American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

AAP Headquarters
141 Northwest Point Blvd
Elk Grove Village, IL 60007-1019
Phone: 847/434-4000
Fax: 847/434-8000
E-mail: kidsdocs@aap.org
www.aap.org

Reply to
Department of Federal Affairs
Homer Building, Suite 400 N
601 13th St NW
Washington, DC 20005
Phone: 202/347-8600
Fax: 202/393-6137
E-mail: kids1st@aap.org

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Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

On behalf of the 62,000 primary care pediatricians, pediatric medical subspecialists, and surgical specialists of the American Academy of Pediatrics (AAP) who are committed to the attainment of optimal physical, mental and social health and well-being for all infants, children, adolescents, and young adults, we appreciate this opportunity to provide comments on the proposed rule to establish national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers [Docket No. CMS – 3178 – P].

The AAP applauds CMS's leadership in attempting to drive improvements in emergency preparedness at facilities that participate in Medicaid and Medicare. Children, who represent twenty-five percent of the U.S. population, are uniquely vulnerable during all-hazards events and it is essential that facilities that care for children have an emergency preparedness plan that includes children. Children are not small adults and emergency preparedness planning must take into account the different medications and medical devices children need, the challenges facing pediatric patient transfer especially for neonatal intensive care and pediatric intensive care patients, and the unique issues around behavioral health and family reunification.

Eighty-nine percent of children in the emergency care system are seen in non-children's hospitals[i]. Therefore, it is critical that all hospitals, including those with low volumes of pediatric patients, assess their current pediatric readiness and work to improve their day-to-day preparedness to meet the needs of children. The better prepared facilities are on a daily basis to provide emergency care to children, the better prepared they will be when an all-hazards emergency occurs.

As such, the AAP strongly recommends the adoption of the *Joint Guidelines for Care of Children in the Emergency Department* [ii] developed by the AAP, the American College of Emergency Physicians, and the Emergency Nurses Association. The joint guidelines have been endorsed by twenty-two other professional organizations. We would offer the joint guidelines as a resource to CMS and encourage the agency to align its efforts with the recommendations contained in the joint guidelines. Adoption of these joint guidelines by states and hospital accrediting bodies was a key recommendation (recommendation 3.4) of the National Commission on Children and Disasters in its 2010 Final Report to the President and Congress[iii].

We applaud CMS for recognizing that current regulatory requirements around emergency preparedness are insufficient for addressing the complexities of actual emergencies and we share the hope that a more consistent regulatory approach will

spur meaningful, comprehensive planning for children that might not otherwise occur. In particular, we commend CMS for taking an all-hazards approach to emergency preparedness that seeks to engage stakeholders across the care continuum. The AAP is pleased to offer comments in response to the questions posed by the agency but we are eager to better understand how these requirements would be overseen and enforced by the agency.

As the agency works to ensure that children's needs are addressed as part of the requirements for Medicaid-participating providers, the AAP would also encourage CMS to collaborate closely with the Emergency Medical Services for Children (EMSC) program administered by the Health Resources and Services Administration. The EMSC program is the only federal program that focuses specifically on improving the pediatric components of the emergency medical services (EMS) system. Currently celebrating its 30th anniversary, the EMSC program is responsible for institutionalizing EMS for critically ill and injured children within states, the District of Columbia, and the U.S. territories and is supporting the *Pediatric Readiness Assessment,* an existing assessment tool that has been adopted by more than 80 percent of hospitals nationwide. The AAP, along with many other organizations, has endorsed this effort.

The AAP would also recommend CMS work closely with the Hospital Preparedness Program that is administered by the Assistant Secretary for Preparedness and Response (ASPR). The ASPR's expertise in health system preparedness would be an asset to CMS as it finalizes this rule.

Specifically, CMS sought feedback on whether inpatient/residential facilities should be required to have policies and procedures to maintain food supplies for patients and staff; whether these facilities should maintain an extra store for visitors and individuals from the community who arrive to offer assistance or seek shelter; and for what time period these subsistence needs would need to be maintained. While the AAP believes that these facilities should not be expected to provide for the subsistence needs of the population at large, we believe it is reasonable to expect them to provide for the needs of staff, patients and their visiting families, and volunteers who come to help. Furthermore, if these facilities serve as a shelter-in-place location for patients and families brought in for evaluation, those needs will also need to be met. We suggest that these facilities should have a minimum store of provisions to meet the needs of those populations for 72-96 hours.

With respect to the question of feasibility of outpatient facilities to track the location of staff and patients, which is a requirement for hospitals under the proposed rule, the AAP does not see a reason why ambulatory facilities should be treated differently for purposes of staff and patient tracking. In past all-hazards emergencies, tracking systems have proven especially critical for locating and reunifying children and other populations who cannot self-identify.

CMS also solicited feedback on whether or not it was reasonable to require that all hospitals, critical access hospitals and long-term care facilities to test their emergency generator systems annually for four hours at 100% of the power load. The AAP supports this proposal. Most generator backups do not operate all electric-powered equipment/systems for a hospital. In order to adequately test the ability to function, the hospital would need to run on the generator for a significant amount of time.

The Agency also asked whether or not it was reasonable to require that policies and procedures be reviewed and updated at least annually. We believe that this is not only reasonable, but also necessary in order to ensure that emergency plans and procedures are adequate and current.

CMS also solicited comments on alternative approaches to implementation. The AAP believes that a targeted approach to emergency preparedness could provide an opportunity to develop best practices and lessons learned. For example, if implementation starts with bigger facilities like hospitals, ambulatory care facilities may benefit from a longer implementation timeline and can learn from the experiences of hospitals prior to developing their emergency preparedness plans. We acknowledge the cost burden that developing an emergency preparedness plan and training staff can place on providers, and believe that a phase-in approach is a reasonable way to alleviate that burden.

The AAP also seeks additional clarification on the section related to training and testing. First of all, we believe that CMS should note that some tabletop exercises are computer-simulated, and this requirement should not limit exercises to those that are paper-based. Furthermore, the AAP believes that the requirement for the training of all hospital staff should include a definition of staff, since much of inpatient hospital-based specialists such as hospitalists or neonatologists now provide much of the inpatient medical care.

The Academy strongly supports the proposal that hospitals and other health care facilities have a robust communications plan that complies with state and federal law. An effective communications plan, which can allow health care facilities to keep family members informed on patient status and promote reunification, is critical before, during, and after an all-hazards event. The AAP recommends that CMS explicitly include social media in their communications plan requirements, as social media has recently proven an essential tool for communication during disasters.

In addition to the important role hospitals play in emergency preparedness, AAP believes it is important that all pediatricians are prepared to provide care to their patients even when normal operations are disrupted. As such, the AAP also encourages all its members, including primary care providers in small practices, to develop a pediatric preparedness plan. The AAP's Disaster Preparedness Advisory Council (DPAC) has developed a pediatric readiness checklist for offices. The AAP recommends that hospitals and other health care facilities explore coordinating with the disaster planning efforts of primary care providers in their communities before a disaster or all-hazards event. These relationships will promote effective care coordination and ensure that children receive continuity of care in a patient-centered medical home to the extent possible.

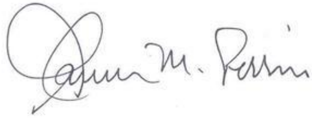
In the proposed rule, CMS suggests that hospitals could use the Emergency System for Advancing Registration of Volunteer Health Professionals (ESAR-VHP), to verify the credentials of volunteer health care professionals during an all-hazard event. The AAP seeks clarification on whether hospitals would have direct access to the ESAR-VHP or need to go through the health department.

Finally, the AAP recommends that CMS consider adding requirements for the provision of behavioral health care, particularly the professional self-care needs of healthcare providers. Although a pediatrician's first response might be to ensure personal safety and that of family and colleagues while also attempting to meet as many of the needs of their patients and families as possible, the experience of personal injury or loss and witnessing the impact of a disaster on

patients and their families will influence their ability to respond professionally. It is critical that staff find ways to have their own personal needs met and appreciate and address impact of supporting children who are grieving or traumatized

Thank you for your attention to the views of the Academy. If you have any questions or wish to discuss the matter further, please contact Tamar Magarik Haro in the AAP's Department of Federal Affairs at 202/347- 8600 or tharo@aap.org.

Sincerely,



James M. Perrin, MD, FAAP President
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[i] Emergency Medical Services for Children National Resource Center. *National Pediatric Readiness Project.* Available: http://pediatricreadiness.org/About_PRP/
[ii] American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Committee; Emergency Nurses Association Pediatric Committee. 2009. Available: http://pediatrics.aappublications.org/content/124/4/1233
[iii] National Commission on Children and Disasters. *2010 Report to the President and Congress.* AHRQ Publication NO. 10-M037. October 2010. Available: http://archive.ahrq.gov/prep/nccdreport/nccdreport.pdf