LeadingAge Iowa

Appendix Z E-Tag Updates

To see Appendix Z in its entirety with updates please view QSO-21-15-All.

E-tag	Entity	Key Notes from Changes	Full Description of Changes
Intro	**All – general info**	• You are encouraged to utilize a health care coalition, however, it is not required. If use of a health care coalition is completed, documentation must reflect efforts for compliance. • All providers included in the term "facilities".	• While the use of health care coalitions are encouraged, this may not always be feasible for all providers and suppliers. For facilities participating in coalitions, the "level" of participation is not specified. However, if facilities use health care coalitions to conduct exercises or assist in their efforts for compliance, these efforts should be documented. The 2016 Emergency Preparedness Final Rule emphasized that health care facilities should continue to engage their health care coalitions and state hospital preparedness program (HPP) coordinators for training and guidance. We encourage health care facilities, particularly those in neighboring geographic areas, to build relationships that will allow facilities to share and leverage resources. For additional information, please visit https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/State-resources • Unless otherwise indicated, the general use of term facility or facilities in this appendix refers to all 17 providers and supplies. Included in this term are Ambulatory Surgical Centers (ASCs); Critical Access Hospitals (CAHs); Clinics; Rehabilitation Agencies, and Language Pathology Services (OPT/OSP); Community Mental Health Centers (CMHCs); Comprehensive Outpatient Rehabilitation Facilities (CORFs); End-Stage Renal Disease (ESRD); Home Health Agencies (HHAs); Hospices; Hospitals; Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID); Long-Term Care (LTC) Facilities; Organ Procurement Organizations (OPOs); Psychiatric Residential Treatment Facilities (PRTFs); Programs of All-Inclusive Care for the Elderly (PACE); Religious Nonmedical Health Care Institutions (RNHCIs); Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs); and Transplant Programs. • Resources: Facilities can consider using the checklists developed by Assistant Secretary for Preparedness and Response's (ASPR's) Technical Resources and Assistance Center and Information Exchange (TRACIE) and identify the location for each of their requirements. ASPR TRACIE developed resources and checklists created from our guidance, under

		• Website addresses for checklists related to EPP. ○ Guidance for surveyors with cross references to LSC surveys. ○ Information regarding requirements for emergency power and emergency power standby systems. ○ No particular manner or format	https://asprtracie.s3.amazonaws.com/documents/aspr-tracie-cms-ep-rule-long-term-care.pdf, or see all checklists under Facility-Specific Requirement Overviews at https://asprtracie.hhs.gov/cmsrule. These checklists can be used by providers and suppliers, as well as the surveyors in order to have a provider-specific checklist. • Survey Protocol: ○ Additionally, Hospitals, CAHs, LTC Facilities, Inpatient Hospices, ASCs, ICF-IIDs, RNHCIs and ESRD facilities all have life safety from fire protection regulations that require compliance with the LSC. The LSC typically requires and emergency system/generator to provide limited emergency power in Hospitals, CAHs, LTC Facilities, Inpatient Hospice Facilities, ESRD facilities and ASCs. For surveys of Hospices, CAHS, LTC Facilities, Inpatient Hospice Facilities, ESRD facilities and ASCs, health surveyors should consult with LSC surveyors when concerns related to emergency power are identified to determine if a deficiency should be cited under EP standards or LSC standards. We note, there may be instances of overlap as emergency preparedness regulations require alternate source power (E0015) for inpatient facilities and also requires emergency standby power systems for hospitals, CAHs and LTC Facilities (E0041). ○ Please note, there may be instances in which the facility chooses, as part of their risk assessment and program, to install an emergency standby power systems with a generator that is not subject to LSC or physical environment regulations under their provider/supplier type. In this instance, the facility should consider the requirements under standard (e) (tag E0041) of the EP regulations related to testing, inspection, fuel and generator location. ○ It is critical to understand that the response process to emergency incidents may be the same for multiple hazards or risks. Facilities have the flexibility to determine how to format the documentation of their program and are not required to have a separate policy and procedure for each type of hazard. As the EP program should be comprehensive and include all potential natural or man-made disasters or EIDs, it is not unusual for surveyors to find facilities with a large volume of documentation needing review. Facilities must address each type of hazard within the emergency preparedness program, but can consolidate these

		that EPP must be presented in. ○ EPP policies and procedures should include when you invoke full evacuation or shelter in place and who is responsible for activation of the EPP. ○ Encourages surveyors to review the EPP with the representative of the program.	policies and procedures based on the designated response without duplication within their program. ○ The facility should identify within their policies and procedures under what circumstance the facility would invoke particular procedures (for example evacuate or shelter) and actions that may vary based on the type of hazard. Also, procedures should include who would initiate the emergency preparedness response. While the documentation formatting is left to the discretion of the facility, the facility should be prepared to provide CMS with written evidence of its emergency preparedness program at the time of the survey. We also note there is no particular method in which the facility must document its review and updates (refer to more information under E0013). ○ We would recommend the surveyor review the program with the responsible facility representative and ask this representative to facilitate this review by referring the surveyor to the specific documentation requested. • Definitions: ○ **Community Partners** – are considered any emergency management officials (fire, police, emergency medical services, etc.) for full scale and community-based exercises, however can also include community partners that assist in an emergency, such as surrounding providers and suppliers. ○ **Full-Scale Exercise** – (added to the definition) Though there is no specific number of entities required to participate in a full-scale community-based exercise, it is recommended that it be a collaborative exercise which involves, at a minimum, local or state emergency officials to develop community-based responses to potential threats. ○ **Functional Exercise (FE**) – The Department of Homeland Security's (DHS's) Homeland Security Exercise and Evaluation Program (HSEEP) explains that FEs are an operations-based exercise that is designed to validate and evaluate capabilities, multiple functions and/or sub-functions or interdependent groups of functions. FEs are typically management, direction, command and control functions. For additional details, please visit HSEEP guidelines located at

			https://preptoolkit.fema.gov/documents/1269812/1269861/HSEEP_Revision_Apr13_Final.pdf/65bc7842-1d10-47b7-bc0d-45118a4d21da. ○ **Mock Disaster Drill** – A mock disaster drill is a coordinated, supervised activity usually employed to validate a specific function or capability in a single agency or organization. Mock disaster drills are commonly used to provide training on new equipment, validate procedures, or practice and maintain current skills. For example, mock disaster drills may be appropriate for establishing a community-designated disaster receiving center or shelter. Mock disaster drills can also be used to determine if plans can be executed as designed, to assess whether more training is required, or to reinforce best practices. A mock disaster drill is useful as a stand-alone tool, but a series of drills can be used to prepare several organizations to collaborate an FSE.
E0001	**All except transplant programs**	• LTC must review EPP annually. • All other providers must review EPP every 2 years, although changes are expected to occur more frequently if required. • EPP must include emerging infectious diseases as part of the plan. ○ There are no requirements for how the EPP is	• The emergency preparedness program (EPP) and its elements must be reviewed and updated annually for LTC facilities. We've identified the differences in regulatory text for LTC facilities. • The EPP must be reviewed every two years for all providers and suppliers with the exception of LTC providers who must review their EPP annually. All facilities are expected to make the appropriate changes to their emergency program in the event changes are required more frequently outside of their update cycles. • As emerging infectious disease (EID) outbreaks may affect any facility in any location across the country, a comprehensive emergency preparedness program should include emerging infectious diseases and pandemics during a public health emergency (PHE). The comprehensive EPP EID planning should encompass how facilities will plan, coordinate and respond to a localized and widespread pandemic, similar to what is occurring with the 2019 Novel Coronavirus (COVID-19) PHE. Facilities should ensure their EPP are aligned with their State and local emergency plans/pandemic plans. • Documentation and Requirements: ○ The EPP must be in writing. The requirements under the EPP final rule allow for documentation flexibility. While facilities are required to meet all of the provisions applicable to their provider/supplier type, how they document their efforts is subject to their discretion. We are not requiring a hard copy/paper,

		formatted. Can be electronic or paper/hard copy. Have to assure that surveyors are able to review documents in writing for EPP. IF there are components located in another location develop a cross-walk to those documents. ○ Must maintain documentation for at least 4 years. ○ No requirement for sign-off, however, verify with State Agency for licensure.	electronic or any particular system for meeting the requirements. It is up to each individual facility to be able to demonstrate in writing their EPP. We would also recommend, but are not requiring, facilities to develop a crosswalk as applicable for where their documents are located. For instance, if their emergency plan is located in a binder, specify this for surveyors. IF there are policies and procedures to specific standards/requirements, identify where these are located. ○ Providers and suppliers are encouraged to keep documentation and their written EPP based on the requirements for their provider type. Inpatient providers for at least 4 years. We are recommending this process due to the requirements related to training and testing exercises. Inpatient providers are required to have 2 exercises per year, therefore surveyors will review most recent two-years of documentation to determine compliance. For outpatient providers, testing exercises are required annually, alternating full-scale exercises every other year, with the opposite years allowing for the exercise of choice. In order to determine compliance, surveyors will be required to review at least the past 2 cycles (generally 4 years) of emergency testing exercises. ○ Additionally, we are not requiring approval of the Emergency Program or official "sign-off" however, we do recommend facilities check with their State Agencies and local emergency planning coordinators (LEPCs) as some states require approval of the emergency preparedness plans as part of state licensure.
E0002	**Transplant Programs**		No updates
E0003	**ESRD**		Not relevant to LAI members.
E0004	**All except transplant programs**	• Guidelines for review of EPP.	• Emergency Plan – General: The plan must be reviewed and updated at least every 2 years, with the exception for LTC facilities which must review and update their plan on an annual basis. This periodic review must be documented to include the date of the review and any updates made to the EPP based on the review. The format of the EPP

			that a facility uses is at its discretion. While this 2-year review process (except for LTC facilities) provides more flexibilities for providers to update their program as they see fit, facilities are encouraged to continue to review and update their EPP and train their staff accordingly as the plan may change on a more frequent basis.
		• Requires addition of EID to EPP. ○ Involving the infection preventionist in emergency plan development and review/revision. ○ Examples to include in EID section. ○ Coordination required with local, state and federal partners. ○ Information on continuity of operations.	• Elements of the EPP: Added Emerging Infectious Diseases such as influenza, ebola, zika, and others. • Emerging Infectious Diseases (EID): ○ As facilities develop or make revisions to their EPP, EID's are a potential threat which can impact the operations and continuity of care within a health care setting and should be considered. The type of infectious diseases are not specified. Adding EID's within a facility's risk assessment ensures that facilities consider having infection prevention personnel involved in the planning, development and revisions to the EPP, as these individuals would likely be coordinating activities within the facility during a potential surge of patients. ○ Some examples of EID's may include, but are not limited to: ➢ Potentially infectious Bio-Hazardous Waste ➢ Bioterrorism ➢ Pandemic Flu ➢ Highly Communicable Diseases (such as Ebola, Zika Virus, SARS, or novel COVID-19 or SARS-CoV-2) ○ EID's may be localized to a certain community or be widespread (as seen with the COVID-19 PHE) and therefore plans for coordination with local, state, and federal officials are essential. Facilities should engage and coordinate with their local health care systems and health care coalitions, and their state and local health departments when deciding on ways to meet surge needs in their community. • Understanding the terminology: ○ CMS recognizes that there are differences in terminology used within the EPP industry pertaining to "continuity of operations" and "business continuity". We consider "continuity of business" to incorporate all continuity operations and business continuity, which involves planning to ensure business operations will continue even during a disaster. The concept of continuity is the facility's ability

		○ Inclusion of a contingency plan if contractors are unavailable to assist during an emergency. ○ Additional items to consider while developing EPP related to EID.	to continue operations or services related to patient care and to ensure patient safety and quality of care is continued in an emergency event. The emergency 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 to services that are necessary during an actual emergency. For additional information related to continuity of operations, please visit the Federal Emergency Management Agency's (FEMA's) Continuity Guidance Circular at https://www.fema.gov/sites/default/files/2020-07/Continuity-Guidance-Circular_031218.pdf. • Essential Services and Continuity of Care: ○ However, we recognize that contractors may be subject to the same hardships as the community they service, and there are no guarantees in the event of a disaster that the contractor would be able to fulfill their duties. ○ The EPP should take into account contingency planning, such as evacuation triggers in the event essential resources provided by the contractor cannot be fulfilled. ○ Finally, facilities should also include in their planning and revisions of existing plans, contracts and inventory of supply needs; availability of personal protective equipment (PPE); critical care equipment; and transportation options/needs to be prepared for surge events. Note this is also further delineated under the facility policies and procedures required by facilities under the EPP.
E0005	**Transplant Program**		No updates
E0006	**All except transplant programs**	○ Develop an all-hazards approach that is based on facility and	• Risk Assessments Using All-Hazards Approach: ○ Are expected to develop an EPP that is based on the facility-based and community-based risk assessment using an "all-hazards" approach. Though a format is not specified, facilities must document the risk assessment. ○ An all-hazards approach is an integrated approach to EPP that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including pandemics and EIDs as noted under E0004.

		community risk assessment. ○ Include EID into the risk assessment. ○ Assure that risk assessment is based on the patient's you serve and their needs as well as continuity of business services. ○ Include all risks that can disrupt the operations and necessitate an emergency response and address risk mitigation requirements to ensure continuity of care. ○ Categorize the risks by likelihood of occurrence. Examples are included of power loss and pandemics.	This approach is specific to the location of the facility considering the types of hazards most likely to occur in the area, but should also include unforeseen widespread communicable diseases. ○ Also, a risk assessment is facility-based, which among other things, considers a facility's patient population and vulnerabilities. Facility-based and community-based risk assessments are intended to 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. For instance, if a facility has a population which is primarily dependent on medical equipment the risk assessment would identify a higher impact for emergencies that lead to power failures. • Risk Assessment Considerations: ○ Based on the community threat and hazard identification process, facilities should select a comprehensive risk assessment tool that evaluates their risk and potential for hazards. The comprehensive risk assessment should include all risks that could disrupt the facility's operations and necessitate emergency response planning to address the risk mitigation requirements and ensure continuity of care. ○ Using an all-hazards approach helps facilities consider and prepare for a variety of risks which may impact their health care settings. Facilities should categorize the various probably risks and hazards identified by likelihood of occurrence and further create supplemental risk assessments based on the disaster or public health emergency. For example: ➢ For power loss and potential disruptions of services: Facilities can consider using a heat index or heat risk assessment to identify situations which present concerns related to patient care and safety. Facilities are required to maintain safe temperatures bunder (b) policies and procedures (see tag E0015), therefore a heat risk assessment can be considered as an additional risk assessment, but is not required. Facilities may find it helpful to refer to ASPR TRACIE for the Natural Disasters Topic Collection at https://asprtracie.hhs.gov/technical-resources/36/natural-disasters/27.

		○ Surveyors should verify the risk assessment is completed and includes EIDs as a risk. Surveyors should not survey the accuracy of the risk assessment as this is based on the facilities expertise.	➢ For public health emergencies, such as EIDs or pandemics: Facilities should consider risk assessments to include the needs of the patient population they serve in relation to a communicable or EID outbreak. Planning should include a process to evaluate the facility's needs based on the specific characteristics of an EID that includes, but is not limited to: ✓ Influx in need for PPE; ✓ Considerations for screening patients and visitors; which may also include testing considerations for staff, visitors and patients for infectious diseases; ✓ Transfers and discharges of patients; ✓ Home-based health care settings; ✓ Physical Environment, including but not limited to changes needed for distancing, isolation or capacity/surge. • Survey Procedures: ○ Verify the risk assessment is facility-based and community-based, and based on an all-hazards approach specific to the geographic location of the facility and encompasses potential hazards such as EIDs. ○ Surveyors are not expected to analyze a facility's risk assessment to determine whether the identified risks are appropriate. Surveyors may take into consideration the geographic location and review the remaining standards to determine that the facility has addressed the hazards within their risk assessment through their policies and procedures. However, the intent is that surveyors review the risk assessments to determine if the facility has a risk assessment which is facility-based and also community-based. The facility's risk assessment should describe a process facilities use to assess and document potential hazards that are likely to impact their geographical region, community, facility and patient population. The ranking of priority of the hazards and the format of the risk assessment is at the discretion and expertise of the facility.
E0007	**All except Transplant**	○ Assure identification of at-	• Patient Population: ○ The EPP must specify at-risk populations, in the event of EIDs and communicable diseases, may also include older adults and people of any age with underlying

	Programs and OPO's	risk residents in your program. ○ Assure there is a succession plan regarding roles during an emergency. Assure that those individuals understand their roles during an emergency. ○ Assure there are strategies in how to provide resident needs in the event of an emergency, including the potential for evacuation. ○ Assure there is someone that is a successor in an emergency that can assure residents	medical conditions or who are immunocompromised, in which exposure may place them at a higher risk for severe illness. • Surge & Staffing: ○ 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 operations of the facility". This does not mean that the facility must have documentation which lists each role and the designee for those roles within the same policy. Facilities may have a general plan which outlines the roles and responsibilities of the different individuals and refers to those individuals by their titles. For example, a facility incident commander may be the facility administrator. Also, an emergency department charge nurse of the day may be the facility's identified person as the safety officer. However, if the facility chooses to follow this process without individual name identification, the individual serving in the role during the time of the survey should be able to adequately describe their role and responsibility during an emergency. ○ The emergency plan should also include ways the facility will respond to identified patient needs that cannot be addressed by in-house services in an emergency, such as use of just-in-time contracts or emergency transfers. As discussed under E0001, CMS recognizes the variability in terminology in continuity of operations, business continuity and other terms used by the emergency management industry. The intent behind this requirement is to ensure continuity of operations, including emergency preparedness succession planning, ultimately to ensure the facility has plans in place to continue functioning during an emergency and provide care in a safe setting, which may require some/all evacuations. ○ Ultimately, the delegations of authority and succession plans, which are different from the "continuity" plans, are documented plans which outline the specific individuals and alternate/successors who can activate the facilities emergency plans to ensure patient safety is protected and patients will receive care at the facility or if transferred, under what circumstances transfers will occur. • General Considerations:

		continue to receive required care. ○ Considerations for surveyors to assure compliance related to succession plans.	○ Interview leadership and ask them to describe – services that the facility would be able to provide during an emergency and any plans to address services needed that cannot be provided by the facility during an emergency as part of continuity of operations and services. ○ If the facility has delegations and succession plans which identifies roles and responsibilities over individual facility staff names, identify the individual who would be designated in one of the roles and interview the individual asking them to describe their role based on the facility's emergency program.
E0008	**OPO only**		Not relevant to LTSS.
E0009	**All except transplant programs**	• Programs need to develop coordinated efforts with local and state emergency preparedness. • Documentation is not expected to be in writing, however, the facility must document sufficient details to support verification of the process. • Facilities should have state and local emergency contacts documented in the plan.	• While the responsibility for ensuring a coordinated disaster preparedness response lies upon the state and local emergency planning authorities, the facility must have a process to engage in collaborative planning for an integrated emergency response. • While every detail of the cooperation and collaboration process is not required to be documented in writing, it is expected that the facility has documented sufficient details to support verification of the process. • When deciding on ways to meet PHE needs in their community, facilities are expected to engage and coordinate with their local health care systems (including any emergency-related Alternate Care Sites), and their local and state health departments, and federal agency staff are also encouraged to engage with their health care coalitions, as applicable. Facility awareness of the state's EPP and pandemic plan ensures coordination occurs with the community. Coordination should be pre-planned and facility management should know the state and local emergency contacts (further defined within a facilities communication plan). • We also note that under state licensure or their accreditation requirements, facilities may still be required to document their collaboration with local, tribal, regional, state and Federal emergency preparedness officials. We recommend facilities contact their State Survey Agency (SA) and/or accrediting organizations (AO) to determine if any additional requirements exist.

		• Additional requirements may be required depending on SA or AO.	
E0010	**Clinics, Rehab Agencies, Public Health Agencies, OPT/OSP**		No changes to this section.
E0011	**CORF, Clinics, Rehab Agencies, Public Health Agencies, OPT/OSP**		No changes to this section.
E0012	**Transplant programs and OPO**		No changes to this section
E0013	**All except transplant programs**	• Facilities must document specifically what parts of the EPP were reviewed and/or updated including what was updated in the EPP	• We also recommend that facilities include strategies and succession planning, as well as contingencies which support their response to any disaster or public health emergency (also see requirements at E0024) • We are also not specifying the type of documentation required – for example hard copy, electronic or other system-based emergency plans. • Furthermore, since the format of the documentation is at the discretion of the facility, surveyors can identify a facility's reviews and updates of the emergency program through meeting minutes (facilities need to be clear if the entire program or any specific

		upon review. The format for this documentation is at the discretion of the facility. • Specific descriptions for ESRD and PACE programs to include in their policies and procedures related to EPP.	policy was reviewed and updated); through electronic or hard copy signatures on the table of contents of the emergency program documentation; or another manner. Facilities should clearly document the date of review and update and what the update entailed. • For ESRD and PACE organizations, the policies and procedures must align with the risk assessment and also include specific policies related to fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Care related emergencies may be specific to the patient population served within these health care entities; as a result, the facility should ensure that in the event of any EID, there are policies and procedures in place which protect the health and safety of patients, to include but not limited to disinfection of patient stations for ESRDs and notification of transportation considerations with local government and community providers. We would expect ESRD and PACE organizations to encompass care related emergencies within their policies and procedures.
E0014	**OPO and Transplant Programs**		No changes to this section
E0015	**All except ASCs, Outpatient Hospice, transplant programs, HHA, CORF, CMHCs, RHC/FQHC, ESRD**	○ In the EPP regulations there are no required amounts of food/water to be held onsite, however, SA or AO may have requirements. Also addresses emergency generators in hospitals.	• Provisions: ○ There are no requirements or standards establishing a set amount of provisions to be provided by facilities. However, some states laws or accrediting organization requirements do specify a set amount or duration of subsistence items to have on hand, therefore facilities should check with their state agencies and accrediting organizations to determine if any additional requirements exist. Facilities also are required to continue to meet existing health and safety standards, such as physical environment for hospitals, which address requirements like the emergency power and lighting in at least the operating, recovery, intensive care and emergency rooms, and stairwells. In all other areas not services by the emergency supply source, battery lamps and flashlights must be available. ○ Inpatient providers must ensure that they have policies and procedures that address food, water, medical/pharmaceutical needs for both staff and patients

		○ Inpatient providers must have policies and procedures that address how they are going to provide adequate food, water, medical supplies and medications during an emergency. ○ LTC facilities must have plans to address maintaining temperatures between 71-81^{o}F during an emergency. ○ Additional regulatory guidance related to temporary and permanent generators and what is acceptable for plugging into the generators. ○ Directions for health surveyors on reviewing generator requirements.	during an emergency, regardless of whether they evacuate or not. Evacuation efforts may be delayed, therefore facilities affected by this provision should account for patient and staff needs leading up to or during an evacuation. ○ This standard does not apply to outpatient facilities (listed to the left) as it is expected that such outpatient providers would close and evacuate their patients to a safer setting during an emergency. • Alternate Energy Sources and Temperatures: ○ For LTC facilities there are additional requirements for facilities who were initially certified after October 1, 1990 who must maintain a temperature range of 71 (min) to 81^{o}F (max). Facilities should include their Medicare (and Medicaid, as applicable) certification date(s) in the front of their plan. ○ If used, portable generators should be connected to the facility's electrical circuits via a power transfer system, as recommended by the generator's manufacturer. A power transfer system typically consists of a transfer switch, generator power cord and power inlet box in accordance with manufacturer instructions and NFPA 70, Article 400.8, individual extension cords should not be run from portable generator outlet receptacles to electrical appliances. ○ Portable generators must be located so that adequate ventilation is provided. Typically, this may be accomplished by locating a portable or mobile generator outside of the building. ○ For requirements regarding permanently installed generators, please refer to applicable NFPA codes and standards. If a health surveyor is unclear whether the facility is complying with the alternate sources of energy and temperature requirements, the health surveyor must consult with their LSC surveyors. ○ For portable generators, they must be connect and provide emergency power to a facility's electrical system circuits via a power transfer system as recommended by the generator manufacturer. A power transfer system typically consists of a generator power supply cord, power inlet box mounted outside, and transfer switch connected to the facility electrical panel.
E0016	**Hospice**	• Requirements for hospices to develop	• Hospices must develop policies and procedures that address the use of hospice employees in an emergency and the hospices' potential surge needs; accordingly,

		surge planning and the need for hospice staff to serve during surges. Also included are requirements for some patients need to be placed in in-patient settings during an emergency based on their needs. • Additional policy and procedure requirements are included in the bullet points. • Requirement for policy and procedure to be developed related to checking in with on-duty and off-duty staff and the frequency. • Requirement for hospice to pre-coordinate on topics such as unaccounted	hospices should give consideration to their roles during a natural disasters and emerging infectious diseases outbreaks or pandemics. Depending on the type of emergency, hospice staff must develop policies and procedures to maintain the continuity of services to hospice patients and should account for variability in the services which they provide – including planning considerations for inpatient versus outpatient hospices and that in a given emergency either setting may need to transfer patients to difference health care settings based on needs. • Hospices must develop policies and procedures which address the requirement to follow up with on duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. These policies and procedures should include considerations such as but not limited to: o Staffing shortages; o Staff ability to provide safe care, to include any potential needs such as PPE; o Care needs of the patients – inpatient or in home-based settings and potential equipment needs; o Screening phone calls prior to arrival and screening questions prior to entry into a home; o Ways to decontaminate equipment and procedures to limit equipment taken into homes. • Additionally, since hospices must inform local and state officials of any on-duty staff or patients that they are unable to contact, the policies and procedures should align with the facility's communication plans. These policies and procedures should outline the timeframes for check-in with the facility's designated individual (for example check in's every 2-4 hours while on shift, and every 8 while off-duty). • A level of pre-coordination activities with state and local emergency officials may be needed. Hospices should work with their state and local officials to determine how to coordinate the reporting of staff or patients who cannot be contacted. Hospices should also account for contingency planning in the event that some staff are unaccounted for and how this relates to providing patient care.

		for staff or patients and how the hospice agency will respond.	
E0017	**HHA**	• HHA's must include EID in their EPP. • HHA's should consider application for appropriate 1135 waivers during an emergency or develop contingency plans.	• HHA's must include EID in their EPP. • Additionally, HHAs should consider potential contingency operations within their policies. For example, how will the HHA ensure the appropriate discipline/staff perform the required initial and comprehensive assessments when access to residences may be hindered due to an emergency? While some contingency plans may include requests for section 1135(b) emergency waiver flexibility during a declared PHE (requiring CMS approval prior to use) HHAs are encouraged to plan ahead for the potential use of alternative staffing options/professions, acting in accordance with their state scope of practice laws. • For additional information on 1135 waivers, please visit: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities and also the CMS frequently asked questions, emergency-related policies and procedures that may be implemented without 1135 waivers at https://www.cms.gov/about-cms/agency-information/emergency/downloads/consolidated_medicare_ffs_emergency_qsas.pdf • Surveyors should review if the HHA has a process related to how to continue to meet the requirements of the individualized care plans.
E0018	**All except Transplant programs, HHA, Clinics, Rehab Agencies, Public Health Agencies, OPT/OSP, RHC/FQHC**	• Facilities should identify a method for tracking staff during an emergency, including ways to track hours for payment.	• Tracking of staff can often be more challenging based on the mechanism used for signing in and out for payment of staff based on hours worked, especially in the event of a power failure. Facilities can consider implementing a staff tracking system such as designating an area or protocol to check in with a designated person(s) during the emergency. • While collaboration with health care coalitions is encouraged, it is not a requirement. Through the precise details of the actual collaboration with state and local emergency officials is not required to be documented, it is expected that sufficient information is documented to support verification of the process as part of the investigation.

E0019	**Homebound hospice, PACE and HHAs**	• Programs should address patients who have special needs and/or are under investigation for a possible communicable disease. • Programs should address staffing contingency plans for staff that are unable to be accounted for during an emergency. • Programs should address patients that require transfer to an inpatient setting but are unable to be transferred.	• Programs should identify special needs patients such as electricity-dependent. • Programs should identify if a patient is under investigation (PUI) for suspected exposure to or a confirmed case of any communicable disease. • A level of pre-coordination activity with state and local emergency officials may be needed. Facilities should work with their state and local officials to determine how to coordinate the reporting of staff or patients who cannot be contacted. Emergency officials may include but are not limited to, emergency management departments/agencies (such as local FEMA or ASPR representatives), the state health department, CMS State Survey Agency or local response public emergency officials. For additional information, please see E0031 under the communications plan. • Facilities should also account for contingency planning in the event that some staff are unaccounted for and how this relates to providing care. • Finally, a facilities policies and procedures should outline a contingency plan in the event patients require evacuation but are unable to be transferred dur to a community-wide impacted emergency. See also E0022 for policy and procedure requirements for shelter in place.
E0020	**All except for HHA, OPO, transplant programs and outpatient hospice**	• Facilities should develop plans for triaging residents/patients for transfer out of the building when needed, how they will be transported including life saving	• Patient safety should be the number one priority and it is expected that facilities provide care in a safe setting, therefore any existing guidance on patient rights and safe setting should be continued. It would be prudent for facilities to consider how they would address a situation where a patient refuses to evacuate therefore leaving a patient in an unsafe environment is not acceptable. • Triage and coordination of evacuation requires planning and communication of plans within the facility and with entities that assist in providing services such as transportation and life-saving equipment.

		equipment and procedures for those that refuse to leave the building.	• Surveyors should interview staff to determine procedures in the event a patient refuses transfer to another location during an emergency.
E0021	**HHA**	• HHA's should develop policies and procedures for on-duty and off-duty staff checking in with a designated person in their communication plans.	• Since HHAs must inform local and state officials of any on-duty staff or patients they are unable to contact, the policies and procedures should align with the facility's communication plans. These policies and procedures should outline the time frames for check-in with the facility's designated individual (for example check-in's every 2-4 hours while on-duty and every 8 hours while off-duty). • A level of pre-coordination activity with state and local emergency officials may be needed. HHAs should work with their state and local officials to determine how to coordinate the reporting of staff or patients who cannot be contacted. HHAS should also accordingly account for contingency planning in the event that some staff are unaccounted for and how this relates to providing patient care.
E0022	**All except transplant programs, HHA, or OPO**		Only change is that LTC facilities must review EPP annually.
E0023	**All except Transplant programs**		Only change is that LTC facilities must review EPP annually.
E0024	**All except transplant programs or OPO**	○ Facilities should identify hazards in the EPP that could produce a need to implement surge strategies including staff strategies to	• Surge Planning: ○ Emergencies, whether natural disasters, man-made disasters or infectious disease outbreaks, stress our health care systems through challenges with capacity and capability. While it is not possible to predict every scenario which could result in surge situations, health care facilities must have policies and procedures which include emergency staffing strategies and plan for emergencies. These strategies encompass procedures which include emergency staffing strategies and plan for emergencies. These strategies encompass procedures to preserve the health care system while continuing to provide care for all patients, at the appropriate

		provide care for surges. ○ Policies and procedures should address ability of the facility to respond to surges including EID and pandemics. ○ Facilities should identify surge planning for specific natural disasters as well as for EID and pandemics. ○ Facilities should identify during surge strategies what non-essential health care visits could entail to slow the surge within the facility. There are specific examples given.	level (such as home-based care, outpatient, urgent care, emergency room, or hospitalization). ○ Facilities must have policies which address their ability to respond to a surge in patients. As required, these policies and procedures must be aligned with a facility's risk assessment, and should include planning for EIDs. Concentrated efforts will be required to mobilize all aspects of the health care system to reduce transmission of disease, direct people to the right level of care, and decrease the burden on the health care system. • Surge Planning During Natural Disasters: In most circumstances, staffing strategies and surge planning surrounding natural disasters, such as hurricanes, are generally event-specific and focus on evacuations, transfers and staffing assistance from areas which are not impacted by the emergency. • Surge Planning for EID/Pandemics: Infectious diseases may rise to the level of pandemic, causing severe impact on response and staffing strategies within the health care system. The primary goals in planning for infectious disease pandemics are to: ○ Reduce morbidity and mortality ○ Minimize disease transmission ○ Protect health care personnel ○ Preserve health care system functioning • Surge Planning Considerations: Facilities are encouraged to consider development of policies and procedures that could be implemented during an emergency to reduce non-essential health care visits and slow surge within the facility such as: ○ Instructing patients to use available advice lines, patient portals, and/or on-line assessment tools; ○ Call options to speak to an office/clinic staff and identification of staff to conduct telephonic interactions with patients; ○ Development of protocols so that staff can triage and assess patients quickly; ○ Determine algorithms to identify which patients can be managed by telephone and advised to stay home, and which patients will need to be sent for emergency care or come to your facility.

		○ Facilities should identify in the EPP policy and procedures where staffing needs may be identified such as triaging. ○ Facilities should consider the use of volunteers for assistance with staffing strategies during a disaster or PHE. Included in the language are specific considerations when using volunteers and what should be included in the policies and procedures.	Note: Facilities are required to have a risk assessment in accordance with E0004, however, we recommend that facilities also consider implications or evaluation of staffing needs. For instance, if a facility identifies a particular hazard, the facility should consider what staffing needs are required to ensure patients continue to receive care. • Volunteers – Medical and Non-Medical: ○ While not required to use volunteers as part of their plans to supplement or increase staffing during an emergency, the facility must have policies and procedures to address plans for emergency staffing needs. This could include the types of health care professionals they would use to assist during an emergency. ○ If facilities use volunteers as part of their emergency staffing strategy, policies and procedures should clearly outline what type of volunteers would be accepted during an emergency and what role these volunteers might play. For example, a facility might decide to use Red Cross Volunteers to assist in directing incoming patients during a surge situation. ○ Emergency staffing strategy policies and procedures should outline how the facility would ensure health care professionals used for emergency staffing are credentialed, licensed (as applicable) or able to provide medical support within the facility in accordance with any state and federal laws. • Resources: Facilities are recommended to review the tools available related to planning for surge. ASPR TRACIE has developed multiple documents which could provide additional assistance during the development of policies and procedures, which include but are not limited to https://asprtracie.s3.amazonaws.com/documents/aspr-tracie-considerations-for-the-use-of-temporary-care-locations-for-managing-seasonal-patient-surge.pdf • Survey Procedures: Surveyors should interview leadership to explain their staffing strategies including use of volunteers or other emergency staffing strategies. Verification of policy and procedures which address surge needs during an emergency.
E0025	**All except ASCs, transplant programs,**	• With transfer agreements facilities should take into account	• When developing transfer agreements, facilities should take into account the patient population and the ability for the receiving facility to provide continuity of services. For example if facility X has a transfer arrangement with facility T, however, facility Y is not able to accommodate and provide continuity of care due to the nature of the

	HHA, CORF, Clinics, Rehab agencies and Public health agencies, OPT/OSP, OPO, RHC/FQHC	facilities that are also able to meet needs of the patient population. • Facilities should also assure that agreements are reviewed and signed again with review of the EPP.	emergency, lack of resources, etc., contingency plans should be implemented. Facility X should have to plan accordingly to have the patient receive services at another facility, not facility Y. For ICF/IID and LTC facilities, the facility is also responsible for the tracking of residents, therefore any written arrangements should account for the patient population, number of patients and the ability for the receiving facility or facilities to continue care to the residents/patients. • Finally, as the regulation requires policies and procedures to be reviewed every 2 years (annually for LTC), facilities should also consider reviewing their developed arrangements on the same scheduled review time frame to ensure the contract/agreement/MOU is still applicable and able to be fulfilled to provide continuity of care.
E0026	**All except transplant programs, HHAs, CORFs, Clinics, rehab agencies and public health agencies, OPT/OSP, OPO, RHC/FQHCs**	• Programs should establish policies and procedures related to providing care at an ACS during an emergency. The policy should include the patient population and continuity of care at the ACS as well as collaboration with local emergency management to determine an ACS.	• General – the facility's emergency preparedness program must include policies and procedures which outline the facility's role in the provision of care and treatment under section 1135 waivers during a declared public health emergency in alternate care sites. Facilities should also be aware of what flexibilities are available with or without an 1135 waiver. • Alternate Care Site (ACS): o ACS is a broad term for any building or structure that is temporarily converted for health care use. An ACS is one of several alternate care strategies that can be used in a disaster. A facility's individual ACS structure and process may include several different models and require different planning considerations based on the type of emergency. Models for a facility's ACS may be dependent on factors such as: emergency/disaster spread across a community; anticipated longevity of operating in the ACS setting; level of capacity the ACS can provide and how this correlates with the need for transfers and discharge, among many other considerations. o The requirement under the emergency program is that facilities must develop and implement policies and procedures which describe the facility's role in providing care at an ACS during emergencies. o Planning related to the development of an ACS is a proactive step to ensuring continuity of services. While the establishment and use of an ACS are generally

		• Programs should include section 1135 waivers in EPP, including how to apply for the waivers and examples of flexibilities that could be waived. Programs should include in these policies the intention to forego or not use the 1135 waiver when no longer needed. Policies and procedures should include that 1135 waivers are time-limited and in what circumstances 1135 waivers will be used	acceptable only during an emergency and require CMS approval, the facility's program must address the facility's ability to provide care in an alternate setting. Considerations may include patient population, supplies, equipment, and staffing as well as physical environment. Planning considerations also include the capabilities of an ACS if authorized during a declared public health emergency. • Section 1135 Emergency Waiver: ○ Policies and procedures must specifically address the facility's role in emergencies where the Secretary waives or modifies certain statutory and regulatory requirements for health care facilities in response to emergencies under section 1135 of the Act related to the provision of care at an alternate care site identified by emergency officials. The Secretary is authorized to issue a section 1135 waiver only when both the President declares a disaster or emergency under the Stafford Act or the National Emergencies Act, and the HHS Secretary declares a Public Health Emergency under section 319 of the Public Health Services Act. Examples of 1135 waivers issued during prior emergencies have included waivers of various CoP's and CFCs; Licensure for Physicians or others to provide services in the affected State, EMTALA requirements; and 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 issued by the Secretary related to alternate care sites. For example, due to mass casualty incident in a geographic location, the Secretary may waiver federal licensure requirements for physicians in order for these individuals to assist at a specific facility where they do not normally practice. In such cases, the provider or supplier should have policies and procedures which address the responsibilities of these physicians during this waiver period. The policies may establish, for example, a lead person in charge for accountability and oversight of assisting physicians not usually under contract with the facility. ○ Waivers issued under section 1135 of the Act are time-limited, and only waive federal requirements, not state requirements under their licensure authority. The

		(for example when the President declares an emergency or the Secretary of HHS declares a PHE, including the possibility of the lengths of waivers extension periods.	purpose of the section 1135 waivers are to ensure that sufficient health care items and services are available to meet the needs of the individuals in such areas. They are also intended to ensure health care providers that can furnish such items or services in good faith, but are unable to comply with federal requirements, are allowed reimbursement during an emergency or disaster even if providers cant comply with certain requirements that would under normal circumstances bar Medicare, Medicaid or CHIP payment. Section 1135 waivers typically end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period. ○ We would expect 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. This requirement encourages providers to collaborate with their local emergency officials in proactive planning to allow an organized and systematic response to assure continuity of care even when services at their facility have been severely disrupted. Health department and emergency management officials, in collaboration with facility staff, would be responsible for determining the need to establish an alternate care site as part of the delivery of care during an emergency. The alternate care site staff would be expected to function in the capacity of their individual licensure and best practice requirements and laws. Decisions regarding staff responsibilities would be determined based on the facility and community based assessments and the type of services staff could provide. These elements should be included in the facilities policy and procedure under this standard. ○ During emergencies such as a widespread pandemic, a PHE may continue for a longer period of time than initially anticipated in the event a facility is operating under a section 1135 waiver, including a potential blanket waiver, facilities should also consider their policies and procedures related to the use of the waiver flexibility and timeframe. While facilities are authorized to use a section 1135 waiver during the duration of the PHE, in accordance with state emergency and

			pandemic plans, it may be prudent for facilities to consider how to continue operations when the 1135 waiver has expired (end of the declared PHE) as facilities are expected to come back into full compliance at the end of the declared emergency. For instance, in the event a pandemic PHE or EID has decreased in a specific community (as generally outlined by the CDC), the facility may no longer need the flexibility provided in an 1135 waiver. Therefore, the facility should consider not using or forgoing the waiver and ensuring it is back in substantial compliance with the specific requirement(s) waived even while the PHE may continue. The intent behind an 1135 waiver is to provide relief and flexibilities while the facility is directly impacted or challenged with meeting the Medicare requirement(s). ○ For additional information on 1135 waivers and process for submission please visit the Quality, Safety & Oversight Group Emergency Preparedness Website https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers. We also recommend providers and suppliers review the ACS toolkit developed by ASPR which can be found at: https://files.asprtracie.hhs.gov/documents/acs-toolkit-ed1-20200220-1022.pdf ○ Note – this policy and procedure requirement does not require a facility to have an 1135 waiver on hand at the time of the survey as such waivers are established or granted by CMS only during a declared emergency period. Section 1135 waivers by nature are time limited.
E0027	**ESRD**		No updates to this section
E0028	**ESRD**		Not relevant to LAI Members
E0029	**All except transplant programs**	• This information is contained in other E-tags.	• Although the requirement for documentation of collaboration with state and local officials was removed, facilities should continue to collaborate with state and local emergency officials. During the creation process for communication plans, facilities should also consult their applicable state and local emergency and pandemic plans. • During survey, surveyors should review evidence of the EPP plan updates at least every 2 years (annually for LTC). In addition, surveyors should ask facility leadership or the designee responsible for the emergency program to verbally explain how they are to

			collaborate with Federal, State and local officials to ensure their communication plan complies with the Federal, State and local requirements.
E0030	**All except transplant programs**	• Programs should at a minimum have the EPP readily available to facility leadership and the individual(s) that are responsible for the EPP. • HHA's should assure that information is maintained on patient's physicians in their written plan of care. • Surveyors should assure that contact information is updated at least every 2 years (annually for LTC).	• Facilities have discretion in the formatting of information, however it should be readily available to leadership, at a minimum, to the individual(s) designated as the emergency preparedness coordinator or person(s) responsible for the facility's emergency preparedness program and management during an emergency event, during an emergency. • For HHAs, contact information should also include patient's physicians or allowed practitioners. Section 484.60 requires that each patient's written plan of care specify the care and services necessary to meet the patient specific needs identified in the comprehensive assessment. Accordingly, additional practitioners at HHAs should also be notified to reflect the interdisciplinary, coordinated approach to home health care delivery consistent with the HHA regulations. • During survey, surveyors should assure that contact information has been reviewed and updated at least every 2 years (annually for LTC).
E0031	**All except transplant programs**	• Programs must include local and state officials in their EPP regarding contact information. Should include fire, police, public health (both state and	• A facility must have contact information for those individuals and entities outlined within the standard. Emergency management officials may include, but are not limited to, emergency management agencies which may be local to the community as well as local officials who support the Incident Command System depending on the nature of the disaster (for example fire, police, public health, etc.) Additionally, emergency management officials also include the state public health departments and State Survey Agencies as well as federal emergency preparedness officials (FEMA, ASPR, DHS, CMS, etc.) and tribal emergency officials as applicable.

		local), emergency management departments, state survey agencies as well as federal emergency preparedness officials.	• During survey, the surveyors should verify contact information is included in the EPP for the state survey agency and/or public health departments. • Note – even though the communications plan must include contact information, it does not specifically require the facility to have an individual contact for emergency management agencies. For instance, a state emergency management agency may have a specific phone line or contact method and not a specific individual person.
E0032	**All except transplant programs**	• A plan for primary and contingency communication plans.	• Facilities should identify their primary and alternate means of communication in their emergency preparedness communication plan. For instance, a primary means of communication may be cellular phones, hard wire lines, and facilities intercom system, whereas the facility alternate means (given interruption of primary means) may be the SHAred RESources.
E0033	**All except transplant programs**		The only change in this section is LTC facilities must update/review EPP annually.
E0034	**All except transplant programs**	• This requirement relates to the facility's need to report during an emergency (or prior to an emergency if it is a forecasted natural disaster). This could include a multitude of things and examples are indicated throughout the text.	• Reporting of a Facility's Needs: o Generally, in small community emergency disasters, reporting the facility's needs will be coordinated through established processes to report directly to local and state emergency officials. Reporting needs may include but are not limited to: shortages in PPE; need to evacuate or transfer patients; requests for assistance in transport; temporarily loss of part or all facility function and, staffing shortages. o In large scale emergency disasters or pandemics, reporting of needs specific to a facility may be altered by local, state and federal public health and emergency management officials due to the potential volume of requests. Some emergency management officials at all levels of governance may require facilities to report specific data or slow reporting to manage volume. It is recommended that facilities verify their reporting requirements with their local Incident Command Structures or State Agencies. o Dependent on the emergency event and the anticipated longevity, facilities may need to report select criteria such as in an EID outbreak or the number of patient's

			positive or persons under investigation (PUI). The facility's process should include monitoring by the facility's emergency management coordinator or designee of reporting requirements issued by CMS or other agencies with jurisdiction. Additional monitoring and reporting may be required by local and state public health agencies due to contact tracing requirements for extended periods of time or for time specific intervals. Facilities should identify local and state policies for reporting and contract tracing to ensure they have appropriate information to address requirements. ○ Facilities should actively engage with their health care coalitions, associations, accrediting organizations and other stakeholders during the onset of any wide-spread emergency. As state and federal emergency organizations may become overwhelmed with requests, these stakeholders may be able to reconcile needs-requests for specific providers and suppliers. In situations in which a Presidential Declaration and a Public Health Emergency (PHE) have been declared, and Section 1135 Waivers may be granted, these stakeholders (health care coalitions, associations, accrediting organizations and others) may have the ability to request and streamline 1135 waiver requests for their members, dependent on the severity of the emergency. • Reporting of a Facility's Ability to Provide Assistance: ○ During widespread disasters, reporting a facility's ability to provide assistance is critical within a community. Pre-planning and collaborating with emergency officials before an emergency to determine what assistance may be necessary directly supports surge planning within a community. For instance, in preparation for a natural disaster such as a hurricane, pre-planning reporting criteria such as the facility's response – such as closing the outpatient services in a forecasted natural disaster – may facilitate the Incident Command as they would be aware of the operating status of the facility. Reporting the ability to provide assistance would also include pre-planning with public health and emergency officials in the local community to make them aware of what capabilities are available within the specific facility (number of beds, critical care equipment, staffing, etc).

			○ During widespread disasters, facilities may be required to report the following to local officials: ➢ Ability to care for patients requiring transfer from different health care settings; ➢ Availability of PPE; ➢ Availability of staff who may be able to assist in a mass casualty incident; ➢ Availability of electricity-dependent medical and assistive equipment, such as ventilators and other oxygen equipment (BiPAP, CPAP, etc.) renal replacement therapy machines (such as home and facility-based hemodialysis, peritoneal dialysis, continuous renal replacement therapy and other machines, etc.) and wheel chairs and beds.
E0035	**LTC and ICF/IIDs**		Only change is the addition of communicating emergency plans to residents/clients.
E0036	**All except transplant programs**	• Each program should establish a training component and document (at programs discretion) the training of all staff, contractors and volunteers. • Each program should have a testing component (2 required	• Training Component: The training component 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. For training requirements, the facility must have a process outlined within its emergency preparedness program which encompasses staff and volunteer training related to the facility's policies and procedures. Facilities must maintain documentation of the training so that surveyors are able to clearly identify staff training and testing conducted. For example, facilities may have a sign-in roster of training conducted within their training files or inclusion of this training in their training program, or individual training certificates of completion within personnel records. A surveyor should be able to ask for a list of employees and to verify training on the emergency preparedness requirements as required under E0037. • Testing Component: ○ Testing requirements based on the provider type. Inpatient providers are required to conduct two testing exercises annually. Outpatient providers are required to conduct one testing exercise annually (that at least every two years their exercise must be a full-scale exercise). Refer to E0039.

		annually) that is reflect of the program's individualized risk assessment. Programs should identify a way to include all staff in the testing program over a period of time.	○ Additionally, facilities should establish a process which includes participation of all staff in testing exercises over a period of time. Facilities are encouraged to consider their scheduled exercises and the appropriate departments to be included. For instance, if a clinically-relevant testing exercise is not necessarily applicable to some other departments or staff, then the staff which did not participate in one year should participate in the next testing exercise to ensure that over a period of time all shifts are incorporated. Additionally, we are not specifying a facility to utilize all required equipment in the testing (drills) or a percentage of the patients/residents that would be included in these drills, however, facilities should test their exercises according to how they would respond to the emergency would it be an actual emergency. ○ Under this standard, surveyors are to assess whether or not the facility has a training and testing program based on the facility's risk assessment and has incorporated its policies and procedures, as well as its communication plan within training required for staff and its testing exercises. • Survey Procedures: Surveyors should refer back to the facility's risk assessment to determine if the training and testing program is reflecting risks and hazards identified within the facility's program.
E0037	**All except transplant programs and ESRD**	• Programs should ensure training is conducted on the programs risk assessment as well as all policies and procedures related to the identified risks and procedures relevant to that risk.	• Training Program – General: ○ The training provided by the facility must be based on the facility's risk assessment policies and procedures as well as the communication plan. The intent is that all staff, volunteers and individuals providing services at the facility are familiar and trained on the facility's processes for responding to an emergency. Training should include individual – based response activities in the event of natural disasters, such as what the process is for staff in the event of a forecasted hurricane. It should also include the policies and procedures on how to shelter-in-place or evacuate. Training should include how the facility manages the continuity of care to its patient population such as triage processes and transfer/discharge during mass casualty or surge events. ○ Furthermore, the facility must train staff based on the facility's risk assessment. Training for staff should mirror the facility's emergency plan and should include

		○ After initial training is completed for all staff, ongoing training of the EPP must be conducted at least every 2 years (annually for LTC). ○ Training should be conducted on newly identified policies and procedures or significant changes in the EPP. Programs may choose to just train on the revisions and not the entire EPP if ongoing training was already conducted.	training staff on procedures that are relevant to the hazards identified. For example, for EIDs this may include proper PPE, assessing needs of patients and how to screen patients and provide care based on the facility's response and capabilities and communications regarding reporting and providing information on patient status with caregiver and family members. • Continued Training: ○ After the initial training has been conducted for staff, facilities must provide training on their facility's emergency plan at least every 2 years (except for LTC facilities which will still be required to provide training annually.) ○ Initial and subsequent training should be modified as needed and if the facility updates the policies and procedures to include but not limited to incorporating any lessens learned from the most recent exercises and real-life emergencies that occurred in and during the review of the facility's emergency program. ○ We would expect the facility be able to demonstrate how they have updated the training as well. ○ While facilities are required to provide initial and subsequent (at least every 2 years except for LTC facilities which will still be required to provide training annually) training to all staff. ○ Facilities must also be able to demonstrate additional training when the emergency plan is significantly updated. Facilities which may have changed their emergency plan should plan to conduct initial training to all staff on the new or revised sections of the plan. If a facility determines the need to add additional policies and procedures based on a new risk identified in the facility's risk assessment, the facility must train all staff on the new policy and procedures and the staff responsibilities. Facilities are not required to re-train staff on the entire emergency plan, but can choose to train staff on the new or revised element of the emergency preparedness program. For example, a facility identifies during an influenza outbreak that additional policies and procedures and adjustments to the risk assessment are needed to address a significant influx of patients/clients/residents. The facility identifies clinical locations in which contagious patients can be triaged in a manner to minimize exposure to non-

			infected individuals. The training for this new or revised policy can be done without needing to re-train staff on the entire program. • Variance by Supplier Type – LTC facilities must continue to provide initial and continued training on an annual basis. • Documentation Requirements – Initial and subsequent (at least every 2 years except LTC facilities which will still be required to provide training annually) • Survey Procedures – Surveyors should review initial and subsequent training. Note – for ease of demonstrating compliance that the facility has updated its training program at least every 2 years, we recommend that facilities retain at a minimum, the past 2 cycles (generally 4 years) of emergency training documentation for both training and exercises for surveyor verification.
E0038	**ESRD**		Not relevant for LAI Members
E0039	**All except transplant programs**	• HHA's must conduct testing at least annually. Descriptions of qualifying events are detailed in the description. In addition, the HHA must analyze the testing to determine if changes are needed to the EPP.	• For HHA: o Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: ➢ Participate in a full-scale exercise that is community-based; or ✓ When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or ✓ If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. ➢ Conduct an additional exercise every 2 years, opposite the year the full-scare or functional exercise is conducted, that may include, but is not limited to the following: ✓ A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or ✓ A mock disaster drill; or

		• RNCHIs must conduct testing annually, which can be a tabletop drill. • Discusses differences between inpatient vs. outpatient requirements for testing and what the requirements are on an annual basis.	✓ A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. ➢ Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan as needed. • RNCHI: o Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: ➢ Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. ➢ Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan as needed. • Variability in Requirements: o For inpatient providers (inpatient hospice facilities, PRTFs, hospitals, LTC facilities, ICFs/IID and CAHs): The types of acceptable testing exercises are expanded. Inpatient providers can choose one of the two annually required testing exercises to be an exercise of their choice, which may include one community-based full-scale exercise (if available), an individual facility-based functional exercise, a mock disaster drill, or a tabletop exercise or workshop that includes a group discussion led by a facilitator. o Note: For LTC facilities, while the types of acceptable testing exercises was expanded, LTC facilities must continue to conduct their exercises on an annual basis.

		• Requirement to conduct testing of EPP based on risk assessment and that testing should not be the same year after year or be done in the same response process. The intention is to identify gaps in the emergency plan so that policies and procedures can identify these gaps.	○ For outpatient providers (ASCs, freestanding/home-based hospice, PACE, HHAs, CORFs, Organizations (which include Clinics, Rehab Agencies, Public Health Agencies as providers of Outpatient Physical Therapy and Speech-Language Pathology Services), CMHCs, OPOs, RHC, FQHCs and ESRD facilities): Facilities are required to only conduct one testing exercise on an annual basis, which may be either one community-based full-scale exercise, if available, or an individual facility-based functional exercise. The opposite years (every other year opposite of the full-scale exercises, these providers may choose the testing exercise of their choice, which can include either another full-scale individual facility-based, a mock disaster drill (using mock patients), tabletop exercise or workshop which includes a facilitator. ○ For OPO's and RNCHIs these providers must at a minimum conduct either a paper-based, tabletop exercise or workshop every year, however, can elect to also participate in full-scale, individual facility-based exercise. • Understanding Exercises and Terminology: ○ Similar to the training expectations outlined under E0037 such as hospitals, a facility's testing exercises require they be based on the individual facility's risk assessment, policies and procedures and communication plan and support the patient population it serves. Testing exercises should vary, based on the facility's requirements by cycles and frequency of testing. The intent is that testing exercise provide a comprehensive testing and training for staff, volunteers and individuals providing services under arrangement as well community partners. Testing exercises must be based on the facility's identified hazards, to include natural or man-made disasters. This should include EID outbreaks. ○ Facilities are expected to test their response to emergency events as outlined within their comprehensive emergency preparedness program. Testing exercises should not test the same scenario year after year the same response process. The intent is to identify gaps in the facility's emergency program as it relates to responding to various emergencies and ensure staff are knowledgeable on the facility's program. In the event gaps are identified, facilities should update their emergency program. In the event gaps are identified, facilities should update

		• Descriptions of full-scale exercises and functional exercises. Included in the descriptions are examples of what all facilities may participate in and examples of what would not be appropriate for the entire "community" to participate in. • Description of facility based exercises with	their emergency programs as outlined with the requirements for after-action report(AAR). • Full-Scale and Community Based Exercises: o Full-scale exercises in the industry setting are large exercises in which multiple agencies participate and may only be available every three to five years; While functioning exercises are similar in nature, but may not involve as many participants and ion which each agency can choose its priorities to test within the confines of the exercise. Therefore, full scale can include what is known as a "functional" exercise or drill in the industry and according to HSEEP. o Facilities which determine that a full-scale community-based exercise will be planned for the facility's exercise requirement must also ensure that the exercise scenario developed is identified within the facility's risk assessment. While generally local and state emergency officials plan emergency exercises which could occur within the geographic location or community, facilities must ensure that participation in the exercise would adequately test the facility's emergency program (specifically its policies and procedures and communication plan). For instance, in the event the local or state full-scale exercise is testing the response to a major multiple care accident requiring airlift transfers of patients, a LTC facility or ESRD facility may not be impacted by this type of disaster or require activation of its emergency program, therefore the exercise may not be as appropriate. In this case, the facility could document that the scenario offered in this full-scale community based exercise and that the facility conducted an individual facility-based exercise to test its emergency program instead. However, if the state or local exercise is testing an EID outbreak, all facilities in the community may be impacted, therefore participation would be strongly recommended. o The intent behind full-scale and community based exercises is to ensure the facility's emergency program and response capabilities complement the local and state emergency plans and support an integrated response while protecting the health and safety of patients.

		community partners included. • The regulations do not require the number of staff to participate in the drills, however, should assure that adequate staff numbers are represented. Facilities should use a sign-in roster to provide documentation for the number and which staff participated in the drill. • Programs should alternate hazards for full-scale exercises and not utilize the same in consecutive years.	• Individual Facility Based Exercises: Community partners are considered any emergency management officials (fire, police, emergency medical services, etc.) for full-scale and community-based exercises, however, can also mean community partners that assist in an emergency, such as surrounding providers and suppliers. • Participation: o While the regulations do not specify a minimum number of staff, or the roles of staff in the exercises, it is strongly encouraged that facility leadership and department heads participate in exercises. If an exercise is conducted at the individual facility-based level and is testing a particular clinical area, staff who work in this clinical area should participate in the exercise for a clear understanding of their roles and responsibilities. Additionally, facilities can review which members of staff participated in the previous exercise, and include those who did not participate in the subsequent exercises to ensure all staff members have an opportunity to participate and gain insight and knowledge. o Facilities can use a sign-in roster for the exercise to substantiate staff participation. A sufficient number of staff should participate in the exercise to test the scenario and thoroughly assess the risk, policy, procedure, or plan being tested. o If the facility uses fire drills based on their risk assessment (such as wild fires) as a full-scale community based exercise in one given year (which is also a requirement for some providers/suppliers under Life Safety Code), the facility is encouraged to choose in the following year a different hazard in their risk assessment to conduct an exercise in order to ensure variability in the training and testing program. The intent of the requirements under the requirement for LTC, is to test the facility's ability to respond to any emergency outlined within their risk assessment. The purpose of testing the facility's emergency program is to identify gaps in response which could result in adverse events for patients and staff and to adjust plans, policies and procedures to ensure patient and staff safety is maintained regardless of the type of emergency which occurs. • Table-top Exercise and Workshops:

		• Description of table-top exercises and workshops. • Programs that enact the EPP during an actual emergency are exempt from their next full-scale exercise, which would be determined based on the schedule individuals have developed. Examples of this are included in the full text. Facilities need to document key data related to activation of the emergency plan,	○ Facilities are also required to conduct an "exercise of choice" or, for some, only conduct a table-top exercise (TTX) or workshop. Please refer back to the definition section above. TTX's or workshops are expected to be group discussions led by a facilitator. We are not defining whether or not the facilitator must be a staff member or contracted service. Some facilities may find that a specific department lead may be best suited dependent on the scenario being tested, while other facilities may find an outside facilitator may be more appropriate to facility. ○ The intent behind the TTX's or workshops is to test an exercise based on the facility's risk assessment. Some facilities may find it prudent to conduct a TTX or workshop prior to a full-scale or individual-facility based exercise in order to identify potential gaps or challenges and then update the policies and procedures accordingly to resolve the potential issue. This would allow for facilities to test their adjustments during a full-scale or individual facility-based exercise to determine if the corrective action was appropriate. • Exemption based on Actual Emergency: ○ An actual emergency event or response of sufficient magnitude that requires activation of the relevant emergency plans meets the full-scale exercise requirement and exempts the facility for engaging in their next required community-based full-scale exercise or individual facility based-exercise for following the actual event; and facilities must be able to demonstrate this through written documentation. With the changed requirements as a result of the 2019 Burden Reduction Rule (81 FR 63859) for outpatient providers required to conduct full-scale exercises only every other year, opposite of their exercises of choice, these facilities are exempt from their next required full-scale or individual facility-based exercise. For inpatient providers, the full-scale exercise would be annually. The intent is to ensure that facilities conduct at least one exercise per year. ○ For example, in the event an outpatient provider conducts a required full-scale community based exercise in January 2019, and completed the optional exercise of its choice in January 2020, and experiences an actual emergency in March 2020, the outpatient provider is exempt from next required full-scale community

		which is found in the last bullet point.	based or individual facility based exercise in January 2021. If the outpatient provider conducts a required full-scale community based exercise in January 2020, and has the optional exercise of its choice scheduled for January 2021, and experiences an actual emergency in March 2020, the outpatient provider is exempt from the next required full-scale community based or individual facility based exercise in January 2022, but must still conduct the required exercise of choice in January 2021. The exemption is based on the facility's required full-scale exercise, not the exercise of choice, therefore the exemption may not be applicable until two years following the activation of the emergency plan, dependent on the cycle the facility has determined and the actual emergency event. ○ For inpatient providers, the exemption would apply for the next required full-scale exercise as well, however, it may be the same year or following year, as inpatient providers are required to perform two exercises per year. If an inpatient provider completed the full-scale exercise in January 2020, but experiences an actual emergency in March 2020 which required activation of its emergency plan, the inpatient provider is example from the next required full-scale exercise in January 2021, but must complete the exercise of choice. IF the inpatient provider conducted an exercise of choice prior to the actual emergency and had a full-scale exercise scheduled for November 2020, then the inpatient provider would be example from that full scale exercise as it would not be the exercise of choice. ○ The exercises of choice, which allow facilities to choose one (another full-scale/individual facility based; mock disaster drill; or table top exercises) are not considered as their required full-scale community based or individual facility based exercises. Facilities which have scheduled fall-scale exercises annually as part of their licensure or accrediting organizations requirements, would be exempt from their scheduled as part of their exercise following an emergency, which would still be July 2021 (using the above example). ○ Facilities must document that they had activated their emergency program based on an actual emergency. Documentation may include but it not limited to: a

			section 1135 waiver issued to the facility (time limited and event specific); documentation alerting the staff of the emergency; documentation of facility closures; meeting minutes which addressed the time and event specific information. The facility must also complete and after action review and integrated corrective actions into their emergency preparedness program. • Survey Procedures: Question facility leadership to explain the participation of management staff during scheduled exercises and documentation must demonstrate the facility has conducted the exercises described in the standard. Note: We recommend facilities to retain, at a minimum, the past 2 cycles (generally 2 years for inpatient providers and 4 years for outpatient providers of emergency testing exercise documentation. This would allow surveyors to assess compliance on the cycle of testing required for outpatient providers.
E0040			Nothing updated in this rule.
E0041	**All**	This addition is contained in previous guidance.	For information regarding permanently installed generators, please refer to applicable NFPA Codes and Standards as discussed under Tag E0015. In the event a health surveyor is unclear whether the facility is complying with these requirements, the health surveyor must consult with their LSC surveyors. Generally, tag E0041 should be reviewed by a LSC surveyor.
E0042	**All except transplant programs**		Only change at E0042 is EPP must be reviewed/updated at least every 2 years and annually by LTC facilities.
E0043	**Transplant hospitals**		No updates in this regulation.
E0044	**OPO**		No updates in this regulation.

To see Appendix Z in its entirety with updates please view QSO-21-15-All.