Health Sector Emergency Preparedness
AWR-336

Student Guide

Module 1
Introduction to the Health Sector Emergency Preparedness Course

Number: Module 1

Title: Introduction to the Health Sector Emergency Preparedness Course

Purpose. As a reminder, this course is not intended to guarantee compliance with Conditions of Participation (CoPs) or Conditions for Coverage (CfC). The purpose of this module is to provide an overview of the course and associated requirements, to introduce staff, and conduct student introductions. This module addresses the following items:

a. an overview of the course,

b. graduation criteria for the course,

c. an overview of the facilities and key student expectations,

d. sources of additional information regarding Center for Domestic Preparedness (CDP) courses, and

e. the facilitation of instructor and class member introductions.

Learning Objectives

a. Terminal Learning Objectives: Not applicable

b. Enabling Learning Objectives: Not applicable

1. **Course Purpose.** The purpose of this course is to provide training and resources to emergency management officials, healthcare coalitions, healthcare providers and suppliers. The course focuses on the general overview of emergency planning and preparedness; development policies and procedures; creation of communication plans and training and exercises for healthcare entities. It is not intended to be a course which will guarantee compliance with Conditions of Participation (CoPs) or Conditions for Coverage (CfC). CMS is responsible for the Interpretive Guidelines for surveyors and is not a primary component for developing provider-based training.

2. **Course Goals**

   a. Develop best practice knowledge in applying and understanding the new emergency preparedness requirements under the CMS Final Rule.

   b. Develop best practice knowledge in the use of tools to develop, train, and exercise an emergency preparedness plan for health sector suppliers and providers

3. **Course Overview.** The following is a concise overview for each administrative and academic learning activity within the course.

   a. Module 2: *Emergency Preparedness Rule* Overview: An overview of the rule, a review of the four requirements, and applicability of each requirement to the 17 affected providers and suppliers.

   b. Module 3: Risk Assessment and Emergency Planning: A discussion of requirements and best practice procedures for conducting a risk assessment and developing a corresponding emergency plan.

   c. Module 4: Policies and Procedures: A discussion of the requirements and best practice procedures for developing policies and procedures in support of an emergency plan.

   d. Module 5: Emergency Preparedness Communication Planning: A discussion of the development and maintenance of an emergency preparedness communication plan.

   e. Module 6: Training and Testing (Exercising): A discussion of an emerg3ency preparedness training and testing (exercising) program.

   f. Module 7: Course Review and Open Forum: A review of the entire course and an open forum for students to address questions or receive clarification on the emergency preparedness requirements.

4. **Course Graduation Criteria.** To receive a certificate of graduation, you must participate in the entire course.

5. **Facilities Orientation and Key Policies and Procedures**

   a. **Classroom**

   b. **Restrooms**

   c. **Dining**

d. Breaks and Timely Return to Class Considerations

e. Evacuation and Shelter in Place

f. Smoking, E-Cigarette, and Smokeless Tobacco Policy

g. Smoking, E-Cigarette, and Smokeless Tobacco Area(s)

h. Cell Phone and Pager Policy and Courtesy Considerations

6. Staff Introductions

7. Student Introductions

8. Additional CDP Information

a. Downloading Student Materials. Using your FEMA student identification (SID) number, you may log into CTAS at https://cdp.dhs.gov/ctas/LogIn/ and download current student materials.

b. CDP Information. If you would like additional information about the CDP or our courses, you may want to:

(1) Check us out on the web at http://cdp.dhs.gov/

(2) Follow us on Facebook® at https://www.facebook.com/CDPFEMA

(3) Join us on Twitter® at https://twitter.com/cdpfema

REFERENCES

Center for Domestic Preparedness. (2013). *Student handbook*. Anniston, AL: Author.

Health Sector Emergency Preparedness
AWR-336

Student Guide

Module 2
Emergency Preparedness Final Rule Overview

Number: Module 2

Title: Emergency Preparedness Final Rule Overview

Purpose. As a reminder, this course is not intended to guarantee compliance with Conditions of Participation (CoPs) or Conditions for Coverage (CfC). The purpose of this module is to provide you with an overview of the Final Rule, a review of the four requirements, and the applicability of each requirement to the 17 affected providers and suppliers.

Learning Objective

a. **Terminal Learning Objective.** Determine requirements for a specific supplier or provider in accordance with *CMS Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* Rule (Final Rule). (HC-0245)

b. **Enabling Learning Objectives**

(1) Discuss the purpose of the emergency preparedness requirements in accordance with the CMS Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Rule. (HC-0245a)

(2) Identify the three key essentials and the additional requirements of the CMS Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Rule. (HC-0245b)

(3) Identify the four components and additional requirements of the CMS Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Rule. (HC-0245c)

(4) Review the requirements for the 17 providers/suppliers impacted by the *CMS Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* Rule. (HC-0245d)

1. **Overview of the Final Rule**

   a. According to the Centers for Medicare and Medicaid Services (CMS), the Final Rule establishes national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers to plan adequately for both natural and man-made disasters, and coordinate with Federal, state, tribal, regional, and local emergency preparedness systems.

   b. It will assist providers and suppliers to adequately prepare to meet the needs of patients, residents, clients, and participants during disasters and emergency situations.

   c. Despite some variations, this regulation will provide a consistent approach to emergency preparedness, enhance patient safety during emergencies for persons served by Medicare- and Medicaid-participating providers/suppliers, and establish a more coordinated and defined response to natural and man-made disasters.

2. **Purpose of the Final Rule**

   a. After review of previous Centers for Medicare and Medicaid Services (CMS) emergency preparedness regulatory requirements, it was found that many providers and suppliers have emergency preparedness requirements, but those requirements do not go far enough to help protect those they serve during emergencies and disasters.

   b. It was recognized that providers and suppliers needed assistance in developing and guiding emergency preparedness and response within the framework of our national healthcare system. These requirements will encourage them to coordinate their preparedness efforts within their own communities, states, and interstates, to achieve their goals.

3. **Three Key Essentials.** This Final Rule addresses the three key essentials necessary for maintaining access to healthcare services during emergencies:

   a. safeguarding human resources,

   b. maintaining business continuity, and

   c. protecting physical resources.

4. **Four Core Elements and Additional Requirements**

   a. The Final Rule identified four core elements that are central to an effective and comprehensive framework of emergency preparedness requirements for the various Medicare- and Medicaid-participating providers and suppliers. The four elements of the emergency preparedness program are risk assessment and emergency planning, policies and procedures, communication, and training and testing.

   b. Risk Assessment

   (1) Providers/suppliers are required to perform a risk assessment that uses an "all-hazards" approach prior to establishing an emergency plan. The all-hazards risk

assessment will be used to identify the essential components to be integrated into the facility emergency plan.

(2) An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities which are critical to preparedness for a full spectrum of emergencies or disasters. This approach is specific to the location of the provider or supplier and considers the particular types of hazards most likely to occur in their areas.

(3) These may include, but are not limited to, care-related emergencies; equipment and power failures; interruptions in communications, including cyber-attacks; loss of a portion or all of a facility; and, interruptions in the normal supply of essentials, such as water and food.

c. Policies and Procedures

(1) Develop and implement policies and procedures based on the emergency plan and risk assessment

(2) Policies and procedures must address a range of issues including subsistence needs, evacuation plans, procedures for sheltering in place, tracking patients and staff during an emergency

(3) Review and update policies and procedures at least annually

d. Communication Plan

(1) Providers/suppliers are required to develop and maintain an emergency preparedness communication plan that complies with both federal and state law. Patient care must be well-coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management agencies and systems to protect patient health and safety in the event of a disaster.

(2) During an emergency, it is critical that hospitals, and all providers/suppliers, have a system to contact appropriate staff, patients' treating physicians, and other necessary persons in a timely manner to ensure continuation of patient care functions throughout the facilities and to ensure that these functions are carried out in a safe and effective manner.

e. Training and Testing

(1) Providers/suppliers are required to develop and maintain an emergency preparedness training and testing program. A well-organized, effective training program must include initial training for new and existing staff in emergency preparedness policies and procedures as well as annual refresher trainings.

(2) The provider/supplier must offer annual emergency preparedness training so that staff can demonstrate knowledge of emergency procedures. The provider/supplier must also conduct drills and exercises to test the emergency plan to identify gaps and areas for improvement.

f. Additional Requirements

(1) Emergency Fuel and Generator Testing. This is only a requirement for Hospitals, Critical Access Hospitals, and Long-Term Care Facilities; however, if a different type of provider/supplier decides to get a permanent generator, applying these additional requirements is prudent. The provider/supplier must implement emergency and standby power systems as follow:

(a) Emergency generator location. The generator must be located in accordance with the location requirements found in National Fire Protection Association (NFPA) 99, NFPA 101, and NFPA 110 when a new structure is built or when an existing structure or building is renovated.

(b) Emergency generator inspection and testing. The provider/supplier must implement the emergency power system inspection, testing, and maintenance requirements found in NFPA 99 and NFPA 101.

(c) Emergency generator fuel. Providers/suppliers that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

(2) Integrated Healthcare Facilities

(a) If a facility is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the facility may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do the following:

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

2 Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.

3 Include a unified and integrated emergency plan which must be based on and include the following:

a A documented community-based risk assessment, utilizing an all-hazards approach.

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

c Include integrated policies and procedures, a coordinated communication plan and training and testing programs.

5. Definition and Exemptions to Requirements by Provider and Supplier

a. Providers and Suppliers. There are 17 specific provider and supplier types affected by the newly released Final Rule. ASPR TRACIE provides the following definitions based on information gleaned from numerous sources to provide a general description of each type. These definitions should not be interpreted as regulatory or interpretive guidance, but used for general informational and awareness purposes only. The hospital emergency preparedness plan is the baseline requirements for other providers/suppliers. Listed alphabetically, providers/suppliers are also categorized based on whether they are inpatient or outpatient, as outpatient providers are not required to provide subsistence needs for staff and patients. The main source for information regarding the Emergency Preparedness Rule can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html

b. Ambulatory Surgical Centers (ASCs) (Outpatient)

(1) An ASC is any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. An unanticipated medical circumstance may arise that would require an ASC patient to stay in the ASC longer than 24 hours, but such situations should be rare.

(2) The exceptions for the ACS are the following:

(a) Communication Plan

1 Occupancy information will not be required.

2 Arrangements with other ASCs and other providers to receive patients in an emergency event are not required.

3 Does not need to include the names and contact information for other ASCs.

(b) Training, Exercising, and Testing

4 Community-based drills are not required.

(3) For more information regarding this provider/supplier please visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/ASCs.html

c. Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services (Outpatient)

(1) The definitions are listed as follow:

(a) Rehabilitation Agency - An agency that provides an integrated, multidisciplinary program designed to upgrade the physical functions of handicapped, disabled individuals by bringing together, as a team, specialized rehabilitation personnel.

(b) Clinic - A facility established primarily for the provision of outpatient physicians' services. To meet the definition of a clinic, the facility must meet the following test of physician participation:

1 The medical services of the clinic are provided by a group of three or more physicians practicing medicine together, and

2 A physician is present in the clinic at all times during hours of operation to perform medical services (rather than only administrative services).

(c) Public Health Agency - An official agency established by a state or local government, the primary function of which is to maintain the health of the population served by providing environmental health services, preventive medical services, and in certain instances, therapeutic services.

(2) The exceptions for the above are the following:

(a) Policies and Procedures

1 Not required to track staff or patients.

(b) Communication Plan

2 Does not need to provide occupancy information.

(3) For more information regarding this provider/supplier please visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/OutpatientRehab.html

d. Community Mental Health Centers (CMHCs) (Outpatient)

(1) A CMHCs is an outpatient organization that provides partial hospitalization services to Medicare beneficiaries for mental health services. It is estimated that there are about 100 CMHCs that provide partial hospitalization services through Medicare that will be affected by this rule.

(2) The exception for the CMHC are the following:

(a) Policies and Procedures

1 Tracking applies to on-duty staff and sheltered clients and is required during and after the emergency.

(3) For more information regarding this provider/supplier please visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CommunityHealthCenters.html

e. Comprehensive Outpatient Rehabilitation Facilities (CORFs) (Outpatient)

(1) CORFs provide a coordinated outpatient diagnostic, therapeutic, and restorative services, at a single fixed location, for the rehabilitation of injured, disabled or sick individuals. Physical therapy, occupational therapy and speech-language pathology services may be provided in an off-site location. Consultation with and medical supervision of non-physician staff, establishment and review of the plan of treatment and other medical and facility administration activities, physical therapy services, social or psychological services are also provided.

(2) The exceptions for CORFs are the following:

1 Policies and Procedures

a Will not need to provide transportation to evacuation locations.

b Will not need to have arrangements with other CORFs to receive patients.

c Not required to track staff or patients.

(3) For more information regarding this provider/supplier please visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CORFs.html

f. Critical Access Hospitals (CAHs) (Inpatient)

(1) CAH is a designation given to certain rural hospitals by the Centers for Medicare and Medicaid Services (CMS).

(2) An additional requirement for the CMHC is having generators.

(3) For more information regarding this provider/supplier please visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CAHs.htm

g. End-Stage Renal Disease (ESRD) Facilities (Outpatient)

(1) A freestanding dialysis center is a facility that provides chronic maintenance dialysis to ESRD patients on an outpatient basis, including dialysis services in the patient's place of residence. A certified ESRD facility provides outpatient maintenance dialysis services, home dialysis training and support services, or both. A dialysis center may be independent or hospital-based.

(2) The exceptions for an ESRD are the following:

(a) Policies and Procedures

1 Must include emergencies regarding fire equipment, power failures, care related emergencies, water supply interruption, and natural disasters.

(b) Communication Plan

1 Does not need to provide occupancy information.

(c) Training, Exercising, and Testing

1 Ensure staff demonstrates knowledge of emergency procedures, informing patients what to do, where to go, whom to contact if emergency occurs while patient is not in facility, and show patients how to disconnect themselves from dialysis machine.

2 Staff must maintain current CPR certification, nursing staff trained in use of emergency equipment and emergency drugs and patient orientation.

(3) For more information regarding this provider/supplier please visit https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/ESRD.html

h. Home Health Agencies (HHAs) (Outpatient)

(1) A HHAs is primarily engaged in providing skilled nursing services and other therapeutic services to patients. HHAs policies are established by a group of professionals (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services which it provides.

(2) The exceptions for a HHA are the following:

(a) Policies and Procedures

1 Will not require shelter in place or provisions of care at alternate sites.

2 Inform officials of patients in need of evacuation.

3 Not required to track staff or patients.

(b) Communication Plan

1 Will not need to provide occupancy information.

2 Not required to include the names and contact information for other HHAs in the plan.

3 Not required to develop arrangements with other HHAs.

(c) Additional Requirements

1 HHAs must have policies in place for following up with patients to determine services that are still needed.

2 They must inform state and local officials of any on-duty staff or patients that they are unable to contact.

(3) For more information regarding this provider/supplier please visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/HHAs.html

i. Hospices (Inpatient and Outpatient)

(1) A hospice is a public agency, private organization, or a subdivision that is primarily engaged in providing care to terminally ill individuals.

(2) Hospice services can also be provided in facilities, such as those located as a part of a hospital, nursing home, or residential facility, or as a freestanding hospice inpatient facility.

(3) The exceptions for a Hospice are the following:

(a) Policies and Procedures

1 For in home services—inform officials of patients in need of evacuation.

2 Home-based hospices not required to track staff or patients.

(b) Communication Plan

1 For in home services—will not need to provide occupancy information.

(4) For more information regarding this provider/supplier please visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospices.html

j. Hospitals (Inpatient)

(1) A hospital is defined as an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services.

(2) The hospital emergency preparedness is the baseline for all suppliers and providers except for noted exceptions.

(3) For more information regarding this provider/supplier please visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals.html

k. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) (Inpatient)

(1) The ICF/IID benefit is an optional Medicaid benefit. The Social Security Act created this benefit to fund "institutions" (4 or more beds) for individuals with intellectual disabilities and other related conditions, and specifies that these institutions must provide "active treatment," as defined by the Secretary of the U.S. Department of Health and Human Services.

(2) The exceptions for an ICF/IID are the following:

(a) Policies and Procedures

1 Tracking during and after the emergency applies to on-duty staff and sheltered clients.

(b) Additional Requirements

1 Share with client/family/representative appropriate information from emergency plan.

(3) For more information regarding this provider/supplier please visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/ICFIID.html

I. Long-Term Care (LTC) Facilities (Inpatient)

(1) Skilled nursing facilities (SNF) and nursing facilities (NF) fall under LTC Facilities.

(2) Skilled nursing facility is an institution (or a distinct part of an institution) which: is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases; has in effect a transfer agreement with one or more hospitals having agreements; and meets the requirements for a SNF.

(3) A nursing facility is an institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for injured, disabled, or sick persons, or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; and, has in effect a transfer agreement with one or more hospitals having agreements in effect under; and meets the requirements for a NF.

(4) The exceptions for a LTC are the following:

(a) Policies and Procedures

1 Tracking during and after the emergency applies to on-duty staff and sheltered residents.

(b) Communication Plan

1 In the event of an evacuation, method to release patient information consistent with the HIPAA Privacy Rule.

(c) Additional Requirements

1 Share with residents/family/representative appropriate information from emergency plan.

2 An additional requirement for the LTC is having generators.

(5) For more information regarding this provider/supplier please visit https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/LTC.html

m. Organ Procurement Organizations (OPOs) (Outpatient)

(1) OPOs, as defined by the Health Resources and Services Administration, offer opportunities for volunteering and helping to raise awareness about the importance of registering as a donor.

(2) OPOs have two major roles in their service area. They are responsible for:

(a) Increasing the number of registered donors. To encourage donor sign-ups, OPOs may reach out to communities by: sponsoring advertising campaigns; organizing programs in schools, worksites, or faith institutions; sharing print and electronic materials, and more.

(b) Coordinating the donation process. When donors become available, representatives from the OPO will evaluate the potential donors, check the deceased's state donor registry, discuss donation with family members, contact the OPTN computer system that matches donors and recipients, obtain a match list for that specific donor, and arrange for the recovery and transport of donated organs. They also provide bereavement support for donor families and volunteer opportunities for interested individuals.

(3) The exceptions for an OPO are the following:

(a) Emergency Plan

1 Address the type of hospitals the OPO has agreements.

(b) Policies and Procedures

1 Needs to have a system to track staff during and after emergency and maintain medical documentation.

(c) Communication Plan

1 Does not need to provide occupancy information, method of sharing patient information, providing information on general condition, or location of patients.

(d) Training, Exercising, and Testing

1 Only tabletop exercises are required.

(e) Additional Requirements

1 Must maintain agreements with other OPOs and hospitals.

(4) For more information regarding this provider/supplier please visit http://organdonor.gov/awareness/organizations/local-opo.html

n. Programs of All-Inclusive Care for the Elderly (PACE) (Outpatient)

(1) The PACE program is an innovative model that provides a range of integrated preventative, acute care, and long-term care services to manage the often complex medical, functional, and social needs of the frail elderly. PACE was created as a way to meet a person's health care needs while allowing them to continue living safely in the community.

(2) The exceptions for a PACE are the following:

(a) Policies and Procedures

1 Inform officials of patients in need of evacuation.

2 Track on-duty staff and sheltered participants during and after the emergency.

(3) For more information regarding this provider/supplier please visit https://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html.

o. Psychiatric Residential Treatment Facilities (PRTFs) (Inpatient)

(1) A PRTF is any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21. The facility must be accredited by the Joint Commission or any other accrediting organization with comparable standards recognized by the state.

(2) The exceptions for a PRTF are the following:

(a) Policies and Procedures

1 Track on-duty staff and sheltered residents during and after the emergency.

(3) For more information regarding this provider/supplier please visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/PRTFs.html

p. Religious Nonmedical Health Care Institutions (RNHCIs) (Inpatient)

(1) RNHCIs is a tax-exempted religious organization that provide nonmedical nursing items and services to beneficiaries who choose to rely solely upon a religious method of healing, and for whom the acceptance of medical services would be inconsistent with their religious beliefs.

(2) RNHCIs furnish nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of nonmedical patients (e.g., assistance with activities of daily living; assistance in moving, positioning, and ambulation, nutritional needs and comfort and support measures).

(3) The exceptions for a RNHCI are the following:

(a) Communication Plan

1 Does not need to include the requirements to coordinate with state and federally designated healthcare professionals.

(b) Training, Exercising, and Testing

2 There is no requirement to conduct drills.

(4) For more information regarding this provider/supplier please visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/RNHCIs.html

q. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (Outpatient)

(1) An RHC is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

(2) FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

(3) Certain tribal organizations and FQHC Look-Alikes (an organization that meets PHS Section 330 eligibility requirements, but does not receive Health Center Program grant funding) also may receive special Medicare and Medicaid reimbursement.

(4) The exceptions for a RHC/FQHC are the following:

(a) Policies and Procedures

1 Does not have to track staff or patients, or have arrangements with other RHCs to receive patients or have alternate care sites.

(b) Communication Plan

1 Does not need to provide occupancy information.

(5) For more information regarding this provider/supplier please visit

(a) http://bphc.hrsa.gov/about/what-is-a-health-center/index.html

(b) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf

r. Transplant Centers (Inpatient)

(1) A transplant center is a component within a transplant hospital that provides transplantation of a particular type of organ and must be located in a hospital that has a Medicare provider agreement.

(2) The exceptions a Transplant Center are the following:

(a) Additional Requirements

1 Maintain agreement with other transplant centers and OPOs.

2 Note that transplant centers fall within hospitals and must coordinate with the hospital for their emergency program to ensure they are included. However, a transplant center is not individually responsible for the emergency preparedness requirements.

(3) For more information regarding this provider/supplier please visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Transplant-Laws-and-Regulations.html

ADDITIONAL RESOURCES

ASPR TRACIE CMS EP Rule Resources at Your Fingertips (https://asprtracie.hhs.gov/documents/cms-ep-rule-resources-at-your-fingertips.pdf)

Definitions of providers and suppliers (https://asprtracie.hhs.gov/documents/aspr-tracie-ta-cms-rule-provider-type-definitions.pdf)

YNHH CMS COP and Accreditation Organizations Crosswalk (https://www.ynhhs.org/emergency/insights/library.aspx)

Ambulatory Care and Federally Qualified Health Centers (FQHC) Topic Collection (https://asprtracie.hhs.gov/technical-resources/49/Ambulatory-Care-and-Federally-Qualified-Health-Centers-FQHC/47)

Dialysis Centers (https://asprtracie.hhs.gov/technical-resources/50/Dialysis-Centers/47)

Homecare and Hospice Topic Collection (https://asprtracie.hhs.gov/technical-resources/51/Homecare-and-Hospice/47)

Long-term Care Facilities Topic Collection (https://asprtracie.hhs.gov/technical-resources/52/Long-term-Care-Facilities/47)

REFERENCES

Centers for Medicare and Medicaid Services (CMS), HHS, September 2016. *Requirements for Medicare and Medicaid Participating Providers and Suppliers.* Retrieved from https://www.federalregister.gov/documents/2016/09/16/2016-21404/medicare-and-medicaid-programs-emergency-preparedness-requirements-for-medicare-and-medicaid

Federal Emergency Management Agency (FEMA), March 2015. *Comprehensive Preparedness Guide 201, Second Edition.* Retrieved from https://www.fema.gov/threat-and-hazard-identification-and-risk-assessment

Federal Emergency Management Agency (FEMA), November 2010. *Developing and Maintaining Emergency Operations Plans: Comprehensive Preparedness Guide (CPG) 101, Version 2.0*. Retrieved from https://www.fema.gov/media-library-data/20130726-1828-25045-0014/cpg_101_comprehensive_preparedness_guide_developing_and_maintaining_emergency_operations_plans_2010.pdf

Federal Emergency Management Agency (FEMA), April 2013. *Homeland Security Exercise and Evaluation Program (HSEEP. Retrieved from* https://www.fema.gov/media-library-data/20130726-1914-25045-8890/hseep_apr13_.pdf

National Fire Protection Association (NFPA) 99, 2015. *Health Care Facilities Code.* Retrieved from http://www.nfpa.org/codes-and-standards/all-codes-and-standards/list-of-codes-and-standards?mode=codeandcode=99

National Fire Protection Association (NFPA) 101, 2015. *Life Safety Code.* Retrieved from http://www.nfpa.org/codes-and-standards/all-codes-and-standards/list-of-codes-and-standards?mode=codeandcode=101

National Fire Protection Association (NFPA) 110, 2016. *Standard for Emergency and Standby Power Systems.* Retrieved from http://www.nfpa.org/codes-and-standards/all-codes-and-standards/list-of-codes-and-standards?mode=codeandcode=110

HHS, Office of the Assistant Secretary for Preparedness and Response (ASPR), Technical Resources, Assistance Center, and Information Exchange (TRACIE), October, 2016. *Provider and Supplier Types Covered by the CMS Emergency Preparedness Rule.* Retrieved from https://asprtracie.hhs.gov/cms-ep-rule-resources-at-your-fingertips.pdf

Health Sector Emergency Preparedness
AWR-336

Student Guide

Module 3
Risk Assessment and Emergency Planning

Number: Module 3

Title: Risk Assessment and Emergency Planning

Purpose. The purpose of this module is to discuss the requirements and best practice procedures for conducting a risk assessment and developing a corresponding emergency plan.

Learning Objective

a. **Terminal Learning Objectives**

(1) Determine requirements and considerations for conducting a health sector risk assessment in accordance with the best practices and *Comprehensive Preparedness Guide 201: Threat and Hazard Identification and Risk Assessment Guide*. (HC-0250)

(2) Determine requirements and considerations for developing an emergency preparedness plan in accordance with *Comprehensive Preparedness Guide 101: Developing and Maintaining Emergency Operations Plans.* (HC-0255)

b. **Enabling Learning Objectives**

(1) Determine requirements for conducting a Hazard Vulnerability Analysis for a healthcare provider or supplier in accordance with the industry best practices. (HC-0250a)

(2) Determine requirements for conducting a Threat and Hazard Identification and Risk Assessment for a healthcare provider or supplier in accordance with *Comprehensive Preparedness Guide 201: Threat and Hazard Identification and Risk Assessment Guide*. (HC-0250b)

(3) Determine planning principles for developing an emergency preparedness plan for a healthcare provider or supplier in accordance with industry best practices. (HC-0255a).

(4) Determine requirements and the best practice process for developing an emergency preparedness plan for a healthcare provider or supplier in accordance with *Comprehensive Preparedness Guide 101: Developing and Maintaining Emergency Operations Plans*. (HC-0255b)

1. Purpose

a. Risk Assessment and Emergency Planning Defined

(1) Risk assessments are systematic approaches to identifying hazards and risks that are most likely to have an impact on a healthcare facility and the surrounding community. Multiple tools and resources are available to help healthcare organizations and public health departments prioritize their planning efforts based on these identified hazards. (A review of applicable tools is located at https://asprtracie.hhs.gov/documents/tracie-evaluation-of-HVA-tools.pdf.)

(2) An emergency plan is a course of action developed in advance of an emergency to guide the response to all hazards situations in order to provide a description of roles and responsibilities, tasks, integration, and actions required of an entity during emergencies in order to prevent the loss of life and property. Emergency plans ensure those involved in a response know how and when to take defined actions to respond in a disaster or emergency.

b. An effective risk assessment and emergency plan of any health care organization must not only consider the immediate facility's needs and desired outcomes, but those of the entire affected community and population. An ideal way to accomplish this is to collaborate with those with whom the response efforts will be shared such as local emergency management agencies, local emergency medical service agencies, local health care coalition, and public health agencies. A successful risk assessment and emergency plan has to have a larger perspective then just the immediate facility.

c. By using this approach, individual facilities, as well as the community experience numerous benefits. These include:

(1) Focused resources—By successfully completing risk assessments and emergency plans, facilities and organizations can focus limited resources where they are most likely needed.

(2) Coordination—When an emergency occurs, organizations, facilities, and communities that planned together can respond together. This coordinated effort ensures casualties are assisted in the most efficient manner.

(3) Grants—Numerous community grant opportunities rely on collaborated risk assessments and emergency plans. Collaboration is essential to gain monetary support for risk reduction and risk mitigation in a community.

d. A successful emergency plan has to be part of the bigger picture. Collaboration, integration, and community involvement are all necessary components to ensuring that the end results are useful in the event of an incident.

e. For your provider type, who do you believe should be part of conducting the risk assessment?

(1) Collaboration efforts—True collaboration means an environment where joint communication and decision making among all members of the planning team becomes the norm. It is not an event, as much as a shared obligation.

(2) Healthcare coalitions offer a unique perspective to existing and new partnerships and how these partnerships within a region can assist each other throughout the assessment and planning process.

(a) An emergency will likely affect more than just one healthcare organization. Chances are whatever occurs to cause a healthcare emergency will affect multiple healthcare facilities/agencies.

(b) Partnerships and planning efforts that occur prior to an emergency allow for more productive and efficient response efforts. These includes the assessment phases of planning to determine needs and priorities of healthcare organizations and the development of operational courses of action used during responses.

f. For your provider type, who do you believe should be part of creating an emergency plan?

g. Assume you are a member of the planning team for a Long Term Care Facility. Who would you need to collaborate with to plan for an evacuation?

(1) Like facilities—facilities that are both inside and outside your risk area. It is better to have residents go to an alternate space in a like facility than to go to a general population shelter.

(2) Local hospitals

(3) Other local medical providers

(4) First responders (fire, law)

(5) Transportation providers—include contracts/agreements and have at least one back-up provider. Consider all types of transport: buses, vans, cars, and ambulances.

(6) Food suppliers

(7) Local emergency management

(8) Medical supply companies

(9) Telecommunications

(10) Utilities—electric, water, sewage, trash, gas, etc.

(11) Security

(12) Volunteer organizations

(13) Local and state public health agency

h. What do you think are the benefits of one organization's risk assessment and emergency plan being integrated with other organizations' risk assessments and plans?

(1) Promote coordination among those that will respond together.

(2) Common risks—Within the same region, organizations will face many of the same risks. By working together a broader perspective of each risk and a more thorough analysis and assessment can be completed.

(3) Align roles and responsibilities across the region.

(4) Coordinate health care delivery system-wide exercise objectives.

(5) Establish communication plans with both other health care organizations and the public.

(6) Resource sharing and resource demand deconfliction—Many resources needed during an emergency can be planned together and shared among planning partners and coalitions. By assessing the regional health care resources, partners (through coalitions or other partnerships) can ensure continuity of health care delivery during an emergency and resource demand de-confliction (i.e., everyone is expecting to use the same transportation company).

(7) Test, exercise, and train together—Tests, exercises, and training events are more realistic when those that will work together during an event participate. If all plans within a particular region are connected then the exercises and training events will run more efficiently.

(8) Share leading practices and lessons learned.

i. How will/are you go(ing) about exploring engagement with community partners?

(1) Establish a functional coalition or join a functional coalition within your region to ensure continuity of care throughout all health sector plans.

(2) Engage with fellow health sector members to ensure continuity of care for patients and family members during and following an emergency.

j. How would/is this collaboration benefit(ing) resources and logistics planning for each healthcare agency or organization?

(1) According to Hick, Hanfling, and Cantrill, "Decisions about medical resource triage during disasters require a planned structured approach, with foundational elements of goals, ethical principles, concepts of operations for reactive and proactive triage, and decision tools understood by the physicians and staff before an incident." All of this requires solid resource management planning prior to a disaster or incident occurring.

(2) When anticipating resource shortfall, planners should prepare for the shortfall and plan for reallocations.

(a) Planning can identify and mitigate resource shortfalls by stockpiling commonly needed and often inexpensive items.

(b) Preparation should also include methods to maintain the equipment and supplies. For example, adherence to preventative maintenance, stock rotation, and restocking schedules.

(c) Resource reallocations can be planned prior to an emergency or incident. Planners should anticipate to the degree possible the types of health care needs and resource shortfalls that will occur and they must identify policy and operational adjustments that will need to take place in response.

(d) It is important to forge partnerships, memoranda of understanding, inter-hospital agreements, and other relationships with key stakeholders from the health care system, emergency management system, state and local public health systems, local emergency responders, emergency medical services, home health care, and other medical providers; volunteer agencies, public safety; and other public and private partners at all levels.

(e) Certain critical resources (e.g., ventilators) may have to be allocated to those patients most likely to benefit. These, clearly last resort options, should be planned for and decisions made long before a disaster occurs.

2. Risk Assessment

a. Preplanning is a key factor in minimizing risk to an organization and the people and community that it serves. Preplanning begins with a thorough assessment for relevant threats and hazards to a specific organization or area that have the potential to adversely affect the organization.

(1) All-hazards approach. An all-hazards approach to risk assessments is essential to gaining a full appreciation of the risks a facility may face. The all-hazards approach allows an ability to respond to a range of emergencies varying in scale, duration, and cause.

(a) A hazard is an act or condition posing the threat of harm, for example, an earthquake or a hurricane.

(b) A disaster is a serious and possibly sudden event on such a scale that the stricken community needs extraordinary efforts to cope with it, often with outside help (e.g., federal aid, surrounding communities). Disasters are a threat to the public's health because they cause:

1 Abrupt increases in illness, injury, or death

2 Destruction of the healthcare infrastructure

3 Population displacement stress

4 Changes in the environment

(c) Risk is defined as the expectation of loss. Disaster planning rests upon risk assessment, which includes a determination of the propensity of things to be damaged (vulnerability) and an assessment of the community resources that will diminish impact.

Risk = Hazard x (Vulnerability – Resources)

b. **Difference between Hazard Vulnerability Analysis (HVA) and Threat Hazard Identification and Risk Assessment (THIRA).** This course will discuss two types of risk assessment: HVAs and THIRAs. It is important to understand the difference between the two. Below is an explanation given by Donald M. Lumpkins, the Executive Director of the PPD-8 Program Executive Office in May 2012.

(1) "HVA which is one methodology and methodologies similar to it are really effective when you are talking about a constrained system. That could be a single facility or the transit system or things like that where you have a defined area with specific points of attack or points of exposure to hazards.

(2) What THIRA does is borrow from those processes but it is applied in a way that it lets us look at a geo-political environment. What we found is that if you took some of the traditional models that were used for critical infrastructure or key resources and try to overlay them on a full size county, or city, township or state, they didn't work right. They weren't designed for a diffuse environment. We took some lessons learned from that process and used them to help shape the THIRA but THIRA is designed more for the geo-political construct. The theory is that you are still doing HVA and looking at critical infrastructure and things like that. That information can help feed into the THIRA process.

(3) When you look in the toolkit and the guide where we talk about data sources, in a number of places we talk about using these existing efforts to feed into, as data sources, in this process and vice versa—the THIRA may feed into other assessments. Ultimately we would like to reduce the number of assessments but one of the lessons I've learned in the last eight years having joined the federal government that it is kind of like trying to reduce the number of screwdrivers you have. It gets to a point where there are different kinds of jobs that have to be done so you need a set of screwdrivers. One screwdriver just won't do it."

(4) Prior to developing an HVA or THIRA from scratch, check with the regional Healthcare Coalition, neighboring hospitals, or hospital partners. Hazards and risks are likely similar and you will want to partner with these organizations to plan.

c. **Hazard Vulnerability Analysis.** An HVA provides a systematic approach to recognizing hazards that may affect demand for the facility's services of its ability to provide those services. The risks associated with each hazard are analyzed to prioritize planning, mitigation, response, and recovery. The HVA serves as a needs assessment for the Emergency Management program and is the cornerstone of the facility's emergency operations plan (EOP). This process should involve community partners and be communicated to community emergency response agencies. For a health sector organization, a potentially vital partner for this process is the healthcare regional coalition.

(1) A HVA provides the facility with a common understanding about the hazard risks that it faces and helps to prioritize issues for the emergency management program to address.

(2) Three parts of the HVA contribute to the results, or risk, to an organization. These three parts are the event (hazard), probability, and severity.

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interuption of services*	*Preplanning*	*Time, effectivness, resouces*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Mass Casualty Incident (trauma)								0%
Mass Casualty Incident (medical/infectious)								0%
Terrorism, Biological								0%
VIP Situation								0%
Infant Abduction								0%
Hostage Situation								0%
Civil Disturbance								0%
Labor Action								0%
Forensic Admission								0%
Bomb Threat								0%
AVERAGE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

**Threat increases with percentage.*

Table 1: Hazard and Vulnerability Assessment Tool

(a) The first step is to identify and prioritize the likely hazards that the organization could face. These often overlap with hazards confronted by the organization and are typically identified using historical and current date from multiple sources.

1 This list of hazards should be all inclusive, covering every hazard that the planning committee can identify.

2 The list is a brainstorming exercise providing every possible event. Not all hazards will pose a risk to the facility, but when performing an HVA, every risk should be listed then analyzed.

3 The planning committee for the organization then scores each hazard to determine which ones pose a threat to the facility and which ones must be addressed because of that vulnerability. The facility cannot possibly prepare for every hazard as the cost would be prohibitive, therefore, the planers determine which hazards are the most serious and plan appropriately.

(b) These hazards are then sorted and prioritized. Significant impact on personnel and mission critical elements contributes to the ranking of the risk for each hazard. This ranking is called probability.

1 The probability of an event includes the known frequency or historical occurrence of specific hazards in the facility or community. Information may be available from facility records, local and state planning agencies, as well as national agencies.

2 Probability may also be based on concern or anticipated occurrence. For example, an industrial accident may have never occurrence in a community. However, construction of a new chemical plant may raise concern for a hazardous materials accident, thereby raising the likelihood of occurrence.

3 Probability entries are based on a scoring system. Each event is scored as to the probability of its occurrence. Scoring ranges from zero for no probability to three for a high probability. A healthcare facility in South Dakota would probably score the natural hazard of hurricane as a zero, while scoring severe winter storm as a three.

4 Scoring is a combination of using objective (i.e., data supported) and subjective (i.e., concern of potential) data inputs. This is important for estimating the risk of certain events that have the potential to occur.

5 In order to avoid over or underestimating risk, scoring should be based on the most realistic scenario. In addition, including internal and external evaluators will help normalize and validate risk scores.

(c) The third section of the HVA is severity. This is the magnitude of potential impact caused by a hazard. Severity is a more complex component. Within this section, the planning committee must consider the impacts caused by an incident as well as any efforts made to mitigate through preparedness and response activities.

1 By including impacts, preparedness, and response in the severity formula, one has a better overall understanding of risk to the organization posed by any specific event.

2 The severity portion is divided into six areas that are divided into two major groups: magnitude and mitigation. For scoring purposes the impacts scales ranges from low (0) to high (3), while the preparedness and responses scales from high (1) to low (3).

a Magnitude is the hazard's impact on a facility. This includes:

1) Human impacts—events that have the potential to cause staff, patient, visitor, or community deaths and injuries

2) Property impacts—events that cause damage to physical resources and require repair or replacement

3) Business impacts—events that interrupt regular business operations or that may negatively affect reputation, image, contracts, or regulations

b Mitigation is the facility's ability to mitigate the hazard. This includes:

1) Preparedness—includes any activity that improves overall response capability such as regularly reviewing the hospital HVA, updating the Emergency Management Plan, or conducting routine staff training

2) Internal response—activities that improve an organization's ability to respond and recover from an incident such as conducting effective exercises, having sufficient supplies accessible, supporting a timely alert and notification program, and developing business continuity plans

3) External response—activities that assist an organization in sustaining operations during an incident including creating pre-established memoranda of understanding with other healthcare facilities and suppliers, coordinating planning activities with community agencies, and ensuring broad communication capability during a disaster

3 The final step in completing the HVA is to calculating the risk.

$$\text{Relative Risk} = \left[\frac{\text{Probability of Event Occurrence (0-3)}}{3}\right] * \left[\frac{\text{Human Impact (1-3)} + \text{Property Impact (1-3)} + \text{Business Impact (1-3)} + \text{Preparedness (1-3)} + \text{Internal Response (1-3)} + \text{External Response (1-3)}}{18}\right]$$

Figure 1. Formula for Calculating Relative Risk

(d) For example, let's evaluate the risk factors of an earthquake for a given hospital.

1 The hospital provides a score of a 1 for the probability of the earthquake. So plugged into the formula, the probability of the earthquake would be 1 divided by 3 (the maximum score) giving a result of 0.33.

2 We can estimate that the impacts resulting from an earthquake will be high.

a Human Impact = 3

b Property impact = 3

c Business impact = 3

3 The hospital has implemented several seismic mitigation and planning activities; therefore the preparedness and mitigation numbers would be

a Preparedness = 1

b Internal response = 1

c External response = 1

4 To calculate severity, add all impact scores with preparedness and response scores and divide by the maximum score (18). This will give an earthquake severity score of 0.67.

5 Then following through with the equation, multiply the probability (0.33) times the severity (0.67) to get 0.22 (or 22%) relative risk.

6 The probability of an earthquake is low, but the impacts would be very high, therefore the mitigation and response actions taken have offset those impacts and given a seemingly low relative risk to the hospital.

(e) Steps are taken to prevent or reduce the risks (mitigation) or to address the consequences post-impact (preparedness). For example, a backup notification system can be developed (mitigation) or procedures established that will guide participants if the notification system fails (preparedness). This demonstrates the important link between the HVA process and other emergency management program activities.

(f) The HVA process is constant and should be reviewed on an annual basis or after major incidents.

d. Threat and Hazard Identification and Risk Assessment

(1) Taking those individual facility identified risks, and incorporating them into a larger, community or regionally focused THIRA can help build collaboration across the preparedness and planning spectrum for a community or region. This collaboration allows all healthcare providers and suppliers to be engaged in the planning process.

(2) According to the *2017 Health Care Preparedness and Response Capabilities* document released by HHS ASPR, the HVA process should be coordinated with the state and local emergency management THIRA and any public health hazard assessments.

(3) According to the *Comprehensive Preparedness Guide* (*CPG*) 201, "every community should understand the risks it faces. By understanding its risks, a community can make smart decisions about how to manage risk, including developing needed capabilities" (p.1). The THIRA offers communities and jurisdictions a tool to identify what threats and hazards that may affect them and then assess the risks of these actually occurring.

(4) The three parts of the THIRA tool are threat, hazard, and risk.

(a) Threat—A natural or man-made occurrence, individual, entity, or action that has or indicates the potential to harm life, information, operations, the environment and/or property.

(b) Hazard—Natural or man-made source or cause of harm or difficulty.

(c) Risk—Potential for an unwanted outcome resulting from an incident, event, or occurrence, as determined by its likelihood and the associated consequences.

(5) A community or jurisdiction also has to account for the resources they have and plan for any gaps in their resource needs. These resources include, but are not limited to:

(a) Properly trained personnel

(b) Necessary teams

(c) Equipment

(d) Vehicles

(6) The THIRA process is a 4 step process established to assist communities and jurisdictions identify the threats, hazards, and risks that have the most likelihood of occurring within their response areas. These steps are as follows.

(a) Step 1: Identify the threats and hazards of concern. This step allows planning contributors to bring in their own identified threats and hazards from their organizations and discuss why some organizations are more affected by specific threats and hazards then others. This step requires the planners to determine only those threats and hazards that are of significant concern. Two factors are used in this determination

1 Likelihood of incident

2 Significance of Threat/Hazard Event

(b) Step 2: Give the threats and hazards context. This step takes the HVA analysis to a deeper level. It requires the planner to take into account the time, place, and condition in which threats or hazards might occur. Communities can use expert judgement or analysis of probability and statistics to inform the descriptions of the different threat and hazard conditions. Consider the following types of questions when developing context for each threat and hazard

1 How would the timing of an incident affect the community's ability to manage it? What time of day and what season would be most likely or have the greatest impacts?

2 How would the location of an incident affect the community's ability to manage it? Which locations would be most likely or have the greatest impacts? Populated areas? Coastal zones? Industrial or residential areas?

3 What other conditions or circumstances make the threat or hazard of particular concern? Atmospheric conditions (e.g., wind speed/direction, relative humidity)? Multiple events occurring at the same time?

4 The table below shows an example of the context descriptions. The community included the following two threats and hazards in its THIRA: an earthquake and a terrorist attack using an improvised explosive device. Each of these threats and hazards includes a context description outlining the conditions, including time and location, which are most relevant to the community.

Threat/Hazard	Earthquake	Terrorism
Context Description	A magnitude 7.8 earthquake along the Mainline Fault occurring at approximately 2:00 PM on a weekday with ground shaking and damage expected in 19 counties, extending from Alpha County in the south to Tau County in the north, and into the Zeta Valley.	A potential threat exists from a domestic group with a history of using IEDs in a furtherance of hate crimes. There are a number of large festivals planned during the summer at open air venues that focus on various ethnic and religious groups. These events draw an average 10,000 attendees daily.

Table 2: Example of Context Descriptions

(c) Step 3: Establish capability targets. Capability targets define success for each core capability based on the threat and hazard contexts developed in Step 2. Communities apply the capability targets from this step to generate resource requirements and consider preparedness activities, including opportunities for mitigation in Step 4.

1 Capability targets should be specific and measurable. To develop specific and measurable targets, community planners should consider impacts and desired outcomes for each threat and hazard.

a Impacts describe how a threat or hazard might affect a core capability

b Desired outcomes describe the timeframe or level of effort needed to successfully deliver core capabilities.

2 Impacts should be specific and include quantitative descriptions as much as possible to allow jurisdictions to gain an understanding of what is needed to manage risk. Communities can use a range of inputs, including expert judgement and advanced modeling, to consider impacts. Communities may seek to express impacts using the following types of categories:

a Size of geographic area affected

b Number of displaced households

c Number of fatalities

d Number of injuries or illnesses

e Disruption to critical infrastructure

f Intelligence requirements and needs

g Amount of direct economic impacts

h Economic effects of supply chain disruption

3 Desired outcomes describe the timeframe or level of effort needed to successfully deliver core capabilities. Capabilities are only useful if communities can deliver them in a timely and effective manner. For example, success in the Response and Recovery mission areas often requires communities to deliver capabilities within a certain timeframe (e.g., complete search and rescue operations within 72 hours). Other mission areas may be better presented in terms of percentages (e.g., ensure 100% verification of identify to authorize, grant, or deny physical and cyber access to specific locations).

4 When considering desired outcomes, communities should not be constrained by current ability to meet timeframes or other conditions of success. Communities should consider various types of time-based desired outcomes. Table 3 contains examples of these time-based desired outcomes.

Outcome Type	Example Outcome Description
Completing Operations	Complete evacuation of neighborhood within four hours
Establishing services	Establish feeding and sheltering operations for displaced populations within 24 hours
Service duration	Maintain behavioral screening checks for affected population for one month
Combination	Establish feeding and sheltering operations within 24 hours and maintain services for a period of two weeks

Table 3: Example Time-based Desired Outcomes

5 Capability targets define success and describe what the community wants to achieve for each core capability. Communities should combine quantitative details from impacts and desired outcomes to develop capability targets. For example, for the above context description (in Table 2) the Capability Target for the Mass Search and Rescue Operations could be

Within 72 hours, rescue:

5,000 people in 1,000 completely collapsed buildings

10,000 people in 2,000 non-collapsed buildings

20,000 people in 5,000 buildings

1,000 people from collapsed light structures

(d) Step 4: Applying the results. Communities apply the results of the THIRA by estimating the resources required to meet capability targets. Communities express resource requirements as a list of resources needed to successfully manage their threats and hazards. Communities can also use resource requirements to support resource allocation decisions, operations planning, and mitigation activities. This is accomplished through capability estimation, resource typing, and applying these results to resource allocation decisions and mitigation activities.

1 Capability estimation

a To estimate resource requirements, communities should consider the resources needed to achieve the capability targets from Step 3. As a first step, community planners can identify the major actions needed to achieve their capability targets. Planners should avoid developing very detailed tactical-level task lists. Rather they should strive to identify mission-critical activities.

b Planners should consider the quantity and types of resources needed to complete each mission-critical activity in support of the capability targets. Each planning group must decide which combination of resources is most appropriate to achieve its capability targets. While any number of combinations may achieve success, communities should consider costs, benefits the resources provide, and the ability to manage the risks associated with each potential solution. Different solutions may fit best within different communities' political and economic frameworks.

2 Resource Typing is categorizing by capability, the resources requested, deployed, and used in incidents. Resource typing helps communities request and deploy needed resources through the use of common terminology. Communities should develop resource requirements expressed as a list of NIMS-typed resources or other standardized resources.

a Type I represents resources that are included in the national resource typing definitions.

b Tier II includes all typed resources defined by the states, tribal, and local jurisdictions, non-governmental organizations, and others that are not predefined in the Tier I definitions.

3 Applying the THIRA results to resource allocation decisions and preparedness activities is the final part of Step 4. Planners can apply their THIRA results to allocate resources and inform preparedness activities (i.e., the emergency preparedness plan) and mitigation opportunities.

a Resource Allocation Decisions. Planners can use the THIRA results to make decisions about how to allocate limited resources. By establishing resource requirements, a community determines the resources needed to achieve capability targets. In some cases, THIRA results may indicate a need to sustain existing capabilities. In other cases, results may identify resource shortfalls and capability gaps. Planners can build capabilities and fill gaps in a variety of ways. For example they can:

1) Establish mutual aid agreements with surrounding communities

2) Work with whole community partners (e.g., faith-based organizations) to augment capabilities

3) Invest community or grant dollars

4) Request technical assistance for planning or exercises to help deploy resources more effectively

b Preparedness activities, including mitigation opportunities, identified by the THIRA results may reduce the amount of resources required in the future. Through the THIRA process, communities can identify opportunities to employ mitigation plans, projects, and insurance to reduce the loss of life and damage to property. The results can also drive the priorities within the emergency plans of both the community and contributing members.

(7) If allowed or requested, health sector providers and suppliers, can participate in the THIRA process. However, even if providers and suppliers do not participate in the development, looking to the THIRA for the analysis of the community/jurisdiction is a wise starting point.

3. Emergency Preparedness Plans

a. Planning Principles

(1) A plan is simply the documented outcome of a planning process and the process is as critical if not more so, than the document.

(2) Planning should include all internal and external stakeholders affected by the plan (i.e., if the plan requires the local law enforcement or ambulance service to help, they should be included in the planning process).

(3) Planning uses a logical, analytical, problem-solving process. By following a set of logical steps that includes gathering and analyzing information, determining operational objectives, and developing alternative ways to achieve the objectives, planning allows a healthcare facility to work through complex situations. Rather than concentrating on every detail of how to achieve the objective, an effective plan structures thinking and supports insight, creativity, and initiative in the face of an uncertain and fluid environment.

(4) Planning considers all threats and hazards. While the causes of emergencies can vary greatly, many of the effects do not. Planners can address common operational functions in their basic plans instead of having unique plans for every type of threat or hazard. For example, numerous situations may lead to an evacuation. Even though each situation may have different characteristics (e.g., speed of onset, size of the affected area), the general tasks for conducting an evacuation are the same. Planning for all threats and hazards ensures that, when addressing emergency functions, planners identify common tasks and those responsible for accomplishing the tasks.

(5) Planning should be flexible. Scalable planning solutions are the most likely to be understood and executed properly by the operational personnel who have practice in applying them. Planners test whether critical plan elements are sufficiently flexible by exercising them against scenarios of varying types and magnitudes.

(6) Plans must clearly identify the mission and supporting goals. More than any other plan element, the clear definition of the mission and supporting goals, with desired results,

enables unity of effort and consistency of purpose among the multiple groups and activities involved in executing the plan.

b. **Plan Development Process.** Regardless of the type of facility, the plan development process is standard. For more information refer to *Developing and Maintaining Emergency Operations Plans* (CPG 101).

(1) Collaborative Planning Team. Establishment of a planning team is the first step in the planning process. This team should work together to ensure that the final outcome meets the needs of the organization. The team should also ensure all stakeholders are collaborated with in the development of the plan.

(2) Understanding the Situation. To understand the situation within a community or jurisdiction, the team should identify the hazards and threats and assess the risks. Incorporating the HVA and THIRA results into this step of the process eliminates the potential for duplication of efforts.

(3) Determine the Goals and Objectives. In determining goals and objectives of a preparedness plan, the team should use all available risk assessments to ensure the appropriate threats, hazards, and risks are identified. Ensure that not only goals and objectives are identified, but all so the desired outcomes and end results for each goal and objective. Again, this part of the process was begun by completing an HVA or THIRA, applying those results here ensures the plan focuses on the primary goals and objectives for the facility or organization.

(a) Goals are broad, general statements that indicate the intended solution to problems identified by planners during the previous step.

(b) Objectives are more specific and identifiable actions carried out during the operation.

(4) Plan Development

(a) Develop and Analyze Courses of Action. Using the HVA and THIRA courses of action are developed and analyzed for each hazard or vulnerability the facility may face. For instance, if tornadoes are a threat to the area the facility is in, then a course of action should be developed specifying the actions that should be taken if the facility is directly hit and/or impacted by a tornado. A course of action should also be developed for if the facility is indirectly impacted by a tornado.

(b) Identify Resources. Once a course of action is developed, then resources for that action should be identified. The THIRA identified resources, but each individual facility will need to take an inventory of their own resources that will be needed. Planners need to ensure resources are readily available or can be readily accessed following an emergency situation. Resources that are not currently acquired need to be purchased or agreements need to be made to ensure they are available when needed.

(c) Resource planning. Depending on the action and resources required, the necessary resources may not always be readily available and/or even acquired. Planning for the availability of each resource is necessary for the overall plan to be

a success. This planning may include collaboration with other providers/suppliers, researching grant opportunities for acquiring necessary resources, and adjusting budgets to ensure the acquisition of required resources.

1 Critical infrastructure supporting health care (e.g., utilities, hospital infrastructure, roadways)

2 Hospital services – inpatient, outpatient, emergency department, and support services

3 Ambulatory health care service delivery

4 Health care workforce

5 Health care supply chain

6 Medical and non-medical transportation system

7 Health care information systems and communications (facility or health system)

8 Electronic platforms for HCC information sharing and coordination activities and appropriate redundancies

9 Caches and community emergency assets

10 Private sector assets that can support emergency operations

(d) Identify Information and intelligence needs. Another outcome from the course of action development is a list of the information and intelligence needs for each of the response participants. Planners should identify the information and intelligence they will need and their deadlines for receiving it to drive decisions and trigger critical actions.

(5) Plan Preparation, Review, and Approval

(a) Write the plan. This step turns the results of course of action development into an emergency plan. The planning team develops a rough draft of the basic plan, functional annexes, hazard-specific annexes, or other parts of the plan as appropriate. As the planning team works through successive drafts, the members add necessary tables, charts, and other graphics. Following these simple rules for writing plans and procedures will help ensure that readers and users understand their content:

1 Keep the language simple and clear by writing in plain English. Summarize important information with checklists and visual aids.

2 Avoid using jargon and minimize the use of acronyms.

3 Use short sentences and the active voice.

4 Provide enough detail to convey an easily understood plan that is actionable.

5 Format the plan and present its contents so that its readers can quickly find solutions and options. When writing a play "stay out of the weeds." Procedural documents (e.g., SOPs and SOGs) should provide the fine details.

6 Ensure accessibility by developing tools and documents so they can be easily converted to alternate formats.

(b) Review the plan. Planners should check the written plan for its:

1 Adequacy—A plan is adequate if the scope and concept of planned operations identify and address critical tasks effectively.

2 Feasibility—A plan is feasible if the organization can accomplish the assigned mission and critical tasks by using available resources within the time contemplated by the plan.

3 Acceptability—A plan is acceptable if it meets the requirements driven by a threat or incident, meets decision maker and public cost and time limitations, and is consistent with the law.

4 Completeness—A plan is complete if it:

a Incorporates all tasks to be accomplished

b Includes all required capabilities

c Integrates the needs of the whole community (general population, access and functional needs individuals, children, etc.)

d Provides a complete picture of the sequence and scope of the planned response operations

e Makes time estimates for achieving objectives

f Identifies success criteria and a desired end-state

5 Compliance—The plan should comply with guidance and doctrine to the maximum extent possible, because these provide a baseline that facilitates both planning and execution.

(c) Approve and Disseminate the Plan. Once the plan has been validated, the planners should present the plan to the appropriate officials and obtain official approval of the plan. Once the plan is officially approved, the planners should arrange to distribute the plan and make it available in alternate formats and upon request.

(6) Plan Implementation and Maintenance

(a) Training. After developing a plan, it must be disseminated and managers must be required to train their personnel so they have the knowledge, skills, and abilities needed to perform the tasks identified in the plan. Personnel should also be

trained on the organization-specific procedures necessary to support those plan tasks.

(b) Exercise the Plan. Evaluating the effectiveness of plans involves a combination of training events, exercises, and real-world incidents to determine whether the goals, objectives, decisions, actions, and timing outlined in the plan led to a successful response.

(c) Review, Revise and Maintain the Plan. This step closes the loop in the planning process. It focuses on adding the information gained by exercising the plan and starting the planning cycle over again. Planning is a continuous process that does not stop when the plan is published. Plans should evolve as lessons are learned, new information and insights are obtained, and priorities are updated.

(7) Templates. Once all the information is gathered and considered, numerous templates exist that planners can use to organize the information in a usable format. Planning does not have to begin from scratch. Taking advantage of the experience of other planners, as well as, plans generated by other facilities and coalitions can help the planning process.

c. **Considerations.** Planners should give special consideration to the type of facility in which they are planning. Even though all facilities should have an emergency preparedness plan, 17 specific providers and suppliers are affected by the final rule, *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers.* Each type of facility has unique considerations during the planning stage. All facilities must develop a plan based on a risk assessment using an all-hazards approach, which is an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies and disasters. The plan must be updated annually. However, in addition to this requirement, the rule also has some special considerations for specific facilities which CMS expects to be met by November 15, 2017. These include:

(1) Long-Term Care (LTC) Facilities—Must account for missing residents.

(2) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)—Must account for missing residents.

(3) Comprehensive Outpatient Rehabilitation Facilities (CORFs)—Must develop the emergency plan with assistance from fire and safety experts and plan for their patient population.

(4) Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services—Must develop the emergency plan with assistance from fire and safety experts. The plan must also address the location and use of alarm systems and signals, as well as, the methods of containing fires.

(5) Organ Procurement Organizations (OPOs)—Must address type of hospitals the OPO has an agreement with.

(6) End-Stage Renal Disease (ESRD) Facilities—Must contact local emergency preparedness agency annually to ensure dialysis facility's needs in an emergency.

d. For additional information on each specific difference, it is highly recommended that providers/suppliers review the CMS regulation in its entirety.

e. Annexes

(1) Annexes are the parts of an emergency plan that begin to provide specific information and direction.

(2) Annexes should focus on operations, what the function is and who is responsible for carrying it out. While the basic plan provides information relevant to the emergency plan as a whole, annexes should emphasize responsibilities, tasks, and operational actions that pertain to the function being covered.

f. What annexes might be included in the plan?

(1) Annexes should clearly define and describe the policies, processes, roles, and responsibilities inherent in the various functions before, during, and after any emergency period. To ensure adequate planning for all appropriate contingencies, it may be necessary to spend time projecting the consequences of various emergencies.

(2) The following is a listing of potential annexes to the EOP.

(a) Warning—this annex is used to outline the organization, operational concepts, responsibilities and procedures to disseminate timely and accurate warnings to the organization or agency

(b) Communications—this annex is to provide information about communications services, procedures, equipment and services available during emergency operations

(c) Shelter and Mass Care—this annex outlines operational concepts and organizational arrangements for shelter and mass care during emergency situations for the organization or agency

(d) Evacuation—this annex is to provide for the orderly and coordinated evacuation of all or part of the organization or agency population from facilities if it is determined that such action is the most effective means available for protecting the population from the effects of an emergency situation

(e) Public Information—this annex outlines the means, organization and process by which an organization or agency will provide appropriate information and instructions to the public during emergency situations

(f) Resource Management—this annex provides guidance and outline procedures for efficiently obtaining, managing, allocating, and monitoring the use of resources during emergency situations or when such situations appear imminent

(g) Recovery—this annex defines the operational concepts, organizational arrangements, responsibilities and procedures to accomplish the tasks required of the organization or agency's employees and patients to recover from a major emergency or disaster

g. What are some additional requirements that may need to be included as annexes?

h. Memorandums of Understanding and Mutual Aid Agreements. During an emergency, collaborations among healthcare entities can be vital to secure the health of individuals and populations. These collaborative efforts are formularized through MOUs and MAAs.

i. What types of MOUs and MAAs should be part of the planning process?

(1) The mutual aid support concept is well established and is considered "standard of care" in most emergency response disciplines. Health care organizations and agencies should consider MOUs with organizations that can provide them resources and services during emergencies and disasters. MOUs are established between hospitals, other healthcare providers and/or emergency response agencies to identify their agreements to collaborate, communicate, respond and support one another during a disaster or other public health emergency.

(2) Understandings regarding the incident command structure, patient and resource management, processes and policies in place for requesting and sharing of staff, equipment, and consumable resources, as well as payment, are generally addressed in a local mutual aid MOU.

(3) Examples include MOUs between a healthcare organization/agency and

(a) Local hospitals for patient transfer, supplies, equipment, pharmaceuticals and personnel

(b) Local nurse registry agencies, temporary agencies, and security personnel providers

(c) Other local healthcare providers including clinics and long term care facilities for personnel, supplies, equipment, and transportation

(d) Venders and suppliers for healthcare and non-health care resources including linen and fuel

(e) County government for services including transportation and security; for supplies; and for assistance in managing the treatment and transportation of staff and patients

(f) Third party payers to suspend lag time for payments

4. Continuity of Operations

a. Disasters and public health emergencies can have a significant impact on the population and critical infrastructure, and health care personnel and facilities are no exception. Plans should allow medical facilities and providers to sustain their mission, core essential functions and services for patients already receiving care. Plans should also allow providers and facilities to respond to potential surges in patients when space, staffing (including leadership), and equipment/supply issues are required.

b. The goal is to ensure continuity of operations and facilitate operational and financial recovery. A well thought out emergency plan includes plans for continuity of operations for the health care organization and/or agency throughout and following an emergency.

c. **How is your organization preparing for potential COOP situations?** For more information https://asprtracie.hhs.gov/technical-resources/17/continutity-of-operations-coop-failure-plan/16.)

5. Question and Answer. This is a time dedicated to any questions students may have that have not been addressed to this point in the module.

ADDITIONAL RESOURCES

ASPR TRACIE Evaluation of Hazard Vulnerability Assessment Tools. https://asprtracie.hhs.gov/documents/tracie-Evaluation-of-HVA-tools.pdf

Hazard Vulnerability/Risk Assessment Topic Collection. https://asprtracie.hhs.gov/technical-resources/3/Hazard-Vulnerability-Risk-Assessment/1

Emergency Operations Plans/Emergency Management Program Topic Collection. https://asprtracie.hhs.gov/technical-resources/84/Emncy-Operations-Plans-Emncy-Management-Program/1

Continuity of Operations Planning Topic Collection. https://asprtracie.hhs.gov/technical-resources/17/continuity-of-operations-coop-failure-plan/16

REFERENCES

Agency for Healthcare Research and Quality. (2007). Mass Medical Care with Scarce Resources: A Community Planning Guide. Available from http://www.calhospitalprepare.org/sites/main/files/resources/Mass%20Medical%20Care%20with%20Scarce%20Resources.pdf

California Hospital Association. (2017). *Memoranda of Understanding*. Available from http://www.calhospitalprepare.org/memoranda-understanding

Hick, J.L., Hanfling, D., Cantrill, S.V. 2012 *Allocating Scare Resources in Disasters: Emergency Department Principles.* Annuals of Emergency Medicine. Volume 59, Issue 3, Pages 177-187. Retrieved from http://www.annemergmed.com/article/S0196-0644(11)00676-7/fulltext

Hodge, J.G. and Anderson, E., Teret, S.P., Vernick, J.S., Kirsch, T.D., Kelen, G. (2009). Model Memorandum of Understanding Between Hospitals during Declared Emergencies. https://emergency.cdc.gov/planning/emac/pdf/pacer_model_mou.pdf

Kaiser Permanente. (2017). HVA Tool/Template. Available from http://www.calhospitalprepare.org/hazard-vulnerability-analysis

Lumpkins, D.M., Sebring, A. (2012). *Threat and Hazard Identification and Risk Assessment. EM Forum Presentation*. Available from http://www1.udel.edu/DRC/emforum/recordings/20120509.html

U.S. Department of Homeland Security. Federal Emergency Management Agency. (2010). *CPG 101: Developing and maintaining emergency operations plans.* Available from https://www.fema.gov/media-library/assets/documents/25975

U.S. Department of Homeland Security. Federal Emergency Management Agency. (2013). *CPG 201: Threat and Hazard Identification and Risk Assessment Guide.* Available from https://www.fema.gov/media-library/assets/documents/26335#

U.S. Health and Human Services. Office of the Assistant Secretary Preparedness and Response. *CMS Emergency Preparedness Rule: Resources at Your Fingertips*. https://asprtracie.hhs.gov/.../cms-ep-rule-resources-at-your-fingertips.pdf

U.S. Health and Human Services. Office of the Assistant Secretary Preparedness and Response. Public Health Emergency. Medical Surge Capacity Capability. MSCC Healthcare Coalition. https://www.phe.gov/Preparedness/planning/mscc/healthcarecoalition/chapter5/Pages/hazards.aspx

U.S. Health and Human Services. Office of the Assistant Secretary Preparedness and Response. TRACIE Healthcare Emergency Preparedness Information Gateway. *Emergency operations plans/Emergency management program topic collection.* https://asprtracie.hhs.gov/documents/EMP-EOP.pdf

U.S. Health and Human Services. Office of the Assistant Secretary Preparedness and Response. (2017). *2017-2022 Health Care Preparedness and Response Capabilities.* Available from https://phe.gov/Preparedness/planning/hpp/reports/Documents/2017-2022-healthcare-pr-capablities.pdf

Health Sector Emergency Preparedness
AWR-366

Student Guide

Module 4
Policies and Procedures

Number: Module 4

Title: Policies and Procedures

Purpose. The purpose of this module is to provide a discussion of the development and maintenance of an emergency preparedness policies and procedures for a health sector facility.

Learning Objectives

a. **Terminal Learning Objective.** Determine requirements and considerations for creating emergency preparedness policies and procedures for a health sector facility consistent with emergency planning principles and best practices. (HC-0260)

b. **Enabling Learning Objectives**

(1) Define emergency preparedness policies and procedures according to emergency preparedness policy and procedures principals and best practices. (HC-0260a)

(2) Determine the emergency preparedness policies and procedures requirements in accordance with the *CMS Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* Rule. (HC-0260b)

(3) Determine the required elements for emergency preparedness policies and procedures consistent with emergency preparedness planning principles and best practices. (HC-0260c)

1. Definition of Emergency Preparedness Policies and Procedures

a. Policies and procedures serve to operationalize the emergency plan to ensure that the processes described in the plan can actually be executed. Having plans that look good, check the boxes, but cannot actually be executed are not effective plans and don't meet the intent of the rule.

b. Policies and procedures allow the actions described in the emergency operations plan to be executed.

c. Policies and procedures are designed to influence and determine all major decisions and actions, and all activities take place within the boundaries set by them. Procedures are the specific methods employed to express policies in action in day-to-day operations of the organization. Together, policies and procedures ensure that a point of view held by the governing body of an organization is translated into steps that result in an outcome compatible with that view.

2. Emergency Preparedness Policies and Procedures Elements

a. Following the development of an emergency plan, policies and procedures are developed for the identified functional areas that require more specific information and direction. Under CMS's Final Rule, providers and suppliers are required to develop and implement emergency preparedness policies and procedures based on the emergency plan, the risk assessment proposed, and the communication plan. The policies and procedures are to be reviewed and updated at least annually.

b. What functions identified by the risk assessment and emergency plan could be developed into policies and procedures?

(1) Subsistence

(a) The organization's policies and procedures need to address the provision of subsistence needs for staff and patients, whether they evacuated or sheltered in place, including, but not limited to food, water, and medical supplies.

(b) The organization's policies and procedures must address how the subsistence needs of patients and staff that were evacuated would be met during an emergency.

(2) Infrastructure

(a) The organization must have policies and procedures that address the provision of alternate sources of energy to maintain:

1 Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions;

2 Emergency lighting; and

3 Fire detection, extinguishing, and alarm systems

(b) The organization must develop policies and procedures to address the provisions of sewage and waste disposal including solid waste, recyclables, chemical, biomedical waste, and waste water.

(3) Patient Tracking

(a) The organization must develop policies and procedures regarding a system to track the location of staff and patients in the organization's care, both during and after an emergency. It is imperative that the organization be able to track a patient's whereabouts, to ensure adequate sharing of patient information with other facilities and to inform a patient's relatives and friends of the patient's location within the organization, whether the patient has been transferred to another facility, or what is planned in respect to such actions.

(b) A requirement is not proposed for a specific type of tracking system. The organization should have the flexibility to determine how best to track patients and staff, whether it uses an electronic database, hard copy documentation, or some other method.

(c) The information must be readily available, accurate, and shareable among officials within and across the emergency response system.

(4) Evacuation and Shelter-in-Place

(a) Organizations must have policies and procedures in place to ensure safe evacuation from the organization, which would include consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

(b) Organizations must have policies and procedures to address a means to shelter in place for patients, staff, and volunteers who remain in the facility. Organizations must include in their policies and procedures both the criteria for selecting patients and staff that would be sheltered in place and a description of how they would ensure their safety.

(5) Patient Records

(a) Organizations are required to have a system of medical documentation that would preserve patient information, protect the confidentiality of patient information, and ensure that patient records are secure and readily available during an emergency.

(b) Organizations are required to ensure that patient records are secure and readily available during an emergency and are in compliance with Health Insurance Portability and Accountability Act (HIPAA) Rules.

(6) Volunteer Management. The facilities must have policies and procedures in place to address the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of state or federally designated healthcare professionals to address surge needs during an emergency.

(7) Continuity of Operations

(a) Organizations must have a process for the development of arrangements with other organizations and other facilities to receive patients in the event of limitations or cessation of operations at their facilities, to ensure the continuity of services to organization patients. This requirement would apply only to facilities that provide continuous care and services for individual patients.

(b) Although this applies to facilities who provide continuous care, many other organizations may request transfers as well. For example, home health agencies may decide it is too dangerous for a patient to remain at home and could shift them into a hospital or other care facility.

(8) Alternate Care. Organization policies and procedures would have to address the role of the organization under a waiver declared by the HHS Secretary for the provision of care and treatment at an alternate care site identified by emergency management officials. This requirement is for inpatient providers only.

(9) Medicare, Medicaid, and CHIP Requirements. Healthcare providers must ensure that sufficient healthcare items and services are available to meet the needs of individuals enrolled in Medicare, Medicaid, and Children's Health Insurance Programs (CHIP) in an emergency area during any portion of an emergency period.

(10) Resource Management. Many resources are needed to support the preparedness program. These resources can be organized into different categories. Health care organizations must ensure each category of resources is addressed as necessary.

(a) Staff

(b) Equipment and Supplies

(c) Funding

(d) Information

3. Developing Emergency Preparedness Plan Policies and Procedures

a. Form a team.

(1) Similar to developing the emergency plan, collaboration is essential to developing functional policies and procedures. If the policy or procedures involve other agencies, developing and reviewing needs and solutions together will ensure functionality. (As a note, transplant cents should be part of the hospital's team.)

(2) Facilities who are part of an integrated health system can have policies and procedures as a system. However, upon a survey, each facility is required to demonstrate compliance. If integrated health system policies and procedures are done as a whole, but facilities are geographically spread out and have different hazards, then this should be considered.

b. **Write the policies and procedures.** The next step is to develop and write the policies and procedures. The following guidance can assist in ensuring the documents are followed when specific instances arise.

(1) Description of purpose or rationale statement—Describe the purpose of the policy and/or procedures, why it is needed, and what it intends to accomplish.

(2) Scope—Describe the situations for which the policy and procedures should be activated and used.

(3) Target audience—Take into account who will be reading and functioning under the policies and procedures is essential.

(4) Level of detail—Ensure necessary details are included, but avoid unnecessary details that will only cause confusion during an emergency situation.

c. **Review, implement, and practice the policies and procedures**

d. **Assume you are responsible for writing the policies and procedures for an evacuation plan at your Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IIDs), what considerations should be taken?**

(1) Interagency coordination. Many times organizations develop policies and procedures in isolation. However, they depend on other organizations to help carry out the processes. Everyone involved in the implementation of the policies and procedures should be involved in the development.

(2) Specific patient needs. Not all patients are alike, any specific needs for patients should be considered during the planning process. Does a patient need to have constant supervision when in unknown surroundings or is there specific dietary concerns of a patient. All of these issues need to be addressed prior to an evacuation situation.

(3) Staffing needs. Given the fact that patients needing specific types of care may have to go to a variety of different facilities, what will the new staffing needs be?

(4) Medical devices/pharmaceuticals. What specific medical devices and medications need to be transferred with the patients? How will these decisions affect modes of transportation (i.e., if an individual is in a wheelchair, wheelchair accessible vehicles may have to be obtained)?

(5) Patient management and tracking. How will the facility keep up with who goes where and if they arrived safely? Will patient records be transferred with patient, electronically ahead of time?

(6) Family member notifications. How and when will family members be notified on the evacuation?

ADDITIONAL RESOURCES

Continuity of Operations (COOP)/Failure Plan. https://asprtracie.hhs.gov/technical-resources/17/Continuity-of-Operations-COOP-Failure-Plan/16

Alternate Care Sites (including shelter medical care). https://asprtracie.hhs.gov/technical-resources/48/Alternate-Care-Sites-including-shelter-medical-care/47

Crisis Standards of Care. https://asprtracie.hhs.gov/technical-resources/63/Crisis-Standards-of-Care/60

Healthcare-Related Disaster Legal/Regulatory/Federal Policy. https://asprtracie.hhs.gov/technical-resources/83/Healthcare-Related-Disaster-Legal-Regulatory-Federal0Policy/1

Hospital Surge Capability and Immediate Bed Availability. https://asprtracie.hhs.gov/technical-resources/58/Hospital-Surge-Capacity-and-Immediate-Bed-Availability/56

Patient Movement and Tracking. https://asprtracie.hhs.gov/technical-resources/70/patient-movement-and-trackingforward-movement-of-patients-tracking-and-tracking-systems/60

REFERENCES

FEMA (November 2010). *Developing and Maintaining Emergency Operations Plans—Comprehensive Preparedness Guide (CPG) 101 Version 2.0.* Retrieved from https://www.fema.gov/media-library-data/20130726-1828-25045-0014/cpg_101_comprehensive_preparedness_guide_developing_and_maintaining_emergency_operations_plans_2010.pdf

FEMA (September 1996). *Guide for All-Hazard Emergency Operations Planning—State and Local Guide*. Retrieved from https://www.fema.gov/pdf/plan/slg101.pdf

U.S. Government Publishing Office (January 2017). *Electronic Code of Federal Regulations.* Retrieved from http://www.ecfr.gov/cgi-bin/text-idx?SID=f6b796ea838e6e3741609abd77ad3346&mc=true&node=pt42.4.441&rgn=div5#se42.4.441_1184

WebFinance Inc. (2017). *BusinessDictionary—Policies and Procedures*. Retrieved from http://www.businessdictionary.com/definition/policies-and-procedures.html

Annex A

Overview of the Emergency Preparedness Plan Policies and Procedures Requirements for the Other Health Care Facilities

Below is a summarization of the Final Rule. For thorough information regarding a specific provider or supplier, please reference CMS regulatory and sub-regulatory guidance.

a. Emergency Preparedness Plan Policies and Procedures requirements will be listed by provider type (inpatient/outpatient). The organization preparedness requirements are the baseline for all facilities.

(1) Organization (42 CFR 482.1)

(a) Refer to 42 CFR 482.15

(2) Critical Access Organization (CAH) (42 CFR 485.625)

(a) The CAH must develop and implement emergency preparedness policies and procedures, based on the emergency plan, risk assessment, and the communication plan. The policies and procedures must be reviewed and updated at least annually.

(b) At a minimum, the policies and procedures must address the following:

1 Safe evacuation from the CAH, which includes staff responsibilities, and needs of the patients.

2 A means to shelter in place for patients, staff, and volunteers who remain in the facility.

3 A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

4 The use of volunteers in an emergency and other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.

(3) Long-Term Care (LTC) Facilities (42 CFR 483.73)

(a) The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan, risk, and the communication plan. The policies and procedures must be reviewed and updated at least annually.

(b) At a minimum, the policies and procedures must address the following:

1 The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following:

a Food, water, medical, and pharmaceutical supplies.

b Alternate sources of energy to maintain:

1) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions;

2) Emergency lighting;

3) Fire detection, extinguishing, and alarm systems; and

4) Sewage and waste disposal.

(c) A system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location.

(d) Safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

(e) A means to shelter in place for residents, staff, and volunteers who remain in the LTC facility.

(f) A system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records.

(g) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.

(h) The development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents.

(i) The role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

(4) Psychiatric Residential Treatment Facilities (PRTFs) (42 CFR 441.184)

(a) The PRTF facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan, risk, and the communication plan. The policies and procedures must be reviewed and updated at least annually.

(b) At a minimum, the policies and procedures must address the following:

1 The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following:

a Food, water, medical, and pharmaceutical supplies.

b Alternate sources of energy to maintain the following:

1) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions.

2) Emergency lighting.

3) Fire detection, extinguishing, and alarm systems.

4) Sewage and waste disposal.

2 A system to track the location of on-duty staff and sheltered residents in the PRTF's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the PRTF must document the specific name and location of the receiving facility or other location.

3 Safe evacuation from the PRTF, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

4 A means to shelter in place for residents, staff, and volunteers who remain in the facility.

5 A system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records.

6 The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

7 The development of arrangements with other PRTFs and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to PRTF residents.

8 The role of the PRTF under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

(5) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) (42 CFR 483.475)

(a) The ICF/IID facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan, risk, and the communication plan. The policies and procedures must be reviewed and updated at least annually.

(b) The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following:

1 Food, water, medical, and pharmaceutical supplies.

2 Alternate sources of energy to maintain the following:

a Temperatures to protect client health and safety and for the safe and sanitary storage of provisions.

b Emergency lighting.

c Fire detection, extinguishing, and alarm systems.

d Sewage and waste disposal.

(c) A system to track the location of on-duty staff and sheltered clients in the ICF/IID's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID must document the specific name and location of the receiving facility or other location.

(d) Safe evacuation from the ICF/IID, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

(e) A means to shelter in place for clients, staff, and volunteers who remain in the facility.

(f) A system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records.

(g) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.

(h) The development of arrangements with other ICF/IIDs or other providers to receive clients in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients.

(i) The role of the ICF/IID under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

(6) Religious Nonmedical Health Care Institutions (RNHCIs) (42 CFR 403.748)

(a) The RNHCI facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan, risk, and the communication plan. The policies and procedures must be reviewed and updated at least annually.

(b) The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place, include, but are not limited to the following:

1 Food, water, and supplies.

2 Alternate sources of energy to maintain the following:

a Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.

b Emergency lighting.

c Fire detection, extinguishing, and alarm systems.

d Sewage and waste disposal.

(c) A system to track the location of on-duty staff and sheltered patients in the RNHCI's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the RNCHI must document the specific name and location of the receiving facility or other location.

(d) Safe evacuation from the RNHCI, which includes the following:

1 Consideration of care needs of evacuees.

2 Staff responsibilities.

3 Transportation.

4 Identification of evacuation location(s).

5 Primary and alternate means of communication with external sources of assistance.

(e) A means to shelter in place for patients, staff, and volunteers who remain in the facility.

(f) A system of care documentation that does the following:

1 Preserves patient information.

2 Protects confidentiality of patient information.

3 Secures and maintains the availability of records.

(g) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.

(h) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of nonmedical services to RNHCI patients.

(i) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternate care site identified by emergency management officials.

(7) Transplant Centers (42 CFR 482.78)

(a) A transplant center must be included in the emergency preparedness planning and the emergency preparedness program as set forth in the hospital in which it is located. However, a transplant center is not individually responsible for the emergency preparedness requirements.

(b) A transplant center must have policies and procedures that address emergency preparedness. These policies and procedures must be included in the hospital's emergency preparedness program.

(c) A transplant center must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the transplant center, the hospital in which the transplant center is operated, and the OPO designated by the Secretary, unless the organization has an approved waiver to work with another OPO, during an emergency.

(8) Hospices (42 CFR 418.113)

(a) The hospice facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan, risk, and the communication plan. The policies and procedures must be reviewed and updated at least annually.

(b) At a minimum, the policies and procedures must address the following:

1 Procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The hospice must inform State and local officials of any on-duty staff or patients that they are unable to contact.

2 Procedures to inform State and local officials about hospice patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment.

3 A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

4 The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

5 The development of arrangements with other hospices and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to hospice patients.

6 The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:

a A means to shelter in place for patients, hospice employees who remain in hospice.

b Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.

c The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:

1) Food, water, medical, and pharmaceutical supplies.

2) Alternate sources of energy to maintain the following:

a) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.

b) Emergency lighting.

c) Fire detection, extinguishing, and alarm systems.

3) Sewage and waste disposal.

d The role of the hospice under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

e A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

(9) Ambulatory Surgical Center (ASCs) (42 CFR 416.54)

(a) The ASC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan, risk, and the communication plan. The policies and procedures must be reviewed and updated at least annually.

(b) A system to track the location of on-duty staff and sheltered patients in the ASC's care during an emergency. If on-duty staff or sheltered patients are relocated during the emergency, the ASC must document the specific name and location of the receiving facility or other location.

(c) Safe evacuation from the ASC, which includes the following:

1 Consideration of care and treatment needs of evacuees.

2 Staff responsibilities.

3 Transportation.

4 Identification of evacuation location(s).

5 Primary and alternate means of communication with external sources of assistance.

(d) A means to shelter in place for patients, staff, and volunteers who remain in the ASC.

(e) A system of medical documentation that does the following:

1 Preserves patient information.

2 Protects confidentiality of patient information.

3 Secures and maintains the availability of records.

(f) The use of volunteers in an emergency and other staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

(g) The role of the ASC under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

(10) Programs of All-Inclusive Care for the Elderly (PACE) (42 CFR 460.84)

(a) The PACE facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan, risk, and the communication plan. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. Policies and procedures must be reviewed and updated at least annually.

(b) The PACE's policies and procedures must do all of the following:

1 The provision of subsistence needs for staff and participants, whether they evacuate or shelter in place, include, but are not limited to the following:

a Food, water, and medical supplies.

b Alternate sources of energy to maintain the following:

1) Temperatures to protect participant health and safety and for the safe and sanitary storage of provisions.

2) Emergency lighting.

3) Fire detection, extinguishing, and alarm systems.

4) Sewage and waste disposal.

2 A system to track the location of on-duty staff and sheltered participants under the PACE center(s) care during and after an emergency. If on-duty staff and sheltered participants are relocated during the emergency, the PACE must document the specific name and location of the receiving facility or other location.

3 Safe evacuation from the PACE center, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

4 The procedures to inform State and local emergency preparedness officials about PACE participants in need of evacuation from their residences at any time due to an emergency situation based on the participant's medical and psychiatric conditions and home environment.

5 A means to shelter in place for participants, staff, and volunteers who remain in the facility.

6 A system of medical documentation that preserves participant information, protects confidentiality of participant information, and secures and maintains the availability of records.

7 The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.

8 The development of arrangements with other PACE organizations, PACE centers, or other providers to receive participants in the event of limitations or cessation of operations to maintain the continuity of services to PACE participants.

9 The role of the PACE organization under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

a Emergency equipment, including easily portable oxygen, airways, suction, and emergency drugs.

b Staff who know how to use the equipment must be on the premises of every center at all times and be immediately available.

c A documented plan to obtain emergency medical assistance from outside sources when needed.

(11) Home Health Agencies (HHAs) (42 CFR 484.22)

(a) The HHA facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan, risk, and the communication plan. The policies and procedures must be reviewed and updated at least annually.

(b) The HHA's policies and procedures must do all of the following:

1 The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted.

2 The procedures to inform State and local emergency preparedness officials about HHA patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment.

3 The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact.

4 A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

5 The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.

(12) Comprehensive Outpatient Rehabilitation Facilities (CORFs) (42 CFR 485.68)

(a) The HHA facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan, risk, and the communication plan. The policies and procedures must be reviewed and updated at least annually.

(b) The HHA's policies and procedures must do all of the following:

1 Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

2 Provide emergency preparedness training at least annually.

3 At a minimum, the policies and procedures must address the following:

a Safe evacuation from the CORF, which includes staff responsibilities, and needs of the patients.

b A means to shelter in place for patients, staff, and volunteers who remain in the facility.

c A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

d The use of volunteers in an emergency and other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.

(13) Community Mental Health Centers (CMHCs) (42 CFR 485.920)

(a) The HHA facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan, risk, and the communication plan. The policies and procedures must be reviewed and updated at least annually.

(b) The HHA's policies and procedures must do all of the following:

1 A system to track the location of on-duty staff and sheltered clients in the CMHC's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the CMHC must document the specific name and location of the receiving facility or other location.

2 Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

3 A means to shelter in place for clients, staff, and volunteers who remain in the facility.

4 A system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records.

5 The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of state or Federally designated health care professionals to address surge needs during an emergency.

6 The development of arrangements with other CMHCs or other providers to receive clients in the event of limitations or cessation of operations to maintain the continuity of services to CMHC clients.

7 The role of the CMHC under a waiver declared by the Secretary of Health and Human Services, in accordance with section 1135 of the Social Security Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

(14) Organ Procurement Organization (OPOs) (42 CFR 486.360)

(a) The OPO's policies and procedures must be based on the OPO's emergency plan, risk assessment, policies and procedures, and communication plan. The policies and procedures must be reviewed and updated at least annually.

(b) The OPO's policies and procedures must do all of the following:

1 A system to track the location of on-duty staff during and after an emergency. If on-duty staff is relocated during the emergency, the OPO must document the specific name and location of the receiving facility or other location.

2 A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

(15) Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services (Organizations) (42 CFR 485.727)

(a) The Organizations policies and procedures must be based on the Organization's emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.

(b) The Organizations policies and procedures must do all of the following:

1 Safe evacuation from the Organizations, which includes staff responsibilities, and needs of the patients.

2 A means to shelter in place for patients, staff, and volunteers who remain in the facility.

3 A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

4 The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

(16) Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (42 CFR 491.12)

(a) The RHC/FQHC's policies and procedures must be based on the emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.

(b) The RHC/FQHC's policies and procedures must do all of the following:

1 Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.

2 A means to shelter in place for patients, staff, and volunteers who remain in the facility.

3 A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

4 The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

(17) End-Stage Renal Disease (ESRD) Facilities (42 CFR 494.62)

(a) The ESRD's training, testing, and orientation program must be based on the ESRD's emergency plan, risk assessment, policies and procedures, and communication plan. The training, testing, and orientation program must be reviewed and updated at least annually.

(b) The ESRD's training program must do all of the following:

1 Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.

2 A means to shelter in place for patients, staff, and volunteers who remain in the facility.

3 A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

4 The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.

5 The development of arrangements with other dialysis facilities or other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to dialysis facility patients.

6 The role of the dialysis facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

7 How emergency medical system assistance can be obtained when needed.

8 A process by which the staff can confirm that emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, are on the premises at all times and immediately available.

Health Sector Emergency Preparedness
AWR-366

Student Guide

Module 5
Emergency Preparedness Communication Plan

Number: Module 5

Title: Emergency Preparedness Communication Plan

Purpose. The purpose of this module is to provide a discussion of the development and maintenance of an emergency preparedness communication plan for a health sector facility.

Learning Objectives

a. **Terminal Learning Objective.** Determine requirements and considerations for creating a communication plan for a health sector facility consistent with emergency planning principles and best practices. (HC-0265)

b. **Enabling Learning Objectives**

   (1) Define emergency preparedness communication plan in accordance with *DHS National Emergency Communications Plan.* (HC-0265a)

   (2) Determine the emergency preparedness communication plan requirements in accordance with emergency preparedness communication principals and best practices. (HC-0265b)

   (3) Determine the elements of an emergency preparedness communication plan in accordance with best practices. (HC-0265c)

1. **Definition of an Emergency Preparedness Communication Plan**

   a. An emergency preparedness communications plan is a document that provides guidelines, contact information and procedures for how information should be shared during all phases of an unexpected occurrence that requires immediate action.

   b. The emergency preparedness communication plan provides step-by-step instructions for how to deal with an unexpected crisis. The plan identifies important people and their backups, explains how information should be communicated and documents what procedures will be enacted to track and share organization and individual employee status. The plan should document instructions for staying in place or evacuating the building. In the event of an emergency, an emergency preparedness communication plan must be able to launch quickly, brief senior management as soon as possible, communicate information to all interested stakeholders and anticipate the need for changing communication channels as events develop.

2. **Requirements of an Emergency Preparedness Communication Plan**

   a. For a facility to operate effectively in an emergency situation, facilities develop and maintain an emergency preparedness communication plan that complies with both Federal and state law. Facilities are required to review and update the communication plan at least annually.

   b. During an emergency, it is critical that facilities, and all providers/suppliers, have a system to contact appropriate staff, patients' treating physicians, and other necessary persons in a timely manner to ensure continuation of patient care functions throughout the organization and to ensure that these functions are carried out in a safe and effective manner.

   c. Updating the plan annually would facilitate effective communication during an emergency. Providers and suppliers are to have contact information for Federal, state, tribal, regional, or local emergency preparedness staff and other sources of assistance. However, facilities should also consider updating the information more frequently as staffing changes, or any changes in contacts, may occur.

   d. Patient care must be well coordinated across healthcare providers, and with state and local public health departments and emergency systems to protect patient health and safety in the event of a disaster.

   e. The communication plan should include names and contact information for staff, entities providing services under arrangement, patients' physicians, other organizations, and volunteers.

   f. During an emergency, it is critical that facilities have a system to contact appropriate staff, patients' treating physicians, and other necessary persons in a timely manner to ensure continuation of patient care functions throughout the organization and to ensure that these functions are carried out in a safe and effective manner.

   g. Facilities are required to have contact information for Federal, state, tribal, regional, or local emergency preparedness staff and other sources of assistance.

h. Facilities are required to have primary and alternate means for communicating with the facility's staff and Federal, state, tribal, regional, or local emergency management agencies.

i. Facilities are required to have a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other healthcare facilities to ensure continuity of care.

j. Facilities are required to have a means, in the event of an evacuation, to release patient information as permitted by the HIPAA Privacy Rule. Thus, facilities would need to have a communication system in place capable of generating timely, accurate information that could be disseminated, as permitted, to family members and others. This requirement would best be applied only to facilities that provide continuous care to patients, as well as to those facilities that take responsibility for and have oversight over or both, care of patients who are homebound or receiving services at home.

k. Facilities are required to have a means of providing information about the general condition and location of patients under the facility's care, as permitted by the HIPAA Privacy Rule. Use and disclosures for disaster relief purposes, establishes requirements for disclosing patient information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts for purposes of notifying family members, personal representatives, or certain others of the patient's location or general condition. The facility should have a means of providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.
(Reference https://asprtracie.hhs.gov/documents/aspr-tracie-hipaa-emergency-fact-sheet.pdf for more information.)

l. Facilities should have some alternate means to communicate with their staff and Federal, state and local emergency management agencies during an emergency. These may need to be purchased; however, providers and suppliers may check with state emergency officials to make sure the alternate means are compatible with what the state uses. The following are examples of alternative devices:

(1) Pagers

(2) Internet provided by satellite or non-telephone cable systems

(3) Cellular telephones (where appropriate). Facilities can also carry accounts with multiple cell phone carriers to mitigate communication failures during an emergency

(4) Radio transceivers (walkie-talkies)

(5) Various other radio devices such as the NOAA Weather Radio and Amateur Radio Operators' (ham) systems

(6) Satellite telephone communication system

m. Smaller institutions, such as rural health clinics, may need assistance when implementing a system for sharing information. It is recommended that these facilities engage in healthcare coalitions in their area for assistance. There are also website available from a

variety of government entities which provide much information about emergency communication planning.

3. Emergency Preparedness Communication Plan Elements

a. During an emergency, the emergency preparedness communication plan should govern all communications within an organization and with external stakeholders, including the media. When developing an emergency preparedness communication plan, the following elements can be a guide in the process of creating a plan.

(1) Form a team

(2) Plan ahead

(3) Know the stakeholders

(4) Know how to contact the stakeholders

(5) Communication channels

(6) Honor confidentiality

b. What are the elements that you think should be included in an emergency preparedness communication plan and why?

(1) According to *The Joint Commission's Organization Accreditation Standards*, which were effective prior to the release of the CMS Final Rule, the rationale of an emergency preparedness communication plan is to have the healthcare facility maintain reliable communications capabilities for the purpose of communicating response efforts to staff, patients, and external organizations. The facility establishes backup communications processes and technologies to communicate essential information if primary communications systems fail. The communication plan describes the following:

(a) The procedure to notify staff that emergency response has been initiated.

(b) The steps the facility will use to communicate information and instructions to its staff and practitioners during an emergency.

(c) How the facility will notify external authorities that emergency response measures have been notified.

(d) The procedure to communicate with external authorities during an emergency.

(e) How the facility will communicate with patients and their families, including how it will notify families when patients are relocated to alternative care sites.

(f) How the facility will communicate with the community or the media during an emergency.

(g) How the facility will communicate with suppliers of essential services, equipment, and supplies during an emergency.

(h) How the facility will communicate with other health care organizations in its contiguous geographic area regarding the essential elements of their respective command structures, including the names and roles of individuals in their command structures and their command center telephone numbers.

(i) How the facility will communicate with other health care organizations in its contiguous geographic area regarding the essential elements of their respective command centers for emergency response.

(j) How the facility will communicate with other health care organizations in its contiguous geographic area regarding the resources and assets that could be shared in an emergency response.

(k) How the organization will communicate and under what circumstances will the organization communicate the names of patients and the deceased with other health care organizations in its contiguous geographic area.

(l) How the organization will communicate and under what circumstances will the organization communicate information about patients to third parties.

c. **Assume you are a member of the emergency preparedness communication planning team for a Community Mental Health Center (CMHC), who are your stakeholders and how would you contact them?**

(1) First responders (911, EMS, fire, police)

(2) Utility companies (power, water, gas)

(3) Patients and families

(4) Employees, volunteers, and their families

(5) News media (print, broadcast, internet)

(6) Regulators (local/state/Federal), elected officials, etc.

(7) Management (up the chain of command)

(8) State health care associations and others

ADDITIONAL RESOURCES

Communications Systems Topic Collection. https://asprtracie.hhs.gov/technical-resources/78/Communication-Systems/77

Emergency Public Information and Warning/Risk Communications Topic Collection. https://asprtracie.hhs.gov/technical-resources/79/Emncy-Public-Information-and-Warning-Risk-Communications/77

Information Sharing (e.g., partners and employees). https://asprtracie.hhs.gov/technical-resources/80/information-sharing-partners-and-employees/77

HIPAA and Disasters. https://asprtracie.hhs.gov/documents/aspr-tracie-hipaa-emergency-fact-sheet.pdf

REFERENCES

AHCA & NCAL, (2014). *Emergency Preparedness requires a Communications Plan: Skilled Nursing and Post-Acute Care Centers, Assisted Living Communities, and Centers for Individuals with Intellectual or Developmental Disabilities.* Retrieved from https://www.ahcancal.org/facility_operations/disaster_planning/Documents/EP%20Comm%20and%20Media%20Plan.pdf

DHS, (October, 2015). *Government Emergency Telecommunications Service (GETS).* Retrieved from https://www.dhs.gov/government-emergency-telecommunications-service-gets

DHS, (2014). *The National Emergency Communications Plan.* Retrieved from https://www.dhs.gov/sites/default/files/publications/2014%20National%20Emergency%20Communications%20Plan_October%2029%202014.pdf

GPO, Electronic Code of Federal Regulations, (December 2016). *CFR 482.15 Condition of Participation: Emergency Preparedness.* Retrieved from http://www.ecfr.gov/cgi-bin/text-idx?SID=0608c485c393ae27d6c1a9408cea008d&mc=true&node=se42.5.482_115&rgn=div8

HHS, Centers for Medicare & Medicaid Services, (September 2016). *Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers.* Retrieved from https://www.federalregister.gov/documents/2016/09/16/2016-21404/medicare-and-medicaid-programs-emergency-preparedness-requirements-for-medicare-and-medicaid

HHS, Office of the Assistant Secretary for Preparedness and Response, (January 2012). *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness.* Retrieved from http://www.phe.gov/preparedness/planning/hpp/reports/documents/capabilities.pdf

HHS, (n.d.). *Emergency Situations: Preparedness, Planning, and Response.* Retrieved from http://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/

HHS, Office for Civil Rights, (November 2014). *HIPAA Privacy in Emergency Situations.* Retrieved from http://www.hhs.gov/sites/default/files/emergencysituations.pdf

HHS, (n.d.). *National Communications System.* Retrieved from http://www.hhs.gov/ocio/ea/National%20Communication%20System/#

The Joint Commission, (2013). *2013 Organization Accreditation Standards.*

Annex A

Overview of the Emergency Preparedness Communication Plan Requirements for the Other Health Care Agencies

Below is a summarization of the Final Rule. For thorough information regarding a specific provider or supplier, please reference CMS regulatory and sub-regulatory guidance.

a. The organization emergency preparedness communication plan requirements are the baseline for all providers/suppliers. Additional emergency preparedness communication plan requirements will be listed by provider and supplier type.

(1) Critical Access Organization (CAH) (42 CFR 485.625)

(a) The CAHs communication plan must have contact information for other CAHs and organizations or both.

(b) The plan must identify backup internal and external communication systems in the event of failure during emergencies.

(c) In the event of staff and patients relocation, the plan must document the specific name and location of the receiving facility or other location to which on-duty staff and patients were relocated.

(2) Long-Term Care (LTC) Facilities (42 CFR 483.73)

(a) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

1 Names and contact information for the following:

a Staff

b Entities providing services under arrangement

c Residents' physicians

d Other LTC facilities

e Volunteers

2 Contact information for the following:

a Federal, State, tribal, regional, or local emergency preparedness staff

b The State Licensing and Certification Agency

c The Office of the State Long-Term Care Ombudsman

d Other sources of assistance

3 Primary and alternate means for communicating with the following:

a LTC facility's staff

b Federal, State, tribal, regional, or local emergency management agencies

(3) Psychiatric Residential Treatment Facilities (PRTFs) (42 CFR 441.184)

(a) No additional requirements above the organization emergency preparedness communication plan requirements.

(4) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) (42 CFR 483.475)

(a) No additional requirements above the organization emergency preparedness communication plan requirements.

(5) Religious Nonmedical Health Care Institutions (RNHCIs) (42 CFR 403.748)

(a) The plan requires organizations to include in their communication plan: Names and contact information for staff, entities providing services under agreement, patients' physicians, other organizations, and volunteers. For RNHCIs, the plan must substitute "next of kin, guardian, or custodian" for "patients' physicians" because RNHCI patients do not have physicians.

(b) They must have a method for sharing information and care documentation for patients with healthcare providers to ensure continuity of care, based on the written election statement made by the patient or his/her legal representative.

(6) Transplant Centers (42 CFR 482.68)

(a) A transplant center must be included in the emergency preparedness planning and the emergency preparedness program as set forth in the organization in which it is located. However, a transplant center is not individually responsible for the emergency preparedness requirements.

(7) Hospices (42 CFR 418.113)

(a) The plan requires all hospices, regardless of whether they operate their own inpatient facilities, to have a procedure to inform state and local officials about hospice patients in need of evacuation from their respective residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment in accordance to HIPPA.

(8) Ambulatory Surgical Center (ASCs) (42 CFR 416.54)

(a) The plan must have a means of providing information about the ASCs' needs and their ability to provide assistance (such as physical space and medical supplies) to the authority having jurisdiction (local, state agencies) or the Incident Command Center (ICC), or designee.

(b) It is required that if any staff or patients are in the ASC during an emergency and transferred elsewhere for continued or additional care, the ASC must document the specific name and location of the receiving facility or other location for those patients and on-duty staff who are relocated during an emergency.

(c) Since ASCs are highly specialized (solely eye procedures or orthopedics), the ASCs, at this time, are not required to maintain the names and contact information for other ASCs in the ASC's communication plan.

(d) The plan does not require the RHSs and FQHCs to provide information regarding their occupancy since the term occupancy usually refers to bed occupancy in an inpatient facility.

(9) Programs of All-Inclusive Care for the Elderly (PACE) (42 CFR 460.84)

(a) No additional requirements above the organization emergency preparedness communication plan requirements.

(10) Home Health Agencies (HHAs) (42 CFR 484.22)

(a) HHAs are not required to include names and contact information for "Other HHAs" in the communication plan.

(b) The plan does not require the HHAs to provide information regarding their occupancy since the term occupancy usually refers to bed occupancy in an inpatient facility.

(11) Comprehensive Outpatient Rehabilitation Facilities (CORFs) (42 CFR 485.68)

(a) The plan does not require the CORFs to provide information regarding their occupancy since the term occupancy usually refers to bed occupancy in an inpatient facility.

(12) Community Mental Health Centers (CMHCs) (42 CFR 485.920)

(a) No additional requirements above the organization emergency preparedness communication plan requirements.

(13) Organ Procurement Organization (OPOs) (42 CFR 486.360)

(a) The OPO must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan only has three requirements. It must include names for the following:

1 Staff

2 Entities providing services under arrangement

3 Volunteers

4 Other OPOs

5 Transplant and donor organizations in the OPO's Donation Service Area (DSA)

(14) Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services (Organizations) (42 CFR 485.727)

(a) No additional requirements above the organization emergency preparedness communication plan requirements.

(15) Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (42 CFR 491.12)

(a) The plan does not require the RHSs and FQHCs to provide information regarding their occupancy since the term occupancy usually refers to bed occupancy in an inpatient facility.

(16) End-Stage Renal Disease (ESRD) Facilities (42 CFR 494.62)

(a) The plan does not require the ESRD facilities to provide information regarding their occupancy since the term occupancy usually refers to bed occupancy in an inpatient facility.

Health Sector Emergency Preparedness
AWR-366

Student Guide

Module 6
Training and Testing (Exercising)

Number: Module 6

Title: Training and Testing (Exercising)

Purpose. The purpose of this module is to provide a discussion of the development and maintenance of an emergency preparedness training, testing, & exercising for a health sector facility.

Learning Objective

a. **Terminal Learning Objective.** Determine requirements and considerations for creating the emergency preparedness training and testing (exercising) for a health sector facility consistent with emergency planning principles and best practices. (HC-0270)

b. **Enabling Learning Objectives**

(1) Define emergency preparedness training and testing (exercising) in accordance with *The Homeland Security Exercise and Evaluation Program (HSEEP).* (HC-0270a)

(2) Determine the emergency preparedness training and testing (exercising) requirements in accordance with the *CMS Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* Rule. (HC-0270b)

(3) Determine the elements of an emergency preparedness training and testing (exercising) in accordance with the *World Health Organization*'*s Designing and Implementing Training Programs*. (HC-0270c)

1. Training and Testing (Exercising) Program

a. Purpose

(1) Building essential response capabilities nationwide requires a systematic program to train individual teams and organizations – to include governmental, nongovernmental, private-sector, and voluntary organizations – to meet a common baseline of performance and certification standards.

(2) Training and testing (exercising) evaluates the effectiveness of your preparedness program and, ensures employees know what to do and find any missing parts. It clarifies roles and responsibilities and reinforces knowledge of procedures, facilities, systems, and equipment. It improves individual performance as well as organizational coordination and communications. It evaluates policies, plans, procedures and the knowledge and skills of team members and reveals weaknesses and resource gaps.

(3) An organization's training and testing (exercise) program must be based on its emergency plan, and risk assessment, policies and procedures, and communication plan and comply with both federal and state laws.

(4) A well-organized, effective training program includes the provision of initial training in emergency preparedness policies and procedures. Organizations must provide such training to all new and existing staff, including any individuals providing services under arrangement and volunteers, consistent with their expected roles, and maintain documentation of such training.

(a) According to The Centers for Medicaid and Medicare Services, "staff" refers to all individuals that are employed directly by a facility.

(b) The phrase "individuals providing services under arrangement" means services furnished under arrangement that are subject to a written contract conforming with the requirements specified in section 1861(w) of the Social Security Act.

b. Training

(1) The majority of training consists of the day-to-day skills, methodologies, and techniques that are required to carry out the elements of the emergency plan. This is doing the "every day" job, right, every time to ensure during an emergency situation, each step will be automatically correct.

(2) Individuals and teams, whether paid or volunteer, should meet relevant local, tribal, State, Federal, or professional qualifications, certifications, or performance standards.

(3) For specialized training, those things that are "every day", the content and methods of training must comply with applicable standards and produce required skills and measurable proficiency. FEMA and other organizations offer response and incident management training in online and classroom formats.

c. Testing (Exercising)

(1) Testing (exercising) requires standards being set within the exercise program for specific capability, task, and objectives and ensuring everyone responsible can perform them at the set benchmarks.

(2) A test (exercise) is an instrument to train for, assess, practice, and improve performance in prevention, protection, response, and recovery capabilities in a low-risk environment.

(3) Tests (exercises) pull multiple pieces of the puzzle together. Where training may focus on one or two aspects of the overall plan, an exercise usually focuses on multiple aspects.

(4) Tests (exercises) can be used for: testing and validating policies, plans, procedures, training, equipment, and interagency agreements; clarifying and training personnel in roles and responsibilities; improving interagency coordination and communications; identifying gaps in resources; improving individual performance; and identifying opportunities for improvement.

(5) Testing (exercising) is performed on a regular basis, usually annually. This is to ensure employees can perform each task correctly.

d. Program Annual Requirements

(1) An organization must offer annual emergency preparedness training so that staff can demonstrate knowledge of emergency procedures. The facility must also conduct drills and exercises to test the emergency plan to identify gaps and areas for improvement.

(2) Some organizations are required to participate in a community based exercise at least annually. To meet the CMS requirements, a functional or full-scale exercise, per HSEEP definitions, will be acceptable for the CMS requirement of a community or facility based full scale exercise. Facilities are encouraged to participate in an existing or already planned exercise in their community at either a functional or full-scale level within their own facility.

(3) Organizations are required to conduct a paper-based tabletop exercise at least annually. The tabletop exercise could be based on the same or a different disaster scenario from the scenario used in the full-scale exercise or the actual emergency. The tabletop exercise is defined as a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

2. Emergency Preparedness Training and Testing (Exercising) Activities

a. The training and testing (exercising) elements are necessary to ensure that all staff have a good understanding of their responsibilities as identified by the emergency plan and defined in the policies and procedures. It allows an organization to evaluate their capability to effectively implement the plan. The elements consist of:

(1) Training for all levels of staff, volunteers, community partners, and external stakeholders.

(2) Roles and responsibilities of all personnel during an emergency.

(3) Plan exercising of staff, volunteers, community partners, and external stakeholders.

(4) Testing all procedures and processes included in existing emergency preparedness plan.

(5) Testing new processes and procedures.

b. What are the activities that you think could be included as part of your organization's training activities?

(1) Specifically, the activities that should be included are training on the plan and the policies and procedures needed to execute the plan.

(2) The key elements of a training program include needs assessment, course work, learning tasks, and practical application. Facilitators introduce new information to trainees through course work or lectures. Learning tasks or activities, such as case numbers or role-players, provide individuals with opportunities to work with the new information in a small group setting. Practical experiences and applications give the trainees the opportunity to apply the knowledge and skills learned in a real-life or simulated situation.

(3) The learning methods that can be used in training are as follows:

(a) Brainstorming—members of a small or large group are encouraged to contribute any suggestion that comes into their heads on a given subject, initially with no criticism, but later with a sifting and assessment of all ideas.

(b) Case study—a real situation is presented in a brief paper or presentation, then analyzed by participants.

(c) Demonstration—the facilitator shows learners how and what should be done while explaining why, when, and where an action is taken; participants then perform the action.

(d) Discussion—a method in which the participants learn from one another, usually with guidance from a facilitator.

(e) Distance learning—a system designed to build knowledge and skills of learners who are not physically on-site to receive training. Facilitators and students may communicate at times of their own choosing by exchanging printed or electronic media or through technology that allows them to communicate in real time.

(f) e-learning—participants interact with facilitators through the use of some of the many electronic, computer-based learning materials that are now available, ranging from CD-ROMs to Web-based systems.

(g) Group exercise—a number of participants undertake an activity together, followed by a critical analysis of the process involved.

(h) Lecture—a direct talk with or without learning aids but without group participation.

(i) Role-playing—participants act out the roles of those represented in a given situation.

(j) Self-paced—participants are allowed to learn anywhere, anytime, and at a pace that suits their levels of skills, knowledge, and aptitudes.

(k) Simulation game—a more advanced version of a case study, where participants are given more detailed information on a situation, including data sets to analyze. On the basis of their analyses, participants develop and defend a plan of action.

(l) Worksheet—a step-by-step approach to identifying problems or solutions through written questions or problems, with space provided for answers.

c. What are the elements that you think could be included in your organization's test/exercise activities?

(1) According to *The Homeland Security Exercise and Evaluation Program (HSEEP),* an effective exercise program helps organizations maximize efficiency, resources, time, and funding by ensuring that exercises are part of a coordinated, integrated approach to building, sustaining, and delivering core capabilities.

(2) This approach—called multi-year planning—begins when elected and appointed officials, working with whole community stakeholders, identify and develop a set of multi-year exercise priorities informed by existing assessments, strategies, and plans. These long-term priorities help exercise planners design and develop a progressive program of individual exercises to build, sustain, and deliver core capabilities.

(3) Discussion-Based Exercises. Discussion-based exercises include seminars, workshops, tabletop exercises (TTXs), and games. These types of exercises can be used to familiarize players with, or develop new, plans, policies, agreements, and procedures. Discussion-based exercises focus on strategic, policy-oriented issues. Facilitators and/or presenters usually lead the discussion, keeping participants on track towards meeting exercise objectives.

(a) Seminars—generally orient participants to, or provide an overview of, authorities, strategies, plans, policies, procedures, protocols, resources, concepts, and ideas. As a discussion-based exercise, seminars can be valuable for entities that are developing or making major changes to existing plans or procedures. Seminars can be similarly helpful when attempting to assess or gain awareness of the capabilities of interagency or inter-jurisdictional operations.

(b) Workshops—although similar to seminars, workshops differ in two important aspects: participant interaction is increased, and the focus is placed on achieving or building a product. Effective workshops entail the broadest attendance by

relevant stakeholders. To be effective, workshops should have clearly defined objectives, products, or goals, and should focus on a specific issue.

(c) Tabletop Exercises—a tabletop exercise is intended to generate discussion of various issues regarding a hypothetical, simulated emergency. Tabletop exercises can be used to enhance general awareness, validate plans and procedures, rehearse concepts, and/or assess the types of systems needed to guide the prevention of, protection from, mitigation of, response to, and recovery from a defined incident. Generally, tabletop exercises are aimed at facilitating conceptual understanding, identifying strengths and areas for improvement, and/or achieving changes in perceptions.

(d) Game—a game is a simulation of operations that often involves two or more teams, usually in a competitive environment, using rules, data, and procedures designed to depict an actual or hypothetical situation. Games explore the consequences of player decisions and actions. They are useful tools for validating plans and procedures or evaluating resource requirements.

(4) Operations-Based Exercises—Operations-based exercises include drills, functional exercises (FEs), and full-scale exercises (FSEs). These exercises can be used to validate plans, policies, agreements, and procedures; clarify roles and responsibilities; and identify resource gaps. Operations-based exercises are characterized by actual reaction to an exercise scenario, such as initiating communications or mobilizing personnel and resources.

(a) Drills—A drill is a coordinated, supervised activity usually employed to validate a specific function or capability in a single agency or organization. Drills are commonly used to provide training on new equipment, validate procedures, or practice and maintain current skills. For example, drills may be appropriate for establishing a community-designated disaster receiving center or shelter. Drills can also be used to determine if plans can be executed as designed, to assess whether more training is required, or to reinforce best practices. A drill is useful as a stand-alone tool, but a series of drills can be used to prepare several organizations to collaborate in an FSE.

(b) Function Exercises (FE)—FEs are designed to validate and evaluate capabilities, multiple functions and/or sub-functions, or interdependent groups of functions. FEs are typically focused on exercising plans, policies, procedures, and staff members involved in management, direction, command, and control functions. In FEs, events are projected through an exercise scenario with event updates that drive activity typically at the management level. An FE is conducted in a realistic, real-time environment; however, movement of personnel and equipment is usually simulated.

(c) Full-Scale Exercises (FSE)—FSEs are typically the most complex and resource-intensive type of exercise. They involve multiple agencies, organizations, and jurisdictions and validate many facets of preparedness.

1 In an FSE, events are projected through an exercise scenario with event updates that drive activity at the operational level.

2 FSEs are usually conducted in a real-time, stressful environment that is intended to mirror a real incident. Personnel and resources may be mobilized and deployed to the scene, where actions are performed as if a real incident had occurred.

3 The FSE simulates reality by presenting complex and realistic problems that require critical thinking, rapid problem solving, and effective responses by trained personnel.

4 The level of support needed to conduct an FSE is greater than that needed for other types of exercises. The exercise site for an FSE is usually large, and site logistics require close monitoring. Safety issues, particularly regarding the use of props and special effects, must be monitored. Throughout the duration of the exercise, many activities occur simultaneously.

d. Assume you are a member of the emergency preparedness training and testing (exercising) team for a Comprehensive Outpatient Rehabilitation Facility (CORF), what type of exercise would you develop to test your response to an incident involving a major disaster and why?

3. After Action Review. Organizations must analyze their response to, and maintain documentation on, all drills, tabletop exercises, and emergency events, and revise the organization's emergency plan as needed.

a. Improvement Planning

(1) Exercises afford organizations the opportunity to evaluate capabilities and assess progress toward meeting capability targets in a controlled, low-risk setting. After the evaluation phase concludes, organizations should reach consensus on identified strengths and areas for improvement and develop a set of improvements that directly addresses core capability gaps.

(2) This information is recorded in the AAR or improvement plan and resolved through the implementation of concrete corrective actions, which are prioritized and tracked as part of a corrective action program. This process constitutes the improvement planning phase and the final step in conducting an exercise.

b. Corrective Actions

(1) Once exercise data are analyzed, organizations should perform an additional qualitative assessment to identify potential corrective actions. Corrective actions are concrete, actionable steps that are intended to resolve capability gaps and shortcomings identified in exercises or real-world events.

(2) In developing corrective actions, elected and appointed officials or their designees should first review and revise the draft AAR, as needed, prior to the After-Action Meeting (AAM) to confirm that the issues identified by evaluators are valid and require resolution.

(3) The reviewer then identifies which issues fall within their organization's authority, and assume responsibility for taking action on those issues. Finally, they determine an initial list of appropriate corrective actions to resolve identified issues.

(4) Once the organization's reviewer has confirmed the draft areas for improvement and identified initial corrective actions, a draft improvement plan is developed for review at an After Action Meeting. These meetings serve as forums to review the revised AAR and the draft improvement plan.

c. After-Action Report/Improvement Plan Finalization

(1) Once all corrective actions have been consolidated in the final improvement plan, the improvement plan may be included as an appendix to the AAR. The AAR and improvement plan is then considered final, and may be distributed to exercise planners, participants, and other preparedness stakeholders as appropriate.

(2) Corrective actions captured in the AAR or improvement plan should be tracked and continually reported on until completion. Organizations should assign points of contact responsible for tracking and reporting on their progress in implementing corrective actions. By tracking corrective actions to completion, preparedness stakeholders are able to demonstrate that exercises have yielded tangible improvements in preparedness.

(3) Stakeholders should also ensure there is a system in place to validate previous corrective actions that have been successfully implemented. These efforts should be considered part of a wider continuous improvement process that applies prior to, during, and after an exercise is completed.

(4) Conducting exercises and documenting the strengths, areas for improvement, and associated corrective actions is an important part of the National Preparedness System, and contributes to the strengthening of preparedness across the Whole Community and achievement of the National Preparedness Goal. Over time, exercises should yield observable improvements in preparedness for future exercises and real-world events.

ADDITIONAL RESOURCES

Exercise Program (Design, Evaluation, Facilitation) Topic Collection. https://asprtracie.hhs.gov/technical-resources/7/Exercise-Program-Design-Evaluation-Facilitation/6

Memo from CMS clarifying training and exercise requirement https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-21.pdf

REFERENCES

DHS (April 2013). The Homeland Security Exercise and Evaluation Program (HSEEP). Retrieved from https://www.fema.gov/media-library-data/20130726-1914-25045-8890/hseep_apr13_.pdf

U.S. Government Publishing Office (January 2017). Electronic Code of Federal Regulations. Retrieved from http://www.ecfr.gov/cgi-bin/text-idx?SID=f6b796ea838e6e3741609abd77ad3346&mc=true&node=pt42.4.441&rgn=div5#se42.4.441_1184

World Health Organization (WHO) (2012). *Designing and Implementing Training Programs. (MDS-3: Managing Access to Medicines and Health Technologies, Chapter 52).* Retrieved from http://www.msh.org/resources/mds-3-managing-access-to-medicines-and-health-technologies

ANNEX A

Overview of the Emergency Preparedness Plan Training and Testing (Exercising) Program Requirements for the 17 Facilities.

Below is a summarization of the Final Rule. For thorough information regarding a specific provider or supplier, please reference CMS regulatory and sub-regulatory guidance.

a. Critical Access Hospital (CAH) (42 CFR 485.625)

(a) Provide initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(b) Provide emergency preparedness training at least annually.

(c) Maintain documentation of the training.

(d) Demonstrate staff knowledge of emergency procedures.

(e) The CAH must conduct exercises to test the emergency plan at least annually.

(f) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based exercise. If the CAH experiences an actual natural or man-made emergency that requires activation of the emergency plan, the CAH is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

(g) Conduct an additional exercise that may include, but is not limited to the following:

5 A second full-scale exercise of its choosing that is community-based or individual, facility-based.

6 A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(h) Analyze the CAH's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the CAH's emergency plan, as needed.

b. Long-Term Care (LTC) Facilities (42 CFR 483.73)

(a) The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan.

(b) The training and testing program must be reviewed and updated at least annually.

(c) The LTC facility must do all of the following:

1 Ensure all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles have initial training in emergency preparedness policies and procedures.

2 Provide emergency preparedness training at least annually.

3 Maintain documentation of the training.

4 Demonstrate staff knowledge of emergency procedures.

(d) The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do the following:

1 Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

2 Conduct an additional exercise that may include, but is not limited to the following:

a A second full-scale exercise that is community-based or individual, facility-based.

b A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

3 Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed.

c. Psychiatric Residential Treatment Facilities (PRTFs) (42 CFR 441.184)

(a) The PRTF's training and testing program must be based on the PRTF's emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.

(b) The training program must include the following:

1 Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

2 After initial training, provide emergency preparedness training at least annually.

3 Demonstrate staff knowledge of emergency procedures.

4 Maintain documentation of all emergency preparedness training.

(c) The PRTF must conduct exercises to test the emergency plan. It must do the following:

1 Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the PRTF experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PRTF is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

2 Conduct an additional exercise that may include, but is not limited to the following:

a A second full-scale exercise that is community-based or individual, facility-based.

b A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

3 Analyze the PRTF's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PRTF's emergency plan, as needed.

d. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) (42 CFR 483.475)

(a) The ICF/IID’s training and testing program must be based on the ICF/IID’s emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.

(b) The training program must do all the following:

1 Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

2 Provide emergency preparedness training at least annually.

3 Maintain documentation of the training.

4 Demonstrate staff knowledge of emergency procedures.

(c) For testing, the ICF/IID must conduct exercises to test the emergency plan at least annually. It must do the following:

1 Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

2 Conduct an additional exercise that may include, but is not limited to the following:

a A second full-scale exercise that is community-based or individual, facility-based.

b A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

3 Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

e. Religious Nonmedical Health Care Institutions (RNHCIs) (42 CFR 403.748)

(a) The RNHCI's training and testing program must be based on the RNHCI's emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.

(b) The training program must do all of the following:

1 Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

2 Provide emergency preparedness training at least annually.

3 Maintain documentation of all emergency preparedness training.

4 Demonstrate staff knowledge of emergency procedures.

(c) The RNHCI's testing must conduct exercises to test the emergency plan. It must do the following:

1 Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

2 Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.

f. Transplant Centers (42 CFR 482.78)

(a) A transplant center must be included in the emergency preparedness planning and the emergency preparedness program as set forth in the hospital in which it is located. However, a transplant center is not individually responsible for the emergency preparedness requirements.

g. Hospices (42 CFR 418.113)

(a) The hospice’s training and testing program must be based on the hospice’s emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.

(b) The hospice’s training program must do all of the following:

1 Demonstrate staff knowledge of emergency procedures.

2 Provide emergency preparedness training at least annually.

3 Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

4 Maintain documentation of all emergency preparedness training.

(c) The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:

1 Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the hospice experiences an actual natural or man-made emergency that requires activation of the emergency plan, the organization is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

2 Conduct an additional exercise that may include, but is not limited to the following:

a A second full-scale exercise that is community-based or individual, facility-based.

b A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

3 Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the hospice's emergency plan, as needed.

h. Ambulatory Surgical Center (ASCs) (42 CFR 416.54)

(a) The ASC’s training and testing program must be based on the ASC’s emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.

(b) The ASC’s training program must do all of the following:

1 Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.

2 Provide emergency preparedness training at least annually.

3 Maintain documentation of all emergency preparedness training.

4 Demonstrate staff knowledge of emergency procedures.

(c) The ASC must conduct exercises to test the emergency plan at least annually. The ASC must do the following:

(d) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, individual, and facility-based. If the ASC experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ASC is exempt from engaging in an community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

(e) Conduct an additional exercise that may include, but is not limited to the following:

1 A second full-scale exercise that is individual, facility-based.

2 A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

3 Analyze the ASC's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the ASC's emergency plan, as needed.

i. Programs of All-Inclusive Care for the Elderly (PACE) (42 CFR 460.84)

(a) The ASC’s training and testing program must be based on the ASC’s emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.

(b) The PACE’s training program must do all of the following:

1 Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.

2 Provide emergency preparedness training at least annually.

3 Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.

4 Maintain documentation of all training.

(c) The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:

1 Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

2 Conduct an additional exercise that may include, but is not limited to the following:

a A second full-scale exercise that is community-based or individual, facility-based.

b A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

c Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

j. Home Health Agencies (HHAs) (42 CFR 484.22)

(a) The HHA’s training and testing program must be based on the HHA’s emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.

(b) The HHA’s training program must do all of the following:

1 Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

2 Provide emergency preparedness training at least annually.

3 Maintain documentation of the training.

4 Demonstrate staff knowledge of emergency procedures.

(c) The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:

1 Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

2 Conduct an additional exercise that may include, but is not limited to the following:

a A second full-scale exercise that is community-based or individual, facility-based.

b A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

3 Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

k. Comprehensive Outpatient Rehabilitation Facilities (CORFs) (42 CFR 485.68)

(a) The CORF's training and testing program must be based on the CORF's emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.

(b) The CORF's training program must do all of the following:

1 Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

2 Provide emergency preparedness training at least annually.

3 Maintain documentation of the training.

4 Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

(c) The CORF must conduct exercises to test the emergency plan at least annually. The CORF must do the following:

1 Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the CORF experiences an actual natural or man-made emergency that requires activation of the emergency plan, the CORF is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

2 Conduct an additional exercise that may include, but is not limited to the following:

a A second full-scale exercise that is community-based or individual, facility-based.

b A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

3 Analyze the CORF's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the CORF's emergency plan, as needed.

I. Community Mental Health Centers (CMHCs) (42 CFR 485.920)

(a) The CMHC's training and testing program must be based on the CMHC's emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.

(b) The CMHC's testing program must do all of the following:

1 Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the CMHC experiences an actual natural or man-made emergency that requires activation of the emergency plan, the CMHC is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

2 Conduct an additional exercise that may include, but is not limited to the following:

a A second full-scale exercise that is community-based or individual, facility-based.

b A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(c) Analyze the CMHC's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the CMHC's emergency plan, as needed.

m. Organ Procurement Organization (OPOs) (42 CFR 486.360)

(a) The OPO’s training and testing program must be based on the OPO’s emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.

(b) The OPO’s training program must do all of the following:

1 Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

2 Provide emergency preparedness training at least annually.

3 Maintain documentation of the training.

4 Demonstrate staff knowledge of emergency procedures.

(c) The OPO must conduct exercises to test the emergency plan. The OPO must do the following:

1 Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

2 Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the OPO's emergency plan, as needed.

n. Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services (Organizations) (42 CFR 485.727)

(a) The Organization’s training and testing program must be based on the Organization’s emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.

(b) The Organization’s training program must do all of the following:

1 Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

2 Provide emergency preparedness training at least annually.

3 Maintain documentation of the training.

4 Demonstrate staff knowledge of emergency procedures.

(c) The Organizations must conduct exercises to test the emergency plan at least annually. The Organizations must do the following:

1 Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the Organizations experience an actual natural or man-made emergency that requires activation of the emergency plan, the organization is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

2 Conduct an additional exercise that may include, but is not limited to the following:

a A second full-scale exercise that is community-based or individual, facility-based.

b A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

3 Analyze the Organization's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise their emergency plan, as needed.

o. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (42 CFR 491.12)

(a) The RHC/FQHC's training and testing program must be based on the RHC/FQHC's emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.

(b) The RHC/FQHC's training program must do all of the following:

1 Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

2 Provide emergency preparedness training at least annually.

3 Maintain documentation of the training.

4 Demonstrate staff knowledge of emergency procedures.

(c) The RHC/FQHC must conduct exercises to test the emergency plan at least annually. The RHC/FQHC must do the following:

1 Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the RHC/FQHC experiences an actual natural or man-made emergency that requires activation of the emergency plan, the RHC/FQHC is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

2 Conduct an additional exercise that may include, but is not limited to following:

a A second full-scale exercise that is community-based or individual, facility-based.

b A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

3 Analyze the RHC/FQHC's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the RHC/FQHC's emergency plan, as needed.

p. End-Stage Renal Disease (ESRD) Facilities (42 CFR 494.62)

(a) The ESRD's training, testing, and orientation program must be based on the ESRD's emergency plan, risk assessment, policies and procedures, and communication plan. The training, testing, and orientation program must be reviewed and updated at least annually.

(b) The ESRD's training program must do all of the following:

1 Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

2 Provide emergency preparedness training at least annually. Staff training must:

3 Demonstrate staff knowledge of emergency procedures, including informing patients of—

a What to do;

b Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated;

c Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and

d How to disconnect themselves from the dialysis machine if an emergency occurs.

4 Demonstrate that, at a minimum, its patient care staff maintains current CPR certification; and

5 Properly train its nursing staff in the use of emergency equipment and emergency drugs.

6 Maintain documentation of the training.

(c) The dialysis facility must conduct exercises to test the emergency plan at least annually. The dialysis facility must do all of the following:

1 Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the dialysis facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ESRD is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

2 Conduct an additional exercise that may include, but is not limited to the following:

a A second full-scale exercise that is community-based or individual, facility-based.

b A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

3 Analyze the dialysis facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the dialysis facility's emergency plan, as needed.

(d) Patient orientation: Emergency preparedness patient training. The facility must provide appropriate orientation and training to patients.