of that provision.

So seemingly because the nondiscrimination rules and remember I told you the language rules that's part of section 1557 of the Affordable Care Act and I think it quite clearly imposes a fiscal burden on healthcare providers such as rural health clinics. Seemingly this falls into that category but it's - I wouldn't bank on Secretary Price or even Administrator Verma changing these. You know, I - these are already in effect. So you need to make sure you start posting those taglines immediately. And if it goes away, this might be how it would go away. Again it's unclear.

And then the final one here is an executive order on reducing regulation and controlling regulatory costs. Effectively the executive order says for every new regulation, you must identify two regulations to be eliminated and the cost of all the new regulatory items for fiscal year 2017 must be zero. So in the final rule, the government itself estimated that compliance for - or the cost of compliance for RHC is just over $6000 per RHC per year. Right?

So we as in the National Association of Rural Health Clinics sent a letter to Secretary Price and Administrator Verma as well as the staff over at CMS responsible for the emergency preparedness stuff basically saying that one, that we don’t believe that these new emergency preparedness rules are necessary and that they’re - they pose too much of a burden especially on independent rural health clinics who can't just take, you know, spend $6000
every year to comply with these rules. But two, we also asked for clarification, you know, since that it's unclear whether or not this last presidential memorandum that I just went over if that applies.

And then finally we said if you do go forward with this new emergency preparedness rule, we expect that you find - in the kind of in the spirit of this reducing regulation executive order, we would expect that you find $6000 worth of regulatory relief for rural health clinics. So that's effectively what the letter said. If anyone has ideas of things that - rules and regulations that could be eliminated that would save rural health clinics money in terms of compliance costs, please send those ideas to NARHC so we can kind of hand those on a silver platter to HHS because they're going to be needing to find in order to comply with this executive order a lot of costs for regulatory relief.

So that - again all of this pending. Do not bank on CMS saying you know what we can't find $6000 worth of offsets. So we're just not going to go forward with the emergency preparedness rules. Act like they are going to - the new rules are going to take effect on November 15 of this year. But we are working to either A, hopefully eliminate rural health clinics from the list of entities that have to follow this or B, at least find some sort of other regulatory relief considering that it's going to cost us $6000 per RHC per year to comply.

So with that, I'm going to close by just going over our listservs. For those of you who are not aware, we have a free - well we actually have two free listservs. One is for technical assistance which is less emails. It's RHC specific info, one way communication from NARHC out to everyone on that listserv. The other one is a two way communication which obviously means more emails but clinics can ask each other questions and, you know, the peer to peer aspect is actually really nice. That's our news listserv. You can find them for both or either at the link above.
And then to view all our webinars both this one will be posted at a later time on the link at the bottom but you can also review every other webinar that we've done since the inception of this program or well I guess every other webinar since we started doing webinars at the link at the bottom. So with that, operator I think we're going to move to our question section and the chat box is - I'll be monitoring the chat box now as well. So I know a lot of people like to ask questions that way. But I'm going to start with a question that was emailed from (Tara Jo Carson) who is in Pinckneyville, Illinois.

And she asks will our hospital emergency operation plans and continuity of operation plan cover the RHC which is hospital based and department - and a department located within the main hospital building? It probably will. I would just make sure you review the subsection - the integrated healthcare system requirements. Right? So that goes if you think - if you look at section E and you think that your hospital emergency operation plan fits with that, then you will probably - that will probably work for you. So hopefully I've answered your question. If not, always follow-up via email. Operator do you want to go over the instructions for how to ask a question?

Coordinator: Yes. Thank you. We'll now begin the question and answer session. If you would like to ask a question, please press star one. You'll be prompted to record your name. Please be sure to unmute your phone. Once again if you'd like to ask a question, please press star one and we'll pause for just a moment to allow those questions to start coming through.

Nathan Baugh: Okay. So (Lynne Hampson) asks do non-rural health clinics have to do this? I'm not sure what this is. I'm assuming she means the emergency preparedness rules and the answer is yes. There are a lot of other covered entities that have to comply with those emergency preparedness rules. However, a traditional doctor's office, a doctor's office that doesn't have a
survey and certification process would not have to comply with those emergency rules. This is one of the reasons we're - one of our talking points at CMS is that hey, you know, a traditional doctor's office or a PA's office wouldn't have to have this emergency preparedness plan. So why do rural health clinics have to have one? Well just because you have a survey and certification process for rural health clinics. So you have a means of enforcing it. So it's one of the points that we're making to CMS.

I'll do one more and then we'll go to the phones. After looking at the top 15 languages -- this is from (Carrie) and we determine that there is only one other language that is significant in our area, then we only have to prevent - print the message in that one other language. Correct? No that is incorrect. You - it doesn't - I don't care if there are three people that speak that 15th language in your state. It does not matter. You have to have - there is no - it is state-based and you have to have the top 15 languages even if there are five people that speak that 15th language. So hopefully that's pretty crystal clear.

Operator do we have any calls over the phone?

Coordinator: Yes. We do have a question. This one comes from (Lauren Harris) Your line is open.

(Lauren Harris): Thank you.

Nathan Baugh: Hi (Lauren) Where are you from?

(Lauren Harris): Hi. We're from Sandy, Oregon.

Nathan Baugh: Great.

(Lauren Harris): My question is regarding the training and testing and the participation in community based exercise.
Nathan Baugh: Right…

(Lauren Harris): Is that a requirement of every employee and provider within the clinic or can representatives be sent to do that?

Nathan Baugh: No. Every - my interpretation if I'm understanding your question correctly is that every single staff on your staff has to go through the training once a year.

(Lauren Harris): Okay. Thank you…

Nathan Baugh: You can't have someone be like the emergency preparedness guy who knows everything.

(Lauren Harris): Right.

Nathan Baugh: Everyone - yes. Everyone has got to know or go through the training every year.

(Lauren Harris): Okay so if the community based training happens say during a workday you would essentially close down the entire clinic and send everyone to participate in the exercise?

Nathan Baugh: I'm sorry. Like I said, the staff training. I thought you were referring to the staff training?

(Lauren Harris): No I meant the community based emergency.

Nathan Baugh: Yes you meant the drill. I - I'm honestly not that familiar with the community based drills and what all they entail. I would assume that whoever is running the community based drills kind of said okay we're going to need, you know, I
don't know if they need the full staff there or if they expect just a few members of the staff. I would defer those questions of how much of your staff have to go to that drill to the organizers of your community based drill. But I’m actually not fully sure on that.

(Lauren Harris): Thank you.

Nathan Baugh: Yes. So I'm going to go to the next question on the chat. It's from (Leslie) and she says I've been in and out trying to see a few patients during the webinar. I'm also looking for a copy of the PowerPoint. Oh okay. (Leslie) there's a bunch of different ways you can get the PowerPoint. One is on NARHC.org and (Bill) sent out the link if you're on the TA web listserv. Furthermore if you look at the top left of your screen there should be a box that says file share. And you can download the PowerPoint there. So there's several different ways. They'll also be posted on a third Web site in a few weeks at the one I have listed here at the bottom. Okay operator do we have any other calls?

Coordinator: We do not have any questions at this time. As a reminder if you'd like to ask a question, please press star one.

Nathan Baugh: Okay so I’m just going to power through some of the chat questions here. (Shirley) asks when considering the languages, does English count? No. The short answer is - well the short and the long answer is no. So it's two - the top two foreign languages, the top 15 foreign languages. English does not count. Okay (Jessica) I've already answered that question.

(Terry Miller), do actual emergency events, example full scale power outage, count toward the requirements for emergency preparedness activities? (Terry) this is a great question and the answer is actually yes. So if you are unfortunate enough to, you know, actually have to implement your emergency
preparedness plan or initiate an emergency event, the silver lining is that these - you do not have to do one of the community based exercises. So that would count as your community - one of your community based exercises for the year. So of course nobody wants to have to do, you know, implement their emergency preparedness plan but if you do again it counts as one of your drills. And that is something that they confirmed last week.

(Dawn Petty) asks we are a physician owned small clinic, 12 employees. Do the nondiscrimination - do the nondiscriminatory regulations affect us as well? Yes (Dawn) they do affect you. So hopefully you have those taglines posted on all of your significant publications. I will say that there are some additional rules that clinics or entities with more than 15 employees have to follow. You don’t have to follow those because you only have 12 employees. But the stuff about the taglines and the significant publications and the language services, all of that does still apply to you even if you only have 12.

Operator do we have any calls on hold?

Coordinator: We do. We have a few waiting now. We have (Liz Hansen) from North Dakota. Your line is open.

Nathan Baugh: Hello.

(Liz Hansen): Hi. We just had a question about posting the taglines in a public place within our lobby. We have TV screens where we have messages that keep scrolling through. Is that something you think that would be acceptable even though it isn't going to be on screen 100% of the time? It would be scrolling through other messages. Or would we have to have that like on a paper sign that's visible 100% of the time at the business office?

Nathan Baugh: Well it sounds like you're pretty high tech. That is cool. I haven't heard of that. That's something that I think I would defer to the interpretive guidelines
for a black and white answer. But my, you know, you're better safe than sorry part of me says. Just post them on a 8 by 11 sheet of paper somewhere in your lobby if you have a board or just somewhere that you can post those. The scrolling - the tagline scrolling across a TV screen might work. Maybe they'll clarify that up in the interpretive guidelines but I would say just better be safe than sorry and have those posted on paper.

(Liz Hansen): Okay. Thank you.

Nathan Baugh: Yes. So next call on line or I'm sorry on the phone. Operator?

Coordinator: So sorry. I was talking on mute. Our next question comes from (Lindsey Bogner) Your line is open.

Nathan Baugh: Hi (Lindsey) Where are you from?

(Lindsey Bogner): Kansas.

Nathan Baugh: Great.

(Lindsey Bogner): We were under the impression -- we've been working with our ESFA group here in our county -- that our community wide exercise would involve something happening but then we would receive patients in our clinics so that we wouldn't have to leave. Now are we required to go somewhere else for this drill or are we required to have the drill in our facility and actually test our own plans?

Nathan Baugh: This is one that I’m not going to guess on. Again I think this is something that will be answered by the specific community - the people who are running your community based drill. Right?
(Lindsey Bogner): That's me.

Nathan Baugh: Does that make sense?

(Lindsey Bogner): Yes but see I'm running the community based exercise. So that's why (unintelligible)…

Nathan Baugh: Oh you're (unintelligible)

(Lindsey Bogner): …how we need to set it up.

Nathan Baugh: Okay. Boy I'm sorry. I do not know the details of how to run a community based drill, especially if you're in charge of it for the entire community. You're asking if the - you're going to have to shut down your clinic or do you have to touch patients that are come in on that day?

(Lindsey Bogner): Well what we were understanding is that everybody stayed in their facilities. We have an exercise, and the community responders take the patients to the local facilities, or you know, in some cases we’ll wipe out one clinic. That way everybody gets to test portions of their emergency plan, but they would actually do it in their own facilities, rather than having them go across town to a facility that they don’t know.

Man: Sure. Right, yes. That – I mean, that seems reasonable and it seems correct to me. Again, I’m not a pro on how to run a community-based drill. I just know that you have to do them. I don’t know the details. And I apologize for that, but I don’t know the answer.

Woman: Do you know, are we going to get any more guidance on that at all?
Man: I’m hoping that the interpretive guidelines will have that, and there may be resources already available, especially on your – in your state Web site that kind of further flesh out what the rules are for the community based drilling in your area. So I would – yes, I would dig around on those links that I gave you, the ask for (Tracy) link, the other link that I gave you, and see if you can’t find your answer there. And if not, maybe it’ll be in the interpretive guidelines.

Woman: Okay, thank you.

Man: Yes.

Man: All right, so I’m going to move on to the next chat question from (Leah Martin), and she says the cyclum of medical documentation that preserves patient info – if an RHC does not have an EHR, what types of suggestions would make this useful toward compliance?

That – my suggested route if you don’t have an EHR is – and I know it’s a pain, but it’s just scan your records to the cloud versus some sort of computer server that’s not onsite that would preserve those records if your clinic burns down. So like, that’s kind of my standard example. If your clinic burns down or there’s a tornado and it goes right through your clinic, God forbid, will you have a system that preserves those – that patient info, right?

I think the easy way to do that is to save your records electronically to the cloud, but you know, I know that that requires a lot of administrative work, so for those with EHRs it will be a little bit easier, for those without it’s a little bit more difficult, and again maybe the interpretive guidelines will say if you have paper records in maybe two areas, so at your clinic and then at some other area that’s away from your clinic, then maybe that would work. I would
defer to the interpretive guidelines as to something like a fireproof cabinet or some sort of really sturdy filing cabinet would also be compliant.

I’ll do one more in the chat, from (Tracy Job), according to section 1557, is it a requirement to ask the patient’s sexual identity? No, this is actually something that I got. Initially there was some confusion about, initially it was something that you – that was one of the things that you could not discriminate based on, but then there was a court case, and it’s kind of like pending right now, especially because the gender matches on certain HCPCs codes were causing it to deny.

So they didn’t really have a system as to if a female patient came in or someone who identified as a female, but had male anatomy and they had some sort of service that was only for males and you put female that claim was denied.

So that one gets complicated. I believe that it was put on a hold pending a court case that is working its way up through the courts. So hopefully that sort of answers your question. Do we have more calls on the phone? In addition, I think we’re going to go – Wakina, can you – are we okay to go past three, maybe to 3:15?

Wakina Scott: Yes.

Man: Okay, so…

Coordinator: Sorry. Were you ready for your next question?

Man: Yes.

Coordinator: Okay. Our next question comes from (Hannah Morrissey) Your line is open.
Man: Hi, (Hannah) Where are you from?

(Hannah Morrissey): I’m from Arkansas.

Man: Great. How can we help?

(Hannah Morrissey): Okay, so my question is in regards to the 15 languages and stuff, when it comes to like medical records requests and like HPPA policy, confidentiality agreements, all that, are you saying that we have to have that available in all 15 languages?

Man: And I’m going to kick this one back to you, and not actually – hopefully I’ll zoom back to it. The official word from CMS is that covered entities are in the best position to determine within reason which of your communications are significant in the context of your own health programs (unintelligible), so that is something that you will have to do. That is a decision that you will have to make. That is the official word from CMS. So I’m – you know, I can’t offer more than what is the – what the rule is.

(Hannah Morrissey): Okay.

Man: All right. Next one on the chat. (Lynn Hamson) asked regarding the community based drills, can that be just representatives from the clinic or does it need to be the whole clinic? Again, on this – on the community based drill, I’m not sure the details, so I’m just going to – hopefully you’ll forgive me, I’m going to take a pass on that. I think we’ve kind of discussed that already.

Next question is from (Lee Sy) Do RA teams need to have a provider and a nurse from each facility in a table top and full scale exercises? I don’t know about again, this is similar to (Lynn)’s question. I don’t know about the
number of staff that is expected to participate in the exercises or the table top exercises. I haven’t seen details on that.

If they are out there, I apologize, but hopefully this is something that I’ll go back and research and we can send it out over our list serve and when we find out more details about the participation expected from their clinic in the exercises. Operator, do we have a call online – on the phone, I’m sorry?

Coordinator: We do, this one comes from (Chanda Spire), your line is open.

(Chanda Spire): Yes, I missed your Web site earlier where we would be able to download this information from. I’ve been able to listen to the call but not download the slides.

Man: Okay, do you see in the top left there’s something called file share? Do you see that on your screen?

(Chanda Spire): I’ve not been able to see any of the presentation, I’ve only been able to hear the audio.

Man: Okay, did you – were – no, I’m sorry, were you – are you on the technical assistance list serve?

(Chanda Spire): I am not, but I can get added to that. Can I – how do I go about it?


Woman: Okay.

Man: Then I can get you all set up and I’ll get you the slides and everything, okay?
Woman: Okay, perfect, thank you.

Man: Operator, one more question on the phone?

Coordinator: Our next question comes from (Marcie Villanueva), your line is open.

(Marcie Villanueva): Thank you. Hello, I had a question about the sign language, because we did have this come up in the past before this all started, we had a patient come in and had somebody – or actually called in, and they were using the third party calling assistance, saying that they wanted an appointment, they needed an interpreter, and that we were having to pay for that interpreter to come in.

We looked around and found someone that could assist us, but it was going to be like $200 just to interpret for the one visit, and obviously that’s more than what we’re getting reimbursed. Is there a resource for that?

Man: I do not think that there is funds available for that. I believe that is something that you are just expected to do as part of a – it’s a cost of – it’s a normal cost of running a (unintelligible)

(Marcie Villanueva): I see.

Man: But it is allowable.

(Marcie Villanueva): Okay. All right.

Man: So it can go in your cost report. Let me get to a few questions in chat. (Becky) says if an RAC is contained in a cause organizational chart, does it need separate policies, procedures, and plans, or can they refer to the cause, policies, and procedures? Again, (Becky), I’m going to refer you to subsection...
E of the rule I just went over. You have to have – identify unique circumstances at your RHC.

But you can have similar policy – you can’t have the same policies and procedures, but it has to be tailored to – you have to identify kind of the unique circumstances at each facility in your larger network. So hopefully that answers your question. (Paul) says you do know that there isn’t a language called Chinese, it’s called Mandarin. (Paul), I do understand that and I apologize if it was offensive.

However, I will say that if you look at HHS’s foreign language estimates, they call it Chinese, so I just wanted to be consistent for the sake – sorry if it’s a confusing one, but yes, it is Mandarin, although I do believe Cantonese is also – I don’t know if it – I don’t know if that’s a dialect or a separate language, but that is how it’s presented in – on the translated resources that I linked to earlier.

(Lily Sousa) says can we get a copy of the power point faxed. Maybe, I’ll look into that. (Theresa) asks when was the letter sent to HHS requesting clarification on emergency preparedness, and if that would be removed as a requirement. (Theresa), we sent that perhaps about a month, maybe a month and a half ago. I would not get your hopes up that these rules will be you know, removed for rural health clinics.

We are trying, it is something that we think (un intelligible) burning some, because I think a lot of this stuff and this is just purely my personal opinion here, a lot of these things are things that people just would do during an emergency kind of by their nature. Of course your rural health clinic’s going to try to see how they can help your community during an emergency.
And you know, we have taken a position that doing all these extra you know, burdensome drills and things like that is probably the costs are outweigh the benefits, so – but with that said, be prepared November 15, 2017. Do not bank on that, even with the executive order seemingly giving us some ammunition to justify not going forward with this. I would be prepared November 15th, 2017. Okay, operator, do we have any – another question on the phone?

Coordinator: We do not have any other questions on the phone lines at this time.

Man: Okay, I’m going to knock out a few more questions in the chat box, and then we’ll probably finish about 3:15. (Marcie Villanueva) asks in regards to having RHC staff phone numbers (unintelligible), does that mean we should have the staff’s personal cell numbers listed? Our staff isn’t allowed to carry phones at work, so they wouldn’t have them on them during work hours.

However you – I would still include the personal cell numbers, doesn’t have – doesn’t hurt to have more contact information listed. So – but maybe also however you contact your staff during the work day, you might list that out as well. Emergencies also happen in non-work hours, so if it’s at the middle of the night, you having their cell phones there would also be useful.

The Pinkneyville Community Hospital says that under section 49112A, (unintelligible) shall address various emergency events. We do an annual hazard vulnerability analysis, and our policy is now hazard approach. (Unintelligible) changed our hazard approach, and we must specifically address each hazard.

Yes, that sounds correct. You have – the plan has to – you have to basically analyze all the hazards (unintelligible) and analyze how you would handle each and every single one, so obviously you would handle an active shooter different than you would handle a tornado, different than you would handle a fire, different than you would handle an epidemic or a power shortage.
So it sounds like you guys are doing the right thing in terms of the all hazards approach to your emergency plan. (Dan Wackand) asks how do we get a copy of – okay, sorry. I’ve already gone over that. (Jessica) says do we have to reprint all of our forms in all 15 languages. No, the answer is no on this, so you don’t have to have all of your forms in all 15 languages. You just have to have the tag lines that you offer language services, just that portion translated.

So hypothetically if someone comes into your clinic and speaks a language that no one really understands, the way it would work is that you would have the form in English, and you would get your language service contractor on the phone, and then together you could walk through that form with the patient, but the form’s like still saying name in English, and it’d still have the instructions of how to fill out the form in English.

It just has the tag line in the translated – in the translation. (Lily Sousa) asks I’m really interested in getting more information on what to post in the lobby of the RHC. (Lily), this is pretty simple. Top 15 tag lines, again I’ll go over some of the examples. So what you got to do, right, so everyone who doesn’t have something posted in there in the waiting room needs to do this immediately.

Go to the link. I have it here, at the very bottom, translated resources. At that link for every single state it will estimate the top 15 foreign languages in your state. It will also give you the exact tag lines that you need to post, okay? And then you would take – so then it basically looks like this, language services are available free of charge, and you can list the phone number that people can call to get the language services.

Although I believe in the FAQ it’s supposed to be your phone number, so it’s pretty much your main line, it’s not that the line of the contractor. So it’d
basically be your phone number, so you would have that tag line posted in the top 15 languages, so you would get at that link, you’ll get something like this, which is just for Iowa, but you’ll find it for your state, and then you print out the taglines in the top 15 languages.

Hopefully that makes sense, so top 15 foreign languages in your state, you have to have that tagline post. That’s what you have to have in your lobby.

(Jerry) asked can we get a copy of the transcription from this Webinar? Yes, (Jerry), we’re going to post the full transcript at the link at the end here, right here at the bottom. So it says to view past Webinars go to HRSA.gov, right?

So all of our Webinars, including every single one, every single Webinar that we’ve done, the transcript is posted there. Operator, do we have any calls on hold?

Coordinator: We do not have any at this time.

Man: Okay, I’m going to try to knock out a few more questions, hopefully this is helpful. We have about five minutes. (Ernan Cherarno), those are statements. He says community based drills are primarily for the emergency response team. You do not have to send your coder to community based drills. Okay, so (Ernan) apparently has done some research on it and says that not everybody in your clinic has to go to community based drills. Thank you for that, (Ernan)

(Jim Wackans) again asked CMS has a Webinar (unintelligible) has different (unintelligible) but you have to use your own emergency plan, whether or not you are in a network. I’ll have to research this. I mean, I think that may be the distinction. Or I’m not sure what would allow you to participate in the healthcare network if you – if the CCN number is the thing that kind of differentiates that, so I’ll have to research that. Send me an email.
(Karen Tidwell), our clients aren’t willing to buy the hospital, can we use part of the nurses experience plan in the clinics? Yes, again section E, subsection E 49112 subsection E, review that portion. (Marcie Villanueva), how do we obtain a sign language interpreter? I believe there’s contractors out there that will do this. I haven’t done this myself, so I can’t say by experience but while there’s more than your reimbursement for an all inclusive rate, it is an allowable cost.

So it can be go on in your cost report. Of course if you’re subject to the cap it doesn’t really help you, or if you’re over the cap and you’re independent clinic or owned by a large hospital and you’re subject to the cap it doesn’t really help you, but if you’re uncapped then you do get paid via a higher all-inclusive rate

(Kelly Harris) asks does the 15 employees count for the clinic only even if you’re owned by a hospital? I’ll have to research this one. My gut tells me that it is for your clinic only, but if you’re part of a larger network do you have to comply with the – do you have to have a point person and do you have to have – do those extra rules? I have to double check on that.

(Donna Clark), again we have right information to look at this, if not their own areas, that we only have to have the top three languages for our area. Nowhere is there ever a rule, at least from the federal standpoint, that there’s anything top three. Now you only first – again, remember there’s top 15 foreign language rules and top two foreign language rules, so for things that are small, so communications that are small, you only have to post the taglines in the top two foreign languages, okay?

So and then you’re also for things that are significant but large, you have to post not only the “we offer free language services” tagline, but you also have to post the non-discrimination statement in those top two languages, so I’m
not sure where that information is. If you have that information, send it to me, I’d love to see it. All right, we’re going to do one – operator, do we have any questions on the phone?

Coordinator: We still do not have any questions. As a reminder if you’d like to ask a question, please press Star one.

Man: All right, we’re coming up on our limit here. This will be my last question, and if I didn’t get to your question and you still want to ask, feel free to email me. My email is right there. The last question that I’ll take is from (Nancy Griego) If the emergency plan is what the hospitals do, we need to assess the plan. Again, I defer you to subsection E, 491.12, subsection E per the federal regulations.

You do not have to be – you do not have to have a separate plan, but you have to have some sort of assessment of the unique needs of your rural health clinic. And it cannot just be here’s an assessment of all of the health clinic’s needs. It has to be an assessment of each location’s needs, or unique attributes in the emergency plan, so that has to be built into the larger plan, but it can be one plan. So with that, I thank everyone for participation, apologies if I didn’t get to your question.

You can email me and I will do my best to answer and if I don’t know, I’ll do my best to research and find the answer for you, and together we will be ready come November 15th for these emergency preparedness rules and we will get all those non-discrimination tag line questions sorted out. Thank you, everyone, and I would say that concludes today’s call. Actually I have closing remarks that I need to make.

We want you to encourage others who may be interested in the technical assistance series to register online. In addition we welcome you to email us
with your thoughts and suggestions for future call topics at info@narhc.org, and be sure to put RHCA topic in our subject line. We do look at those emails. Make sure that we’re getting good topics out to you guys, and we anticipate that scheduling the next RHC technical assistance call sometime in June.

A notice will be sent by email to those on the technical assistance list serve with the details about that next call. Thank you for participation and that concludes today’s call.

Coordinator: Thank you, that concludes today’s conference. Thank you for participating. You may now disconnect.

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