Emergency Preparedness

LONG-TERM CARE SURVEY MANUAL
PREPARED BY MU LEADERSHIP
COACHES

SECTION 3 – Emergency Preparedness

CMS and Emergency Preparedness – *The CMS released S&C 17-29-ALL, the Advanced Copy of Appendix Z of the State Operations Manual (SOM) on June 2, 2017. Appendix Z applies to 17 provider types and contains the interpretive guidelines and survey procedures for the Emergency Preparedness Final Rule. The information found in Section 3 of this manual will apply to Long-Term Care Providers, including Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF).*

Emergency Preparedness links to information from the CMS Center for Clinical Standards and Quality/Quality, Safety & Oversight Group are in the first section below. These memos have important information that providers should know regarding the Emergency Preparedness Final Rule.

1. **S&C 17-05-ALL *Information on the Implementation Plans for the Emergency Preparedness Regulation*** - https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/survey-and-cert-letter-17-05.pdf

2. **S&C 17-29-ALL *Advanced Copy- Appendix Z, Emergency Preparedness Final Rule Interpretive Guidelines and Survey Procedures*** - https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/survey-and-cert-letter-17-29.pdf

3. **QSO-21-15-ALL *Updated Guidance for Emergency Preparedness-Appendix Z*** of the State Operations Manual (SOM) - https://www.cms.gov/files/document/qso-21-15-all.pdf

4. **QSO-20-41-ALL *Guidance related to Emergency Preparedness-Exercise Exemption based on a Facility's Activation of their Emergency Plan*** - https://www.cms.gov/files/document/qso-20-41-all-revised-05262022.pdf

MISSOURI-SPECIFIC INFORMATION AND HELPFUL RESOURCES:

5. Missouri Department of Public Safety State Emergency Management Agency (SEMA) - https://sema.dps.mo.gov/

6. Missouri Emergency Management Director Listing - https://sema.dps.mo.gov/reports/EMD_Listing.php

7. Statewide Regional Coordinators Program - https://sema.dps.mo.gov/programs/area_coordinator.php

    a. Regional Coordinator Contact Information https://sema.dps.mo.gov/programs/documents/statewide-regional-coordinators-map.pdf

8. Missouri Department of Health and Senior Services (DHSS) Disaster and Emergency Planning - https://health.mo.gov/emergencies/

9. Missouri Hospital Association Healthcare Coalition Information - https://web.mhanet.com/HCC-resources.aspx

10. Nonurban Missouri Healthcare Coalition Preparedness Plan - https://web.mhanet.com/wp-content/uploads/2022/06/06_2022-NUMO-HCC-Preparedness-Plan.pdf

11. Quality Improvement Program for Missouri (QIPMO) - www.nursinghomehelp.org

MISCELLANEOUS WEBSITES AND RESOURCES:

12. Emergency Operation Plan Samples and Resources - https://www.cahfdisasterprep.com/eop
13. HHS ASPR, Technical Resources, Assistance Center, and Information Exchange (TRACIE) - https://asprtracie.hhs.gov/
14. Florida Long-Term Care Emergency Preparedness - http://ltcprepare.org/sample-template?page=1
15. Template for Long Term Care Disaster Plan - https://docs.wixstatic.com/ugd/e06278_358ed3a8b38a411f92a3dfee2d75683c.pdf
16. Free online training for NIMS and ICS - https://training.fema.gov/is/

Tag #	Title	Effective Date	LTC	ICF	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM
0001	Establishment of the Emergency Program (EP)	11/15/2017	Yes	Yes	§403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.22, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12	The facility must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements:	Under this condition/requirement, facilities are required to develop an emergency preparedness program that meets all of the standards specified within the condition/requirement. The emergency preparedness program must describe a facility's comprehensive approach to meeting the health, safety, and security needs of their staff and patient population during an emergency or disaster situation. The program must also address how the facility would coordinate with other healthcare facilities, as well as the whole community during an emergency or disaster (natural, man-made, facility). The emergency preparedness program must be reviewed annually. A comprehensive approach to meeting the health and safety needs of a patient population should encompass the elements for emergency preparedness planning based on the "all-hazards" definition and specific to the location of the facility. For instance, a facility in a large flood zone, or tornado prone region, should have included these elements in their overall planning in order to meet the health, safety, and security needs of the staff and of the patient population. Additionally, if the patient population has limited mobility, facilities should have an approach to address these challenges during emergency events. The term "comprehensive" in this requirement is to ensure that facilities do not only choose one potential emergency that may occur in their area, but rather consider a multitude of events and be able to demonstrate that they have considered this during their development of the emergency preparedness plan. Survey Procedures • Interview the facility leadership and ask him/her/them to describe the facility's emergency preparedness program. • Ask to see the facility's written policy and documentation on the emergency preparedness program. • Ask the facility leadership if the plan was developed based on an all-hazards approach by asking their leadership to describe how the facility used an all-hazards approach when developing its program.
0004	Develop and Maintain EP Program	11/15/2017	Yes	Yes	§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.22(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).	[The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.	Facilities are required to develop and maintain an emergency preparedness plan. The plan must include all of the required elements under the standard. The plan must be reviewed and updated at least annually. The annual review must be documented to include the date of the review and any updates made to the emergency plan based on the review. The format of the emergency preparedness plan that a facility uses is at its discretion. An emergency plan is one part of a facility's emergency preparedness program. The plan provides the framework, which includes conducting facility-based and community-based risk assessments that will assist a facility in addressing the needs of their patient populations, along with identifying the continuity of business operations which will provide support during an actual emergency. In addition, the emergency plan supports, guides, and ensures a facility's ability to collaborate with local emergency preparedness officials. This approach is specific to the location of the facility and considers particular hazards most likely to occur in the surrounding area. These include, but are not limited to: • Natural disasters • Man-made disasters, • Facility-based disasters that include but are not limited to: o Care-related emergencies; o Equipment and utility failures, including but not limited to power, water, gas, etc.; o Interruptions in communication, including cyber-attacks; o Loss of all or portion of a facility; and o Interruptions to the normal supply of essential resources, such as water, food, fuel (heating, cooking, and generators), and in some cases, medications and medical supplies (including medical gases, if applicable). When evaluating potential interruptions to the normal supply of essential services, the facility should take into account the likely durations of such interruptions. Arrangements or contracts to re-establish essential utility services during an emergency should describe the timeframe within which the contractor is required to initiate services after the start of the emergency, how they will be procured and delivered in the facility's local area, and that the contractor will continue to supply the essential items throughout and to the end of emergencies of varying duration. Survey Procedures • Verify the facility has an emergency preparedness plan by asking to see a copy of the plan. • Ask facility leadership to identify the hazards (e.g. natural, man-made, facility, geographic, etc.) that were identified in the facility's risk

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0006	Maintain and Annual EP Updates	11/15/2017	Yes	Yes	§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.22(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.	Facilities are expected to develop an emergency preparedness plan that is based on the facility-based and community-based risk assessment using an "all-hazards" approach. Facilities must document both risk assessments. An example consideration may include, but is not limited to, natural disasters prevalent in a facility's geographic region such as wildfires, tornados, flooding, etc. An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. This approach is specific to the location of the facility considering the types of hazards most likely to occur in the area. Thus, all-hazards planning does not specifically address every possible threat or risk but ensures the facility will have the capacity to address a broad range of related emergencies. Facilities are encouraged to utilize the concepts outlined in the National Preparedness System, published by the United States Department of Homeland Security's Federal Emergency Management Agency (FEMA), as well as guidance provided by the Agency for Healthcare Research and Quality (AHRQ). "Community" is not defined in order to afford facilities the flexibility in deciding which healthcare facilities and agencies it considers to be part of its community for emergency planning purposes. However, the term could mean entities within a state or multi-state region. The goal of the provision is to ensure that healthcare providers collaborate with other entities within a given community to promote an integrated response. Conducting integrated planning with state and local entities could identify potential gaps in state and local capabilities that can then be addressed in advance of an emergency. Facilities may rely on a community-based risk assessment developed by other entities, such as public health agencies, emergency management agencies, and regional health care coalitions or in conjunction with conducting its own facility-based assessment. If this approach is used, facilities are expected to have a copy of the community-based risk assessment and to work with the entity that developed it to ensure that the facility's emergency plan is in alignment. When developing an emergency preparedness plan, facilities are expected to consider, among other things, the following: • Identification of all business functions essential to the facility's operations that should be continued during an emergency; • Identification of all risks or emergencies that the facility may reasonably expect to confront; • Identification of all contingencies for which the facility should plan; • Consideration of the facility's location; • Assessment of the extent to which natural or man-made emergencies may cause the facility to cease or limit operations; and, • Determination of what arrangements may be necessary with other health care facilities, or other entities that might be needed to ensure that
0007	EP Program Patient Population	11/15/2017	Yes	Yes	§403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.22(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3).	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**	The emergency plan must specify the population served within the facility, such as inpatients and/or outpatients, and their unique vulnerabilities in the event of an emergency or disaster. A facility's emergency plan must also address persons at-risk. As defined by the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006, members of at-risk populations may have additional needs in one or more of the following functional areas: maintaining independence, communication, transportation, supervision, and medical care. In addition to those individuals specifically recognized as at-risk in the PAHPA (children, senior citizens, and pregnant women), "at-risk populations" are also individuals who may need additional response assistance including those who have disabilities, live in institutionalized settings, are from diverse cultures and racial and ethnic backgrounds, have limited English proficiency or are non-English speaking, lack transportation, have chronic medical disorders, or have pharmacological dependency. At-risk populations would also include, but are not limited to, the elderly, persons in hospitals and nursing homes, people with physical and mental disabilities as well as others with access and functional needs, and infants and children. Mobility is an important part in effective and timely evacuations, and therefore facilities are expected to properly plan to identify patients who would require additional assistance, ensure that means for transport are accessible and available and that those involved in transport, as well as the patients and residents are made aware of the procedures to evacuate. The emergency plan must also address the types of services that the facility would be able to provide in an emergency. The emergency plan must identify which staff would assume specific roles in another's absence through succession planning and delegations of authority. Succession planning is a process for identifying and developing internal people with the potential to fill key business leadership positions in the company. Succession planning increases the availability of experienced and capable employees that are prepared to assume these roles as they become available. During times of emergency, facilities must have employees who are capable of assuming various critical roles in the event that current staff and leadership are not available. At a minimum, there should be a qualified person who "is authorized in writing to act in the absence of the administrator or person legally responsible for the operations of the facility." In addition to the facility- and community-based risk assessment, continuity of operations planning generally considers elements such as: essential personnel, essential functions, critical resources, vital records and IT data protection, alternate facility identification and location, and financial resources. Facilities are encouraged to refer to and utilize resources from various agencies such as FEMA and Assistant Secretary for Preparedness and Response (ASPR) when developing strategies for ensuring continuity of operations. Facilities are encouraged to refer to and utilize resources from various agencies such as FEMA and ASPR when developing strategies for ensuring continuity of operations.

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0009	Process for EP Collaboration	11/15/2017	Yes	Yes	§403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.22(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4)	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. **	While the responsibility for ensuring a coordinated disaster preparedness response lies upon the state and local emergency planning authorities, the facility must document its efforts to contact these officials to engage in collaborative planning for an integrated emergency response. The facility must include this integrated response process in its emergency plan. Facilities are encouraged to participate in a healthcare coalition as it may provide assistance in planning and addressing broader community needs that may also be supported by local health department and emergency management resources. Survey Procedures Interview facility leadership and ask them to describe their process for ensuring cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation. • Ask for documentation of the facility's efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts.
0013	Development of EP Policies and Procedures	11/15/2017	Yes	Yes	§403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.22(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).	(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.	Facilities must develop and implement policies and procedures per the requirements of this standard. The policies and procedures are expected to align with the identified hazards within the facility's risk assessment and the facility's overall emergency preparedness program. We are not specifying where the facility must have the emergency preparedness policies and procedures. A facility may choose whether to incorporate the emergency policies and procedures within their emergency plan or to be part of the facility's Standard Operating Procedures or Operating Manual. However, the facility must be able to demonstrate compliance upon survey, therefore we recommend that facilities have a central place to house the emergency preparedness program documents (to include all policies and procedures) to facilitate review. Survey Procedures Review the written policies and procedures which address the facility's emergency plan and verify the following: • Policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach. • Ask to see documentation that verifies the policies and procedures have been reviewed and updated on an annual basis.

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0015	Subsistence needs for staff and patients	11/15/2017	Yes	Yes	§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)	[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) 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.	Facilities must be able to provide for adequate subsistence for all patients and staff for the duration of an emergency or until all its patients have been evacuated and its operations cease. Facilities have flexibility in identifying their individual subsistence needs that would be required during an emergency. There are no set requirements or standards for the amount of provisions to be provided in facilities, Provisions include, but are not limited to, food, pharmaceuticals and medical supplies. Provisions should be stored in an area which is less likely to be affected by disaster, such as storing these resources above ground-level to protect from possible flooding. Additionally, when inpatient facilities determine their supply needs, they are expected to consider the possibility that volunteers, visitors, and individuals from the community may arrive at the facility to offer assistance or seek shelter. Alternate sources of energy depend on the resources available to a facility, such as battery-operated lights, or heating and cooling, in order to meet the needs of a facility during an emergency. Facilities are not required to upgrade their electrical systems, but after review of their risk assessment, facilities may find it prudent to make any necessary adjustments to ensure that occupants health and safety needs are met, and that facilities maintain safe and sanitary storage areas for provisions. This specific standard does not require facilities to have or install generators or any other specific type of energy source. (However, for hospitals at §482.15(e), CAHs at §485.625(e) and LTC facilities at §483.73(e) please also refer to Tag E-0041 for Emergency and Stand-by Power Systems.) It is up to each individual facility, based on its risk assessment, to determine the most appropriate alternate energy sources to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, and alarm systems and sewage and waste disposal. Whatever alternate sources of energy a facility chooses to utilize must be in accordance with local and state laws as well as relevant LSC requirements. Facilities must establish policies and procedures that determine how required heating and cooling of their facility will be maintained during an emergency situation, as necessary, if there were a loss of the primary power source. If a facility determines the best way to maintain temperatures, emergency lighting, fire detection and extinguishing systems and sewage and waste disposal would be through the use of a portable generator, then the Life Safety Code (LSC) provisions, such as generator testing and fuel storage, etc. outlined under the NFPA guidelines would not be applicable. Portable generators should be operated, tested, and maintained in accordance with manufacturer, local and/or State requirements. If a facility, however, chooses to utilize a permanent generator to maintain emergency power, LSC provisions such as generator testing and maintenance will apply and the facility may be subject to LSC surveys to ensure compliance is met.
0018	Procedures for Tracking of Staff and Patients	11/15/2017	Yes	Yes	§403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. LTC at §483.73(b), ICF at §483.475(b), Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [LTC, ICF] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [LTC, ICF] must document the specific name and location of the receiving facility or other location. Interpretive Guidelines applies to: §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).	Facilities must develop a means to track patients and on-duty staff in the facility's care during an emergency event. In the event staff and patients are relocated, the facility must document the specific name and location of the receiving facility or other location for sheltered patients and on-duty staff who leave the facility during the emergency. LTC facilities and ICF organizations are required to track the location of sheltered patients and staff during and after an emergency. We are not specifying which type of tracking system should be used; rather, a facility has the flexibility to determine how best to track patients and staff, whether it uses an electronic database, hard copy documentation, or some other method. However, it is important that the information be readily available, accurate, and shareable among officials within and across the emergency response systems as needed in the interest of the patient. It is recommended that a facility that is using an electronic database consider backing up its computer system with a secondary source, such as hard copy documentation in the event of power outages. The tracking systems set up by facilities may want to consider who is responsible for compiling/securing patient records and what information is needed during tracking a patient throughout an evacuation. A number of states already have such tracking systems in place or under development and the systems are available for use by health care providers and suppliers. Facilities are encouraged to leverage the support and resources available to them through local and national healthcare systems, healthcare coalitions, and healthcare organizations for resources and tools for tracking patients. Facilities are not required to track the location of patients who have voluntarily left on their own, or have been appropriately discharged, since they are no longer in the facility's care. However, this information must be documented in the patient's medical record should any questions later arise as to the patient's whereabouts. Survey Procedures • Ask staff to describe and/or demonstrate the tracking system used to document locations of patients and staff. • Verify that the tracking system is documented as part of the facilities' emergency plan policies and procedures.

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0020	Policies and Procedures including Evacuation	11/15/2017	Yes	Yes	§403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2)	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [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.	Facilities must develop policies and procedures that provide for the safe evacuation of patients from the facility and include all of the requirements of this standard. RHCs and FQHCs must also place exit signs to guide patients and staff in the event of an evacuation from the facility. Facilities must have policies and procedures which address the needs of evacuees. The facility should also consider in development of the policies and procedures, the evacuation protocols for not only the evacuees, but also staff members and families/patient representatives or other personnel who sought potential refuge at the facility. Additionally, the policies and procedures must address staff responsibilities during evacuations. Facilities must consider the patient population needs as well as their care and treatment. For example, if an evacuation is in progress and the facility must evacuate, leadership should consider the needs for critically ill patients to be evacuated and accompanied by staff who could provide care and treatment enroute to the designated relocation site, in the event trained medical professionals are unavailable by the transportation services. Facilities must consider in their development of policies and procedures, the needs of their patient population and what designated transportation services would be most appropriate. For instance, if a facility primarily cares for critically ill patients with ventilation needs and life-saving equipment, the transportation services should be able to assist in evacuation of this special population and be equipped to do so. Additionally, facilities may also find it prudent to consider alternative methods for evacuation and patient care and treatment, such as mentioned above to have staff members evacuate with patients in given situations. Additionally, facilities should consider their triaging system when coordinating the tracking and potential evacuation of patient/residents/clients. For instance, a triaging system for evacuation may consider the most critical patients first followed by those less critical and dependent on life-saving equipment. Considerations for prioritization may be based on, among other things, acuity, mobility status (stretch-bound/wheelchair/ambulatory), and location of the unit, availability of a known transfer destination or some combination thereof. Included within this system should be who (specifically) will be tasked with making triage decisions. Following the triaging system, staff should consider the communication of patient care requirements to the in-taking facility, such as attaching hard copy of standard abbreviated patient health condition/history, injuries, allergies, and treatment rendered. On the same method for communicating this information, a facility could consider color coordination of triage level (i.e. green folder with this information is for less critical patients; red folders for critical and urgent evacuated patients, etc.). Additionally, this hard copy could include family member/representative contact information. Finally, facilities policies and procedures must outline primary and alternate means for communication with external sources for assistance.

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0022	Policies and Procedures for Sheltering	11/15/2017	Yes	Yes	§403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3).	(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility].	Emergency plans must include a means for sheltering all patients, staff, and volunteers who remain in the facility in the event that an evacuation cannot be executed. . In certain disaster situations (such as tornadoes) , sheltering in place may be more appropriate as opposed to evacuation and would require a facility to have a means to shelter in place for such emergencies. Therefore, facilities are required to have policies and procedures for sheltering in place which align with the facility's risk assessment. Facilities are expected to include in their policies and procedures the criteria for determining which patients and staff that would be sheltered in place. When developing policies and procedures for sheltering in place, facilities should consider the ability of their building(s) to survive a disaster and what proactive steps they could take prior to an emergency to facilitate sheltering in place or transferring of patients to alternate settings if their facilities were affected by the emergency. For example, if it is dangerous to evacuate or the emergency affects available sites for transfer or discharge, then the patients would remain in the facility until it was safe to effectuate transfers or discharges. The plan should take into account the appropriate facilities in the community to which patients could be transferred in the event of an emergency. Facilities must determine their policies based on the type of emergency and the types of patients, staff, volunteers and visitors that may be present during an emergency. Based on its emergency plan, a facility could decide to have various approaches to sheltering some or all of its patients and staff. Survey Procedures • Verify the emergency plan includes policies and procedures for how it will provide a means to shelter in place for patients, staff and volunteers who remain in a facility. • Review the policies and procedures for sheltering in place and evaluate if they aligned with the facility's emergency plan and risk assessment.
0023	Policies and Procedures for Medical Docs.	11/15/2017	Yes	Yes	§403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.22(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4).	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.	In addition to any existing requirements for patient records found in existing laws, under this standard, facilities are required to ensure that patient records are secure and readily available to support continuity of care during emergency. This requirement does not supersede or take away any requirements found under the provider/supplier's medical records regulations, but rather, this standard adds to such policies and procedures. These policies and procedures must also be in compliance with the Health Insurance Portability and Accountability Act (HIPAA), Privacy and Security Rules at 45 CFR parts 160 and 164, which protect the privacy and security of individual's personal health information.

Tag #	Title	Effective Date	LTC	ICF	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM
0024	Policies and Procedures for Volunteers	11/15/2017	Yes	Yes	§403.748(b)(6), §416.54(b)(5), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.22(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5).	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] 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. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.	During an emergency, a facility may need to accept volunteer support from individuals with varying levels of skills and training. The facility must have policies and procedures in place to facilitate this support. In order for volunteering healthcare professionals to be able to perform services within their scope of practice and training, facilities must include any necessary privileging and credentialing processes in its emergency preparedness plan policies and procedures. Non-medical volunteers would perform non-medical tasks. Facilities have flexibility in determining how best to utilize volunteers during an emergency as long as such utilization is in accordance with State law, State scope of practice rules, and facility policy. These may also include federally designated health care professionals, such as Public Health Service (PHS) staff, National Disaster Medical System (NDMS) medical teams, Department of Defense (DOD) Nurse Corps, Medical Reserve Corps (MRC), or personnel such as those identified in federally designated Health Professional Shortage Areas (HPSAs) to include licensed primary care medical, dental, and mental/behavioral health professionals. Facilities are also encouraged to integrate State-established volunteer registries, and where possible, State-based Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP). Facilities are expected to include in its emergency plan a method for contacting off-duty staff during an emergency and procedures to address other contingencies in the event staff are not able to report to duty which may include, but are not limited to, utilizing staff from other facilities and state or federally-designated health professionals. Survey Procedures • Verify the facility has included policies and procedures for the use of volunteers and other staffing strategies in its emergency plan.
0025	Arrangement with other Facilities	11/15/2017	Yes	Yes	§403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6).	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]	Facilities are required to have policies and procedures which include prearranged transfer agreements, which may include written agreements or contracted arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. Facilities should consider all needed arrangements for the transfer of patients during an evacuation. Survey Procedures • Ask to see copies of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency. • Ask facility leadership to explain the arrangements in place for transportation in the event of an evacuation.
0026	Roles under a Waiver Declared by Secretary	11/15/2017	Yes	Yes	§403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7) §494.62(b)(7).	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [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.	Facilities must develop and implement policies and procedures that describe its role in providing care at alternate care sites during emergencies. It is expected that state or local emergency management officials might designate such alternate sites, and would plan jointly with local facilities on issues related to staffing, equipment and supplies at such alternate sites. This requirement encourages providers to collaborate with their local emergency officials in such proactive planning to allow an organized and systematic response to assure continuity of care even when services at their facilities have been severely disrupted. Facility's policies and procedures must specifically address the facility's role in emergencies where the President declares a major disaster or emergency under the Stafford Act or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency Examples of 1135 waivers include some of the existing CoPs; Licensure for Physicians or others to provide services in the affected State; EMTALA; Medicare Advantage out of network providers and HIPAA. Facilities policies and procedures should address what coordination efforts are required during a declared emergency in which a waiver of federal requirements under section 1135 of the Act has been granted by the Secretary. For example, if due to a mass casualty incident in a geographic location, an 1135 waiver may be granted to waive licensure for physicians in order for these individuals to assist at a specific facility where they do not normally practice, then the facility should have policies and procedures which outline the responsibilities during the duration of this waiver period. For instance, the policies may establish a lead person in charge for accountability and oversight of assisting physicians not usually under contract with the facility. Additionally, facilities should also have in place policies and procedures which address emergency situations in which a declaration was not made and where an 1135 waiver may not be applicable, such as during a disaster affecting the single facility. In this case, policies and procedures should address potential transfers of patients; timelines of patients at alternate facilities, etc. For additional 1135 Waiver information, the SCG Emergency Preparedness Website has resources. Survey Procedures • Verify the facility has included policies and procedures in its emergency plan describing the facility's role in providing care and treatment (except for RNHCI, for care only) at alternate care sites under an 1135 waiver.

Tag #	Title	Effective Date	LTC	ICF	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM
0029	Development of Communication Plan	11/15/2017	Yes	Yes	§403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.22(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).	(c) The [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.	Facilities must have a written emergency communication plan that contains how the facility coordinates patient care within the facility, across healthcare providers, and with state and local public health departments. The communication plan should include how the facility interacts and coordinates with emergency management agencies and systems to protect patient health and safety in the event of a disaster. The development of a communication plan will support the coordination of care. The plan must be reviewed annually and updated as necessary. We are allowing facilities flexibility in how they formulate and operationalize the requirements of the communication plan. Facilities in rural or remote areas with limited connectivity to communication methodologies such as the Internet, World Wide Web, or cellular capabilities need to ensure their communication plan addresses how they would communicate and comply with this requirement in the absence of these communication methodologies. For example, if a facility is located in a rural area, which has limited or no Internet and phone connectivity during an emergency, it must address what alternate means are available to alert local and State emergency officials. Optional communication methods facilities may consider include satellite phones, radios and short wave radios. Survey Procedures • Verify that the facility has a written communication plan by asking to see the plan. • Ask to see evidence that the plan has been reviewed (and updated as necessary) on an annual basis.
0030	Names and Contact Information	11/15/2017	Yes	Yes	§403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.22(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).	[(c) The 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: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.	A facility must have the contact information for those individuals and entities outlined within the standard. The requirement to have contact information for “other facilities” requires a provider or supplier to have the contact information for another provider or supplier of the same type as itself. Facilities have discretion in the formatting of this information, however it should be readily available and accessible to leadership and staff during an emergency event. Facilities which utilize electronic data storage should be able to provide evidence of data back-up with hard copies or demonstrate capability to reproduce contact lists or access this data during emergencies. All contact information must be reviewed and updated as necessary at least annually. Contact information contained in the communication plan must be accurate and current. Facilities must update contact information for incoming new staff and departing staff throughout the year and any other changes to information for those individuals and entities on the contact list. Survey Procedures • Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information. • Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review.

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0031	Emergency Officials Contact Information	11/15/2017	Yes	Yes	§403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.22(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2).	[(c) The [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: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.	A facility must have the contact information for those individuals and entities outlined within the standard. Facilities have discretion in the formatting of this information, however it should be readily available and accessible to leadership during an emergency event. Facilities are encouraged but not required to maintain these contact lists both in electronic format and hard-copy format in the event that network systems to retrieve electronic files are not accessible. All contact information must be reviewed and updated at least annually. Survey Procedures • Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information. • Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review.
0032	Primary/Alternate Means for Communication	11/15/2017	Yes	Yes	§403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.22(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3).	[(c) The [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: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.	Facilities are required to have primary and alternate means of communicating with staff, Federal, State, tribal, regional, and local emergency management agencies. Facilities have the discretion to utilize alternate communication systems that best meets their needs. However, it is expected that facilities would consider pagers, cellular telephones, radio transceivers (that is, walkie-talkies), and various other radio devices such as the NOAA Weather Radio and Amateur Radio Operators' (HAM Radio) systems, as well as satellite telephone communications systems. We recognize that some facilities, especially in remote areas, may have difficulty using some communication systems, such as cellular phones, even in non-emergency situations, which should be outlined within their risk assessment and addressed within the communications plan. It is expected these facilities would address such challenges when establishing and maintaining a well-designed communication system that will function during an emergency. The communication plan should include procedures regarding when and how alternate communication methods are used, and who uses them. In addition the facility should ensure that its selected alternative means of communication is compatible with communication systems of other facilities, agencies and state and local officials it plans to communicate with during emergencies. For example, if State X local emergency officials use the SHAred RESources (SHARES) High Frequency (HF) Radio program and facility Y is trying to communicate with RACES, it may be prudent to consider if these two alternate communication systems can communicate on the same frequencies. Facilities may seek information about the National Communication System (NCS), which offers a wide range of National Security and Emergency Preparedness communications services, the Government Emergency Telecommunications Services (GETS), the Telecommunications Service Priority (TSP) Program, Wireless Priority Service (WPS), and SHARES. Other communication methods could include, but are not limited to, satellite phones, radio, and short wave radio. The Radio Amateur Civil Emergency Services (RACES) is an integral part of emergency management operations. Survey Procedures • Verify the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies by reviewing the communication plan. • Ask to see the communications equipment or communication systems listed in the plan.

Tag #	Title	Effective Date	LTC	ICF	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM
0033	Methods for Sharing Information	11/15/2017	Yes	Yes	§403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.22(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4),	[(c) The [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: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).	Facilities are required to develop a method for sharing information and medical (or for RNHCIs only, care) documentation for patients under the facility's care, as necessary, with other health care providers to maintain continuity of care. Such a system must ensure that information necessary to provide patient care is sent with an evacuated patient to the next care provider and would also be readily available for patients being sheltered in place. While the regulation does not specify timelines for delivering patient care information, facilities are expected to provide patient care information to receiving facilities during an evacuation, within a timeframe that allows for effective patient treatment and continuity of care. Facilities should not delay patient transfers during an emergency to assemble all patient reports, tests, etc. to send with the patient. Facilities should send all necessary patient information that is readily available and should include at least, patient name, age, DOB, allergies, current medications, medical diagnoses, current reason for admission (if inpatient), blood type, advance directives and next of kin/emergency contacts. There is no specified means (such as paper or electronic) for how facilities are to share the required information. Facilities are also required to have a means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510 and a means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). Thus, facilities must have a communication system in place capable of generating timely, accurate information that could be disseminated, as permitted under 45 CFR 164.510(b)(4), to family members and others. Facilities have the flexibility to develop and maintain their own system in a manner that best meets its needs. HIPAA requirements are not suspended during a national or public health emergency. However, the HIPAA Privacy Rule specifically permits certain uses and disclosures of protected health information in emergency circumstances and for disaster relief purposes. Section 164.510 ‘‘Uses and disclosures requiring an opportunity for the individual to agree to or to object,’’ is part of the ‘‘Standards for Privacy of Individually Identifiable Health Information,’’ commonly known as ‘‘The Privacy Rule.’’ HIPAA Privacy Regulations at 45 CFR 164.510(b)(4), ‘‘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. Survey Procedures • Verify the communication plan includes a method for sharing information and medical (or for RNHCIs only, care) documentation for patients under the facility's care, as necessary, with other health (or care for RNHCIs) providers to maintain the continuity of care by reviewing the communication plan. • Verify the facility has developed policies and procedures that address the means the facility will use to release patient information to include
0034	Sharing Information on Occupancy/Needs	11/15/2017	Yes	Yes	§403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.22(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7).	[(c) The [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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.	Facilities, except for transplant centers, must have a means of providing information about the facility’s needs and its ability to provide assistance to the authority having jurisdiction (local and State emergency management agencies, local and state public health departments, the Incident Command Center, the Emergency Operations Center, or designee). For hospitals, CAHs, RNHCIs, inpatient hospices, PRTFs, LTC facilities, and ICF/IIDs, they must also have a means for providing information about their occupancy. Occupancy reporting is considered, but not limited to, reporting the number of patients currently at the facility receiving treatment and care or the facility’s occupancy percentage. The facility should consider how its occupancy affects its ability to provide assistance. For example, if the facility’s occupancy is close to 100% the facility may not be able to accept patients from nearby facilities. The types of “needs” a facility may have during an emergency and should communicate to the appropriate authority would include but is not limited to, shortage of provisions such as food, water, medical supplies, assistance with evacuation and transfers, etc. Note: The authority having jurisdiction varies by local, state and federal emergency management structures as well as the type of disaster. For example, in the event of a multi-state wildfire, the jurisdictional authority who would take over the Incident Command Center or state-wide coordination of the disaster would likely be a fire-related agency. We are not prescribing the means that facilities must use in disseminating the required information. However, facilities should include in its communication plan, a process to communicate the required information. Note: As defined by the Federal Emergency Management Administration (FEMA), an Incident Command System (ICS) is a management system designed to enable effective and efficient domestic incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. (FEMA, 2016). The industry, as well as providers/suppliers, use various terms to refer to the same function and we have used the term ‘‘Incident Command Center’’ to mean ‘‘Emergency Operations Center’’ or ‘‘Incident Command Post.’’ Local, State, Tribal and Federal emergency preparedness officials, as well as regional healthcare coalitions, can assist facilities in the identification of their Incident Command Centers and reporting requirements dependent on an emergency. Survey Procedures • Verify the communication plan includes a means of providing information about the facility’s needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee by reviewing the communication plan.

Tag #	Title	Effective Date	LTC	ICF	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM
0035	LTC and ICF/IID Family Notifications	11/15/2017	Yes	Yes	§483.73(c)(8); §483.475(c)(8)	[(c) The [LTC facility and ICF] 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: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.	LTC facilities and ICF are required to share emergency preparedness plans and policies with family members and resident representative s or client representatives, respectively. Facilities have flexibility in deciding what information from the emergency plan should be shared, as well as the timing and manner in which it should be disseminated. While we are not requiring facilities take specific steps or utilize specific strategies to share this information with residents or clients and their families or representatives, we would recommend that facilities provide a quick “Fact Sheet” or informational brochure to the family members and resident or client representatives which may highlight the major sections of the emergency plan and policies and procedures deemed appropriate by the facility. Other options include providing instructions on how to contact the facility in the event of an emergency on the public website or to include the information as part of the facility’s check-in procedures. The facility may provide this information to the surveyor during the survey to demonstrate compliance with the requirement. Survey Procedures • Ask staff to demonstrate the method the facility has developed for sharing the emergency plan with residents or clients and their families or representatives. • Interview residents or clients and their families or representatives and ask them if they have been given information regarding the facility’s emergency plan. • Verify the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan.
0036	Emergency Prep Training and Testing	11/15/2017	Yes	Yes	§403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.22(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).	(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF at §483.475(d):] Training and testing. The ICF must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF must meet the requirements for evacuation drills and training at §483.470(h).	An emergency preparedness training and testing program as specified in this requirement must be documented and reviewed and updated on at least an annual basis. The training and testing program must reflect the risks identified in the facility’s risk assessment and be included in their emergency plan. For example, a facility that identifies flooding as a risk should also include policies and procedures in their emergency plan for closing or evacuating their facility and include these in their training and testing program. This would include, but is not limited to, training and testing on how the facility will communicate the facility closure to required individuals and agencies, testing patient tracking systems and testing transportation procedures for safely moving patients to other facilities. Additionally, for facilities with multiple locations, such as multi-campus or multi-location hospitals, the facility’s training and testing program must reflect the facility’s risk assessment for each specific location. Training refers to a facility’s responsibility to provide education and instruction to staff, contractors, and facility volunteers to ensure all individuals are aware of the emergency preparedness program. Testing is the concept in which training is operationalized and the facility is able to evaluate the effectiveness of the training as well as the overall emergency preparedness program. Testing includes conducting drills and/or exercises to test the emergency plan to identify gaps and areas for improvement. Survey Procedures • Verify that the facility has a written training and testing program that meets the requirements of the regulation. • Verify the program has been reviewed and updated on, at least, an annual basis by asking for documentation of the annual review as well as any updates made. • Verify that ICF emergency plans also meet the requirements for evacuation drills and training at §483.470(i).

Tag #	Title	Effective Date	LTC	ICF	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM
0037	Emergency Prep Training Program	11/5/2017	Yes	Yes	§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.22(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).	(1) Training program. The organizations must do all of the following: (i) 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 role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.	Facilities are required to provide initial training in emergency preparedness policies and procedures that are consistent with their roles in an emergency to all new and existing staff, individuals providing services under arrangement, and volunteers. This includes individuals who provide services on a per diem basis such as agency nursing staff and any other individuals who provide services on an intermittent basis and would be expected to assist during an emergency. Facilities should provide initial emergency training during orientation (or shortly thereafter) to ensure initial training is not delayed. . Additionally, in the case of facilities with multiple locations, such as multi-campus hospitals, staff, individuals providing services under arrangement, or volunteers should be provided initial training at their specific location and when they are assigned to a new location. Facilities have the flexibility to determine the focus of their annual training, as long as it aligns with the emergency plan and risk assessment. Ideally, annual training should be modified each year, incorporating any lessons learned from the most recent exercises, real-life emergencies that occurred in the last year and during the annual review of the facility's emergency program. For example, annual training could include training staff on new evacuation procedures that were identified as a best practice and documented in the facility "After Action Report" (AAR) during the last emergency drill and were incorporated into the emergency plan during the program's annual review. While facilities are required to provide annual training to all staff, it is up to the facility to decide what level of training each staff member will be required to complete each year based on an individual's involvement or expected role during an emergency. There may be core topics that apply to all staff, while certain clinical staff may require additional topics. For example, dietary staff who prepare meals may not need to complete annual training that is focused on patient evacuation procedures. Instead, the facility may provide training that focuses on the proper preparation and storage of food in an emergency. In addition, depending on specific staff duties during an emergency, a facility may determine that documented external training is sufficient to meet some or all of the facility's annual training requirements. For example, staff who work with radiopharmaceuticals may attend external training that teach staff how to handle radiopharmaceutical emergencies. It is up to the facility to decide if the external training meets the facility's requirements. Facilities must maintain documentation of the annual training for all staff. The documentation must include the specific training completed as well as the methods used for demonstrating knowledge of the training program. Facilities have flexibility in ways to demonstrate staff knowledge of emergency procedures. The method chosen is likely based on the training delivery method. For example: computer-based or printed self-learning packets may contain a test to demonstrate knowledge. If facilities choose instructor-led training, a question and answer session could follow the training. Regardless of the method, facilities must maintain documentation that training was completed and that staff
0039	Emergency Prep Testing Requirements	11/5/2017	Yes	Yes	§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.22(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).	(2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. 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 all of the following:] (i) 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 [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [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. (ii) 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. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.	Facilities must on an annual basis conduct exercises to test the emergency plan, which for LTC facilities also includes unannounced staff drills using the emergency procedures. Specifically, facilities are required to conduct a tabletop exercise and participate in a full-scale community-based exercise or conduct an individual facility exercise if a community-based exercise is not available. As the term full-scale exercise may vary by sector, facilities are not required to conduct a full-scale exercise as defined by FEMA or DHS's Homeland Security Exercise and Evaluation Program (HSEEP). For the purposes of this requirement, a full scale exercise is defined and accepted as any operations-based exercise (drill, functional, or full-scale exercise) that assesses a facility's functional capabilities by simulating a response to an emergency that would impact the facility's operations and their given community. There is also definition for "community" as it is subject to variation based on geographic setting, (e.g. rural, suburban, urban, etc.), state and local agency roles and responsibilities, types of providers in a given area in addition to other factors. In doing so, facilities have the flexibility to participate in and conduct exercises that more realistically reflect the risks and composition of their communities. Facilities are expected to consider their physical location, agency and other facility responsibilities and needs of the community when planning or participating in their exercises. The term could, however, mean entities within a state or multi-state region. In many areas of the country, State and local agencies (emergency management agencies and health departments) and some regional entities, such as healthcare coalitions may conduct an annual full-scale, community-based exercise in an effort to more broadly assess community-wide emergency planning, potential gaps, and the integration of response capabilities in an emergency. Facilities should actively engage these entities to identify potential opportunities, as appropriate, as they offer the facility the opportunity to not only assess their emergency plan but also better understand how they can contribute to, coordinate with, and integrate into the broader community's response during an emergency. They also provide a collective forum for assessing their communications plans to ensure they have the appropriate contacts and understand how best to engage and communicate with their state and local public health and emergency management agencies and other relevant partners, such as a local healthcare coalition, during an emergency. Facilities are expected to contact their local and state agencies and healthcare coalitions, where appropriate, to determine if an opportunity exists and determine if their participation would fulfill this requirement. In doing so, they are expected to document the date, the personnel and the agency or healthcare coalition that they contacted. It is also important to note that agencies and or healthcare coalitions conducting these exercises will not have the resources to fulfill individual facility requirements and thus will only serve as a conduit for broader community engagement and coordination prior to, during and after the full-scale community-based exercise. Facilities are responsible for resourcing their participation and ensuring that all requisite documentation is developed and available to demonstrate their compliance with this requirement.

Tag #	Title	Effective Date	LTC	ICF	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM
0041	Hospital CAH and LTC Emergency Power	11/5/2017	Yes	No	482.15(e), §485.625(e), §483.73(e).	§482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, and TIA 12–6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.	Note: This provision for hospitals, CAHs and LTC facilities requires these facility types to base their emergency power and stand-by systems on their emergency plan, risk assessment and policies and procedures. The determination for a generator should be made through the development of the facility's risk assessment and policies and procedures. If these facilities determine that no generator is required to meet the emergency power and stand-by systems requirements, then §§482.15(e)(1) and (2), §483.73(e)(1) and (2), §485.625(e)(1) and (2), would not apply. However, these facility types are must continue to meet the existing provisions and requirements for their provider/supplier types under physical environment CoPs or any existing LSC guidance. Emergency and standby power systems CMS requires Hospitals, CAHs and LTC facilities to comply with the 2012 edition of the National Fire Protection Association (NFPA) 101 – Life Safety Code (LSC) and the 2012 edition of the NFPA 99 – Health Care Facilities Code in accordance with the Final Rule (CMS–3277–F). NFPA 99 requires Hospitals, CAHs and certain LTC facilities to install, maintain, inspect and test an Essential Electric System (EES) in areas of a building where the failure of equipment or systems is likely to cause the injury or death of patients or caregivers. An EES is a system which includes an alternate source of power, distribution system, and associated equipment that is designed to ensure continuity of electricity to elected areas and functions during the interruption of normal electrical service. The EES alternate source of power for these facility types is typically a generator. (Note: LTC facilities are also expected to meet the requirements under Life Safety Code and NFPA 99 as outlined within the LTC Appendix of the SOM). In addition, NFPA 99 identifies the 2010 edition of NFPA 110 – Standard for Emergency and Standby Power Systems as a mandatory reference, which addresses the performance requirements for emergency and standby power systems and includes installation, maintenance, operation, and testing requirements. In addition to the LSC, NFPA 99 and NFPA 110 requirements, the Emergency Preparedness regulation requires all Hospitals, CAHs, and LTC facilities to implement emergency and standby power systems based upon a facility's established emergency plan, policies, and procedures. Emergency preparedness policies and procedures (substandard (b) of the emergency preparedness requirements) are required to address the subsistence needs of staff and residents, whether the facility decides to evacuate or shelter in place. Subsistence needs include, but are not limited to, food, water, medical, and pharmaceutical supplies, and alternate sources of energy to maintain: temperatures to protect patient/resident health and safety and sanitary storage of provisions; emergency lighting; fire detection, extinguishing, and alarm systems; and sewage and waste disposal.
0042	Integrated Health Systems	11/5/2017	Yes	Yes	§416.54(e), §418.113(e), §441.184(e), §460.84(e), §482.15(f), §483.73(f), §483.475(e), §484.22(e), §485.68(e), §485.625(f), §485.727(e), §485.920(e), §486.360(f), §491.12(e), §494.62(e).	(e) [or (f)]Integrated healthcare systems. 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 all of 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. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. (3) 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]. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following: (i) A documented community-based risk assessment, utilizing an all-hazards approach.	Healthcare systems that include multiple facilities that are each separately certified as a Medicare-participating provider or supplier have the option of developing a unified and integrated emergency preparedness program that includes all of the facilities within the healthcare system instead of each facility developing a separate emergency preparedness program. If an integrated healthcare system chooses this option, each certified facility in the system may elect to participate in the system's unified and integrated emergency program or develop its own separate emergency preparedness program. It is important to understand that healthcare systems are not required to develop a unified and integrated emergency program. Rather it is a permissible option. In addition, the separately certified facilities within the healthcare system are not required to participate in the unified and integrated emergency preparedness program. It is simply an option for each facility. If this option is taken, the healthcare system's unified emergency preparedness program should be updated each time a facility enters or leaves the healthcare system's program. If a healthcare system elects to have a unified emergency preparedness program, the integrated program must demonstrate that each separately certified facility within the system that elected to participate in the system's integrated program actively participated in the development of the program. Therefore, each facility should designate personnel who will collaborate with the healthcare system to develop the plan. The unified and integrated plan should include documentation that verifies each facility participated in the development of the plan. This could include the names of personnel at each facility who assisted in the development of the plan and the minutes from planning meetings. All components of the emergency preparedness program that are required to be reviewed and updated at least annually must include all participating facilities. Again, each facility must be able to prove that it was involved in the annual reviews and updates of the program. The healthcare system and each facility must document each facility's active involvement with the reviews and updates, as applicable. A unified program must be developed and maintained in a manner that takes into account the unique circumstances, patient populations, and services offered at each facility participating in the integrated program. For example, for a unified plan covering both a hospital and a LTC facility, the emergency plan must account for the residents in the LTC facility as well as those patients within a hospital, while taking into consideration the difference in services that are provided at a LTC facility and a hospital. The unique circumstances that should be addressed at each facility would include anything that would impact operations during an emergency, such as the location of the facility, resources such as the availability of staffing, medical supplies, subsistence, patients' and residents' varying acuity and mobility at the different types of facilities in a unified healthcare system, etc. Each separately certified facility must be capable of demonstrating during a survey that it can effectively implement the emergency

TAG	DESCRIPTION	MY EOP	UPDATES/NOTES
E-0001	**Establishment of the Emergency Preparedness Program**	**Section:**	**Date Last Updated:**
The facility must comply with all applicable Federal, State and local emergency preparedness requirements. The facility must establish and maintain a comprehensive emergency preparedness program that must include, but not be limited to, the following elements:		**3.0**	
E-0004	**Annual Updates to the EP Program**	**Section:**	**Date Last Updated:**
The facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The emergency plan supports, guides, and ensures a facility's ability to collaborate with local emergency preparedness officials. This approach is specific to the location of the facility and considers particular hazards most likely to occur in the surrounding area.		**1.4**	
E-0006	**All Hazards Approach/Assessment**	**Section:**	**Date Last Updated:**
Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. Include strategies for addressing emergency events identified by the risk assessment.		**3.1**	
E-0007	**Unique Needs of Residents, Continuity of Operations**	**Section:**	**Date Last Updated:**
Address patient/client population, including, but not limited to, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.		**3.2 - 3.3**	

TAG	DESCRIPTION	MY EOP	UPDATES/NOTES
E-0009	**Process for Planning with Response Authorities**	**Section:**	**Date Last Updated:**
Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.		**3.7 - 3.9, 5.0**	
E-0013	**Policies & Procedures Based on Risk Assessment**	**Section:**	**Date Last Updated:**
Facilities 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.		**4.0**	
E-0015	**Subsistence Needs for Residents**	**Section:**	**Date Last Updated:**
The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) 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.		**4.16**	

TAG	DESCRIPTION	MY EOP	UPDATES/NOTES
E-0018	**Resident & Staff Tracking Systems**	**Section:**	**Date Last Updated:**
A system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the facility must document the specific name and location of the receiving facility or other location.		**4.5**	
E-0020	**Safe Evacuation**	**Section:**	**Date Last Updated:**
Safe evacuation from the 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.		**4.5**	
E-0022	**Shelter in Place**	**Section:**	**Date Last Updated:**
A means to shelter in place for patients, staff, and volunteers who remain in the facility.		**4.15**	
E-0023	**Sharing Medical Documents Under HIPAA**	**Section:**	**Date Last Updated:**
A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.		**4.12**	
E-0024	**Staffing Strategies/Volunteer Management**	**Section:**	**Date Last Updated:**
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.		**3.5**	

TAG	DESCRIPTION	MY EOP	UPDATES/NOTES
E-0025	**Memorandum of Understanding/Agreement (MOU)**	**Section:**	**Date Last Updated:**
The development of arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.		**3.6, Appendix J**	
E-0026	**1135 Waiver/Alternate Care Sites**	**Section:**	**Date Last Updated:**
The role of the 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.		**3.7**	
E-0029	**Emergency Communication Plan**	**Section:**	**Date Last Updated:**
The 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.		**5.0**	
E-0030	**Emergency Communications Plan (Internal)**	**Section:**	**Date Last Updated:**
Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.		**2.0**	

TAG	DESCRIPTION	MY EOP	UPDATES/NOTES
E-0031	**Emergency Communications Plan (External)**	**Section:**	**Date Last Updated:**
The 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. It must have contact information from the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The State Ombudsman, or other advocacy agency. (iv) Other sources of assistance.		**2.0, 5.0**	
E-0032	**Primary & Alternate Means of Communication**	**Section:**	**Date Last Updated:**
The 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 Primary and alternate means for communicating with facility staff and external emergency management agencies.		**5.0**	
E-0033	**Methods of Sharing Medical Information to Other Providers**	**Section:**	**Date Last Updated:**
The communication plan must include all of the following: (i) A method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care. (ii) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). (iii) A means of providing information about the general condition and location of patients under the facility's care.		**4.12, 5.0**	

TAG	DESCRIPTION	MY EOP	UPDATES/NOTES
E-0034	**Sharing Information on Occupancy/Needs to Authorities**	**Section:**	**Date Last Updated:**
The communication plan must include all of the following: (i) A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.		**2.0, 5.0**	
E-0035	**Informing Residents' Families of the Emergency Plan**	**Section:**	**Date Last Updated:**
The communication plan must include all of the following: (i) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.		**5.0**	
E-0036	**Testing the Emergency Preparedness Program**	**Section:**	**Date Last Updated:**
The facility must develop and maintain an emergency preparedness training and testing program that is 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. Additionally, for facilities with multiple locations, the facility's training and testing program must reflect the facility's individual risk assessment for each specific location.		**3.10**	
E-0037	**Training Staff on the Emergency Preparedness Program**	**Section:**	**Date Last Updated:**
The facility must do all of the following: (i) 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 role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.		**3.10**	

TAG	DESCRIPTION	MY EOP	UPDATES/NOTES
E-0039	**Exercise Requirements for the Emergency Prep Program**	**Section:**	**Date Last Updated:**
The facility must do all of the following: (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. a. If the facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the 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. (ii) 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. (iii) Analyze the facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the facility's emergency plan, as needed.		**3.10**	
E-0041	**LTC Emergency Power Requirements**	**Section:**	**Date Last Updated:**
Facilities are required to base their emergency power and stand-by systems on their emergency plan, risk assessment and policies and procedures. The determination for a generator should be made through the development of the facility's risk assessment and policies and procedures. (i) The facility must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.		**4.14, 4.16**	

TAG	DESCRIPTION	MY EOP	UPDATES/NOTES
(ii) Facilities 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. This includes maintaining fuel onsite to maintain generator operation, or it could include making arrangements for fuel delivery for an emergency event.			
E-0042	**Integrated Health Systems**	**Section:**	**Date Last Updated:**
If a facility is part of a healthcare system, the facility may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the program must do all of the following: (i) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (ii) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. (iii) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and complies with the healthcare system's program. (iv) Include a unified and integrated emergency plan that includes 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 that meet unique needs of each facility's residents, a coordinated communication plan, and coordinated training and testing programs.		**3.0, 4.0, 5.0**	

LONG TERM CARE

EMERGENCY PREPAREDNESS WORKSHEET

1. DATE OF SURVEY
2. NAME OF FACILITY
3. PROVIDER NUMBER
4. SURVEYOR
5. SURVEYOR ID

TAG #	TITLE	MET	NOT MET
E - 0001	Establishment of the Emergency Program (EP)		

Reg Text: The LTC facility must comply with all applicable Federal, State and local EP requirements. The LTC facility must establish and maintain a comprehensive EP program that meets the requirements of this section.The EP program must include, but not be limited to, the following elements:

TAG #	TITLE	MET	NOT MET
E - 0004	Develop and Maintain EP Program		

Reg Text: (a) Emergency Plan. The LTC facility must develop and maintain an EP plan that must be reviewed, and updated at least annually.

TAG #	TITLE	MET	NOT MET
E - 0006	Maintain and Annual EP Updates		

Reg Text: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.

TAG #	TITLE	MET	NOT MET
E - 0007	EP Program Patient Population		

Reg Text: (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

TAG #	TITLE	MET	NOT MET
E - 0009	Process for EP Collaboration		

Reg Text: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal EP officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

TAG #	TITLE	MET	NOT MET
E - 0013	Development of EP Policies and Procedures		

Reg Text: (b) Policies and procedures. LTC facilities must develop and implement EP policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.

TAG #	TITLE	MET	NOT MET
E - 0015	Subsistence needs for staff and patients		

Reg Text: At a minimum, the policies and procedures must address the following:
(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:
(i) Food, water, medical and pharmaceutical supplies
(ii) 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.

TAG #	TITLE	MET	NOT MET
E - 0018	Procedures for Tracking of Staff and Patients		

Reg Text: (2) A system to track the location of on-duty staff and sheltered patients in the LTC facility's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location.

TAG #	TITLE	MET	NOT MET
E - 0020	Policies and Procedures including Evacuation		

Reg Text: 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.

TAG #	TITLE	MET	NOT MET
E - 0022	Policies and Procedures for Sheltering		

Reg Text: (4) A means to shelter in place for patients, staff, and volunteers who remain in the LTC facility.

TAG #	TITLE	MET	NOT MET
E - 0023	Policies and Procedures for Medical Docs.		

Reg Text: (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.

TAG #	TITLE	MET	NOT MET
E - 0024	Policies and Procedures for Volunteers		

Reg Text: (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.

TAG #	TITLE	MET	NOT MET
E - 0025	Arrangement with other Facilities		

Reg Text: (7) The development of arrangements with other LTC facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.

TAG #	TITLE	MET	NOT MET
E - 0026	Roles under a Waiver Declared by Secretary		

Reg Text: (8) 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.

TAG #	TITLE	MET	NOT MET
E - 0029	Development of Communication Plan		

Reg Text: (c) The LTC facility must develop and maintain an EP communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.

TAG #	TITLE	MET	NOT MET
E - 0030	Names and Contact Information		

Reg Text: The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Residents' physicians
(iv) Other LTC facilities.
(v) Volunteers.

TAG #	TITLE	MET	NOT MET
E - 0031	Emergency Officials Contact Information		

Reg Text: (2) Contact information for the following: (i)
Federal, State, tribal, regional, or local emergency preparedness staff.
(ii) The State Licensing and Certification Agency.
(iii) The Office of the State Long-Term Care Ombudsman.
(iv) Other sources of assistance.

TAG #	TITLE	MET	NOT MET
E - 0032	Primary/Alternate Means for Communication		

Reg Text: (3) Primary and alternate means for communicating with the following:
(i) LTC facility's staff.
(ii) Federal, State, tribal, regional, and local emergency management agencies.

TAG #	TITLE	MET	NOT MET
E - 0033	Methods for Sharing Information		

Reg Text: (4) A method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health providers to maintain the continuity of care.

TAG #	TITLE	MET	NOT MET
E - 0034	Sharing Information on Occupancy/Needs		

Reg Text: (7) A means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

TAG #	TITLE	MET	NOT MET
E - 0035	LTC and ICF/IID Family Notifications		

Reg Text: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents and their families or representatives.

TAG #	TITLE	MET	NOT MET
E - 0036	Emergency Prep Training and Testing		

Reg Text: (d) Training and testing. The LTC facility must develop and maintain an EP training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

TAG #	TITLE	MET	NOT MET
E - 0037	Emergency Prep Training Program		

Reg Text: (1) Training program. The LTC facility must do all of the following:
(i) 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.
(ii) Provide EP training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

TAG #	TITLE	MET	NOT MET
E - 0039	Emergency Prep Testing Requirements		

Reg Text: (2) Testing. 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 all of the following:
(i) 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.
(ii) 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.
(iii) 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.

TAG #	TITLE	MET	NOT MET
E - 0041	Hospital CAH and LTC Emergency Power		

Reg Text: (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.
(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99), Life Safety Code (NFPA 101), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.
(e)(2) Emergency generator inspection and testing. The LTC facility must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.
(e)(3) Emergency generator fuel. LTC facilities 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.

TAG #	TITLE	MET	NOT MET
E - 0042	Integrated Health Systems		

Reg Text: (f) Integrated healthcare systems. If a LTC 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 LTC facility may choose to participate in the healthcare system's coordinated emergency preparedness program.
If elected, the unified and integrated EP program must do all of the following:
(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated EPprogram.
(2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.
(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated EP program and is in compliance with the program.
(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:
(i) A documented community-based risk assessment, utilizing an all-hazards approach.
(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.
(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Emergency Preparedness Rule

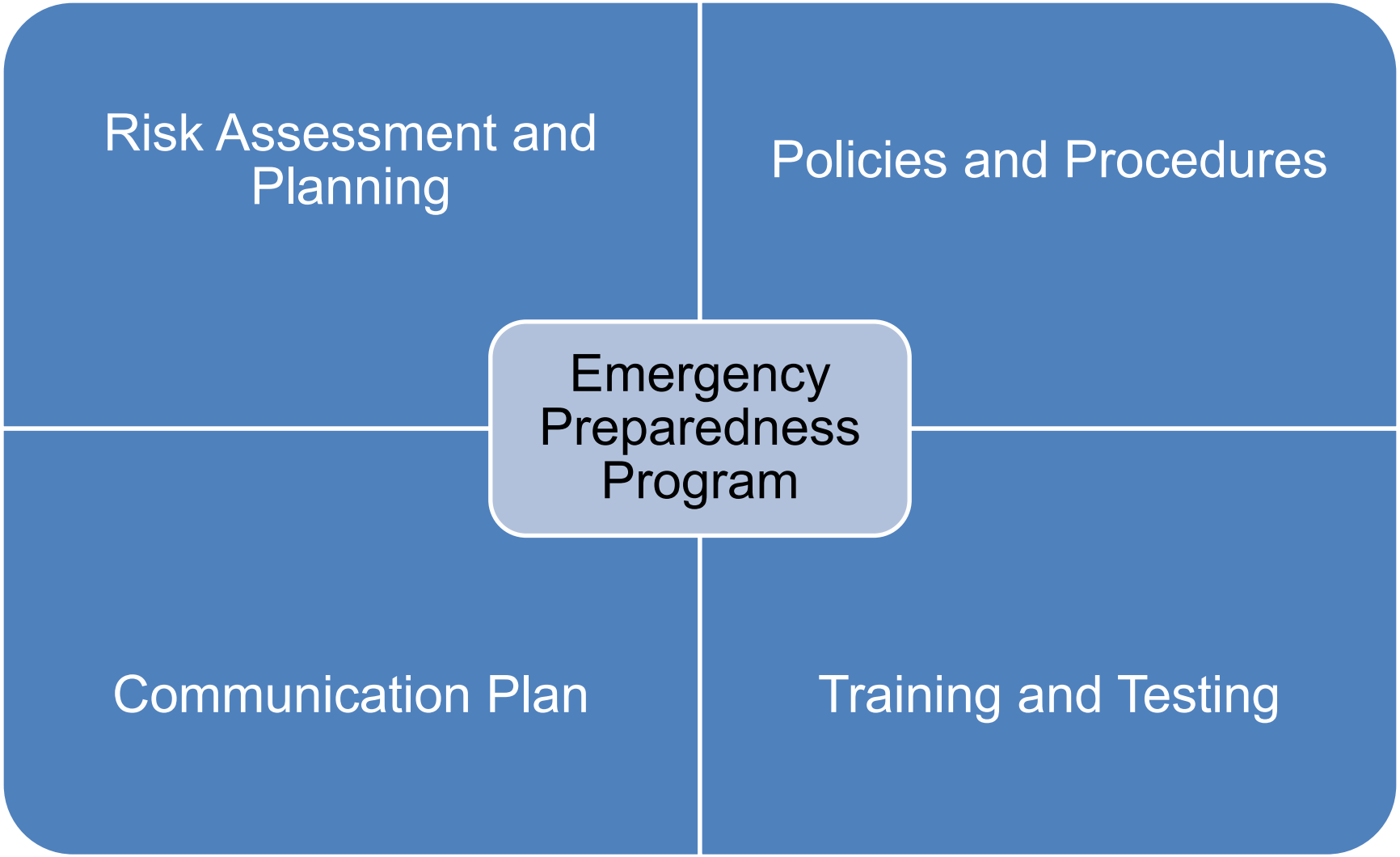
Understanding the Emergency Preparedness Final Rule

Centers for Medicare & Medicaid Services

Final Rule

- *Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers*
- Published September 16, 2016
- Applies to all 17 provider and supplier types
- Implementation date November 15, 2017
- Compliance required for participation in Medicare
- Emergency Preparedness is one new CoP/CfC of many already required

Four Provisions for All Provider Types



Risk Assessment and Planning

- Develop an emergency plan based on a risk assessment.
- Perform risk assessment using an “all-hazards” approach, focusing on capacities and capabilities.
- Update emergency plan at least annually.

All-Hazards Approach:

- An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies and a man-made emergency (or both) or natural disaster. This approach is specific to the location of the provider or supplier and considers the particular type of hazards most likely to occur in their areas. **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.**

Policies and Procedures

- Develop and implement policies and procedures based on the emergency plan and risk assessment.
- 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.
- Review and update policies and procedures at least annually.

Communication Plan

- Develop a communication plan that complies with both Federal and State laws.
- Coordinate patient care within the facility, across health care providers, and with state and local public health departments and emergency management systems.
- Review and update plan annually.

Training and Testing Program

- Develop and maintain training and testing programs, including initial training in policies and procedures.
- Demonstrate knowledge of emergency procedures and provide training at least annually.
- Conduct drills and exercises to test the emergency plan.

Training & Testing Requirements

- Facilities are expected to meet all Training and Testing Requirements by the implementation date (11/15/17).
  - Participation in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based exercise.
- Conduct an additional exercise that may include, but is not limited to the following:
  - A second full-scale exercise that is individual, facility-based.
  - 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.

Training & Testing Program Definitions

- **Facility-Based:** When discussing the terms “all-hazards approach” and facility-based risk assessments, we consider the term “facility-based” to mean that the emergency preparedness program is specific to the facility. Facility-based includes, but is not limited to, hazards specific to a facility based on the geographic location; Patient/Resident/Client population; facility type and potential surrounding community assets (i.e. rural area versus a large metropolitan area).

- **Full-Scale Exercise:** A full scale exercise is a multi-agency, multijurisdictional, multi-discipline exercise involving functional (for example, joint field office, emergency operation centers, etc.) and “boots on the ground” response (for example, firefighters decontaminating mock victims).

Training & Testing Program Definitions

- **Table-top Exercise (TTX):** A table-top exercise is a group discussion led by a facilitator, using narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. It involves key personnel discussing simulated scenarios, including computer-simulated exercises, in an informal setting. TTXs can be used to assess plans, policies, and procedures.

Final Rule- There are Requirements Which Vary by Provider Type

- Outpatient providers are not required to have policies and procedures for the provision of subsistence needs.
- Home health agencies and hospices required to inform officials of patients in need of evacuation.
- Long-term care and psychiatric residential treatment facilities must share information from the emergency plan with residents and family members or representatives.

Temperature Controls and Emergency and Standby Power Systems

- Under the Policies and Procedures, Standard (b) there are requirements for subsistence needs and temperature controls.

- Additional requirements for hospitals, critical access hospitals, and long-term care facilities are located within the Final Rule under Standard (e) for Emergency Power and Stand-by Systems.

Interpretive Guidelines

- The Survey & Certification Group (SCG) is in the process of developing the Interpretive Guidelines (IGs) which will assist in implementation of the new regulation.

- We are working to finalize the IGs and will inform you when they become available.

- The IGs will be formatted into one new Appendix within the State Operations Manual (SOM) applicable to all 17 provider/supplier types

Compliance

- Facilities are expected to be in compliance with the requirements by 11/15/2017.
- In the event facilities are non-compliant, the same general enforcement procedures will occur as is currently in place for any other conditions or requirements cited for non-compliance.
- Training for surveyors is under development

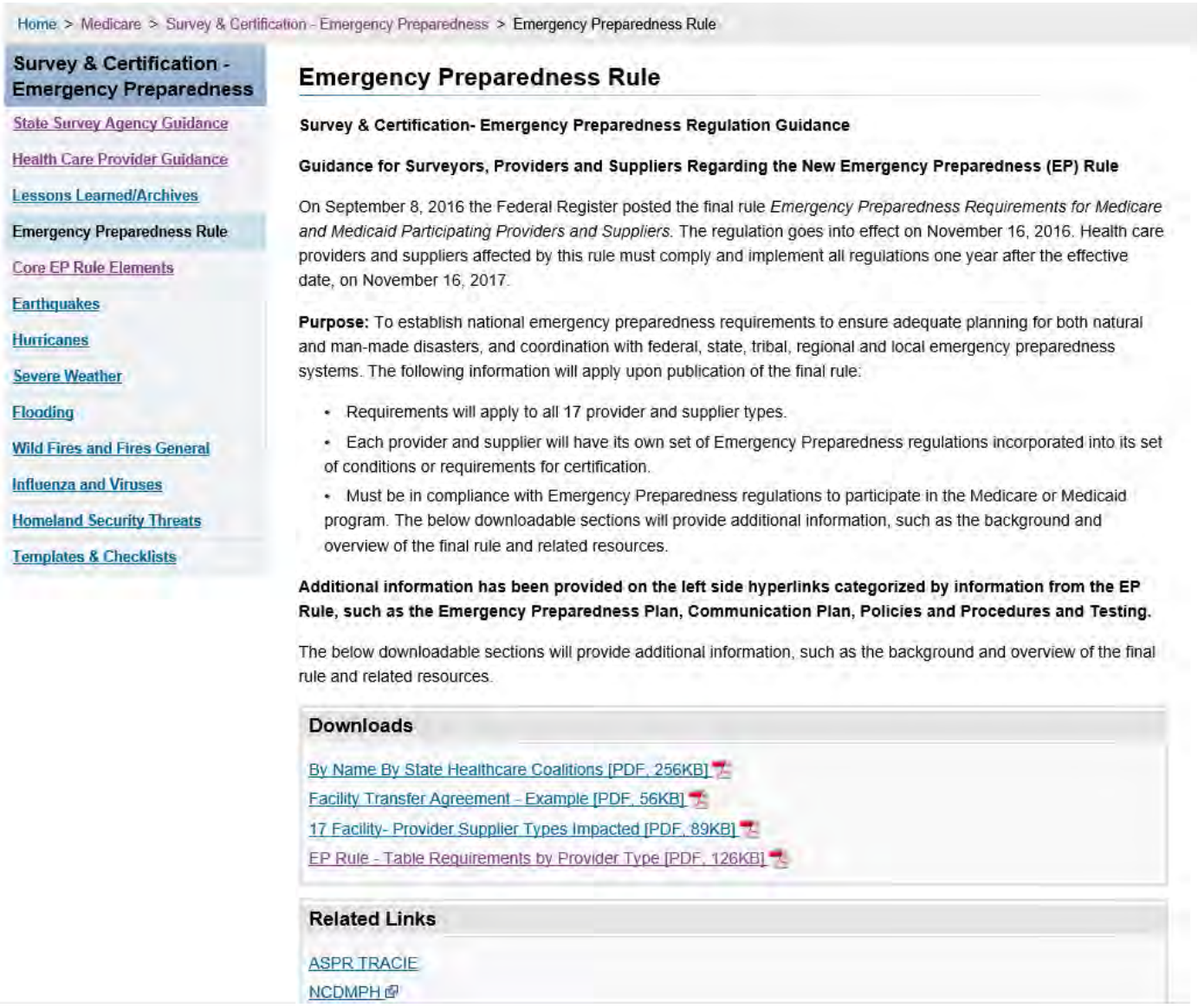
The SCG Website

- Providers and Suppliers should refer to the resources on the CMS website for assistance in developing emergency preparedness plans.

- The website also provides important links to additional resources and organizations who can assist.

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html

The SCG Website



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Survey & Certification - Emergency Preparedness

- State Survey Agency Guidance
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Emergency Preparedness Rule

Survey & Certification- Emergency Preparedness Regulation Guidance

Guidance for Surveyors, Providers and Suppliers Regarding the New Emergency Preparedness (EP) Rule

On September 8, 2016 the Federal Register posted the final rule *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers*. The regulation goes into effect on November 16, 2016. Health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date, on November 16, 2017.

Purpose: To establish national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems. The following information will apply upon publication of the final rule:

- Requirements will apply to all 17 provider and supplier types.
- Each provider and supplier will have its own set of Emergency Preparedness regulations incorporated into its set of conditions or requirements for certification.
- Must be in compliance with Emergency Preparedness regulations to participate in the Medicare or Medicaid program. The below downloadable sections will provide additional information, such as the background and overview of the final rule and related resources.

Additional information has been provided on the left side hyperlinks categorized by information from the EP Rule, such as the Emergency Preparedness Plan, Communication Plan, Policies and Procedures and Testing.

The below downloadable sections will provide additional information, such as the background and overview of the final rule and related resources.

Downloads

By Name By State Healthcare Coalitions [PDF, 256KB]
Facility Transfer Agreement - Example [PDF, 56KB]
17 Facility- Provider Supplier Types Impacted [PDF, 89KB]
EP Rule - Table Requirements by Provider Type [PDF, 126KB]

Related Links

ASPR TRACIE
NCDMPH

Collaboration with ASPR TRACIE

- SCG has been collaborating for several months with the ASPR TRACIE
- SCG's primary focus is on the development of Interpretive Guidelines and Surveyor Training
- Currently working to provide additional recommendations through ASPR TRACIE for stakeholders who are interested in developing training for providers

Some FAQs Not Posted

- Term “Community”:
  - CMS did not define community to afford providers and supplies the flexibility to develop emergency exercises that reflect their risk assessments. This can mean multi-state regions. The goals behind the full-scale exercises and broad term of community is to ensure healthcare providers collaborate with other entities, when possible, to promote an integrated response to disasters.
  - By allowing this flexibility, especially taking into account rural areas, facilities are able to more realistically reflect the risks and composition of their communities.

Some FAQs Not Posted

- Real-World Activation of the EP Plan:
  - If a facility experienced an actual natural or manmade emergency that required activation of its emergency plan, it will be exempt from engaging in a community or individual, facility-based full-scale exercise for 1 year following the onset of the actual event, as under sections (d)(2)(i) of the provider and suppliers specific testing requirements.

Thank you!

SCGEmergencyPrep@cms.hhs.gov

To: Health Care Coalitions

Dear Health Care Coalitions:

Thank you for your recent and continued efforts to assist with the implementation of the Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule. CMS and the Assistant Secretary for Preparedness and Response (ASPR) National Healthcare Preparedness Programs (NHPP) have collaborated greatly together to ensure facilities affected by this rule have a variety of resources available to them, including more participation with your coalitions.

With the implementation date of November 15, 2017 fast approaching, CMS and NHPP are requesting that health care coalitions assist in providing documentation to support verification of the Emergency Preparedness training and testing exercise requirements. CMS requires that facilities annually complete two exercises and document their participation. To assist facilities in demonstrating this compliance, we request that health care coalitions provide facilities who participate in their exercises with some confirmation of their participation, which could include an email confirmation, listing of facilities, meeting minutes, or After-Action Reviews, as long as they identify the participating facilities.

Providing documentation that verifies participation will allow CMS surveyors to assess compliance with these requirements during a survey. We appreciate your assistance in providing this documentation to facilities that participate with you in these exercises.

We thank you for your continued efforts and assistance.

Sincerely,

David R. Wright
Director, Survey and Certification Group
CMS

Melissa Harvey, RN, MSPH
Director, Division of National Healthcare Preparedness Programs (NHPP)
ASPR

Transfer Agreement Example

This agreement is made and entered into by and between YOUR FACILITY NAME, CITY, STATE, a nonprofit corporation (hereinafter called "YOUR FACILITY") and RECEIVING FACILITY NAME, CITY, STATE, a nonprofit corporation, (hereinafter called "RECEIVING FACILITY"):

WHEREAS, both YOUR FACILITY and RECEIVING FACILITY desire, by both means of this Agreement, to assist physicians and the parties hereto in the treatment of trauma patients (e.g., burn, traumatic brain injuries, spinal cord injuries, pediatrics); and whereas the parties specifically wish to facilitate: (a) the timely transfer of patients and information necessary or useful in the care and treatment of trauma patients transferred, (b) the continuity of the care and treatment appropriate to the needs of trauma patients, and (c) the utilization of knowledge and other resources of both facilities in a coordinated and cooperative manner to improve the professional health care of trauma patients.

IT IS, THEREFORE, AGREED by and between the parties as follows:

1. PATIENT TRANSFER: The need for transfer of a patient from YOUR FACILITY to RECEIVING FACILITY shall be determined and recommended by the patient's attending physician in such physician's own medical judgment. When a transfer is recommended as medically appropriate, a trauma patient at YOUR FACILITY shall be transferred and admitted to RECEIVING FACILITY as promptly as possible under the circumstances, provided that beds and other appropriate resources are available. Acceptance of the patient by RECEIVING FACILITY will be made pursuant to admission policies and procedures of RECEIVING FACILITY.

2. YOUR FACILITY agrees that it shall:

    a. Notify RECEIVING FACILITY as far in advance as possible of transfer of a trauma patient.
    b. Transfer to RECEIVING FACILITY the personal effects, including money and valuables and information relating to same.
    c. Make every effort within its resources to stabilize the patient to avoid all immediate threats to life and limbs. If stabilization is not possible, YOUR FACILITY shall either establish that the transfer is the result of an informed written request of the patient or his or her surrogate or shall have obtained a written certification from a physician or other qualified medical person in consultation with a physician that the medical benefits expected from the transfer outweigh the increased risk of transfer.
    d. Affect the transfer to RECEIVING FACILITY through qualified personnel and appropriate transportation equipment, including the use of necessary and medically appropriate life support measures.

3. YOUR FACILITY agrees to transmit with each patient at the time of transfer, or in the case of emergency, as promptly as possible thereafter, pertinent medical information and records necessary to continue the patient's treatment and to provide identifying and other information.

4. RECEIVING FACILITY agrees to state where the patient is to be delivered and agrees to provide information about the type of resources it has available.

5. Bills incurred with respect to services preformed by either party to the Agreement shall be collected by the party rendering such services directly from the patient, third party, and neither party shall have any liability to the other for such charges.

6. This agreement shall be effective from the date of execution and shall continue in effect indefinitely. Either party may terminate this agreement on thirty (30) days notice in writing to the other party. If either party shall have its license to operate revoked by the state, this Agreement shall terminate on the date such revocation becomes effective.

7. Each party to the Agreement shall be responsible for its own acts and omissions and those of their employees and contractors and shall not be responsible for the acts and omissions of the other institutions.

8. Nothing in this Agreement shall be construed as limiting the right of either to affiliate or contract with any hospital or nursing home on either a limited or general basis while this agreement is in effect.

9. Neither party shall use the name of the other in any promotional or advertising material unless review and written approval of the intended use shall first be obtained from the party whose name is to be used.

10. This agreement shall be governed by the laws of the State of INSERT STATE. Both parties agree to comply with the Emergency Medical Treatment and Active Labor Act of 1986, and the Health Insurance Portability and Accountability Act of 1996 and the rules now and hereafter promulgated thereunder.

11. This Agreement may be modified or amended from time to time by mutual agreement of the parties, and any such modification or amendment shall be attached to and become part of the Agreement.

YOUR FACILITY	RECEIVING FACILITY
SIGNED BY:	SIGNED BY:
DATE:	DATE: