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**WELCOME**


In September 2016, the Centers for Medicare & Medicaid Services (CMS) released a new emergency preparedness rule for 17 sectors of the U.S. health care system. The new rule asks the affected provider types to demonstrate that they are doing risk assessments; writing appropriate plans, policies and procedures; and training and testing their plans with staff and partners in the community.

One of the resources CMS suggests providers can seek out to assist them are the regional emergency-response focused healthcare coalitions. In Wisconsin, we have seven of these coalitions. The memberships of these coalitions—which include hospitals, emergency medical services, public health agencies, emergency management agencies, and a range of other partners—plan, train, and exercise together to be ready to support one another in large-scale emergencies. We invite you to reach out to your region’s coordinator, if you haven’t already, to find out more. A map of the regions and a link to the current contact information for their coordinators can be found on the next page.

Each of these toolkits gives facilities that fall under the new rule an overview of the requirements for their provider type, as well as some sample templates that can be used in their planning efforts. In topic areas where there wasn’t a tool or template readily available, the toolkit offers planning worksheets that feature a list of example questions to help facilities think through relevant issues that can help them draft their plans and policies.

As you may be aware, the Division of Quality Assurance (DQA, another part of the Wisconsin Department of Health Services), is the state survey agency that oversees Wisconsin’s certification process on behalf of CMS. While DQA has provided our staff with information and background on the CMS rule, our provider toolkits were produced independently and are intended for advisory purposes only. None of the tools or assistance provided by our office or the regional healthcare coalitions guarantees any outcome during survey visits. Facilities are solely responsible for meeting CMS requirements.

We wish you success in your efforts to enhance your readiness to protect your patients, clients, residents, their families, and your staff during emergency situations, and hope the contents of this toolkit help you on your way!

Best Wishes,

*Michelle Seitz*

Michelle Seitz  
Health Care Preparedness Program Manager  
Office of Preparedness and Emergency Health Care  
Division of Public Health  
Wisconsin Department of Health Services
WISCONSIN’S HEALTHCARE COALITIONS

Below is a map of the regional healthcare coalitions in Wisconsin. Contact information for coalition leaders is provided in the Healthcare Coalition Regional Contact document: https://www.dhs.wisconsin.gov/preparedness/healthcare/hcc-contacts.pdf. Questions about the federal regulation for emergency preparedness can be directed to your regional healthcare coalition coordinator.

In addition, the HCC Emergency Preparedness website can provide links to regional websites, answers, and updates on many emergency preparedness topics: https://www.dhs.wisconsin.gov/preparedness/hospital/index.htm
On September 16, 2016, the Centers for Medicare & Medicaid Services (CMS) published new federal regulations that included updated emergency preparedness requirements for providers and suppliers participating in Medicare and Medicaid. For provider-specific text and a link to the full text regulation, see Appendix A. These requirements fall under new conditions of participation/conditions for coverage; if these requirements are not met, providers and suppliers risk citation and consequent loss of Medicare or Medicaid reimbursement. The regulation went into effect on November 15, 2016, and will be included in any surveys conducted following November 15, 2017.

Seventeen provider and supplier types receiving Medicare or Medicaid reimbursement are affected by the CMS emergency preparedness rule. The provider and supplier types are:

- Ambulatory surgical centers
- Clinics and rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals
- End-stage renal disease facilities
- Home health agencies
- Hospices (inpatient and outpatient)
- Hospitals
- Intermediate care facilities for individuals with intellectual disabilities
- Long term care (skilled nursing facilities)
- Organ procurement organizations (OPOs)
- Programs of all inclusive care for the elderly
- Psychiatric residential treatment facilities
- Religious nonmedical health care institutions
- Rural health clinics and federally qualified health clinics
- Transplant center

The regulation requires affected providers and suppliers to comply with all applicable federal, state, and local emergency preparedness requirements. The regulation also requires providers and suppliers to develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach that includes, but is not limited to, the following domains:

- **Error! Reference source not found.**: Develop an emergency preparedness plan based on facility and community risk assessments and utilizing an all-hazards approach; address patient populations, services offered for continuity of operations, and succession plans.
- **Policies and Procedures**: Develop emergency preparedness policies and procedures based on the risk assessment, emergency plan, and communication plan; address subsistence needs, patient tracking, evacuation, sheltering in place, protection of medical documentation, and arrangements with other providers in the event of patient transfer.
- **Communication Plan**: Develop an emergency preparedness communication plan that complies with federal, state, and local laws; include contact information for relevant partners, methods to share protected patient information, and primary and alternate means of communication.
- **Error! Reference source not found.**: Develop an emergency preparedness training and testing program based on the risk assessment, emergency plan, and communication plan; provide annual training on all emergency preparedness policies and procedures; participate annually in two exercises, one of which must be a full-scale community-based exercise.
This toolkit provides information on the CMS Emergency Preparedness rule for hospitals (children’s hospitals, long-term hospitals, psychiatric hospitals, rehabilitation hospitals, short term hospitals), critical access hospitals, and transplant hospitals. There are four major content sections: Risk Assessment and Planning, Policies and Procedures, Communication Plan, and Training and Testing. The content sections contain detailed information about the given portion of the rule.

At the end of each of the four content sections, there is a subsection titled Tools and Templates. The Tools and Templates subsection contains relevant tools, templates, and resources for the given section. These tools, templates, and resources are mentioned in the content portion of each section, and are linked to the tools and templates subsection for further explanation and provision.

The parts of the document that follow the four content sections include: additional requirements that may be applicable to the provider type; pertinent resources; definitions; acronyms; and the appendices.
RISK ASSESSMENT AND PLANNING

Hospitals should develop and maintain an emergency preparedness plan that is reviewed and updated at least annually. A checklist that can help hospitals in emergency preparedness planning can be found here: [Emergency Preparedness Planning Checklist](#). Hospitals should have an emergency plan that includes, at the least, the following elements:

### Risk Assessment

Hospitals should base their emergency plan on documented facility-based and community-based risk assessments, using an all-hazards approach. An all-hazards approach integrates response and focuses on capacities and capabilities that support preparedness for a spectrum of emergencies. The all-hazards approach does account for location; all-hazards planning does not address any specific potential threat, but promotes a facility’s readiness to respond to a broad range of applicable emergencies. Facilities may use community-based risk assessments developed by other entities, but should have a copy of the risk assessment and ensure their emergency plan is in alignment with the community-based risk assessment. Additionally, the emergency plan should include strategies to address the emergencies identified by the risk assessments.

One source of community-based risk assessments is a facility’s healthcare coalition: [Wisconsin’s Healthcare Coalitions](#). A template and instructions for conducting a [Facility-based Hazard Vulnerability Assessment (HVA)](#) are linked below.

### Continuity of Operations

Hospital emergency plans should address their patient population, including at-risk patients; services provided in emergencies; and continuity of operations, including delegations of authority and succession plans. Hospitals need to identify and plan for patients who may require additional assistance. Additionally, hospitals should identify staff roles as necessitated by the emergency, through succession planning and clear delegations of authority. At the least, hospitals should identify a qualified individual who is authorized in writing to act in the absence of the administrator or person legally responsible for the operations of the facility. Continuity of operations plans should include facility- and community-based risk assessments and identify essential personnel, essential functions, and critical resources. These plans should also describe how the facility will protect vital records and IT data, as well as identify and locate alternate facilities and financial resources as needed.

Examples of useful continuity of operations tools include:

- [Emergency Operations Plan Activation](#)
- [Essential Services Roles and Responsibilities](#)

A link to Hospital Incident Command System (HICS) documents can be found here: [HICS Documents](#).

### Cooperation and Collaboration

In the development of an emergency plan, hospitals should include a process for cooperation with local, tribal, regional, state, and federal emergency preparedness officials. Collaboration with these officials will encourage
integrated responses during emergency situations. Hospitals should include documentation of their efforts to contact such officials. When hospitals are able to participate in cooperative planning efforts, they should include documentation of that participation as well.

The Collaboration Contact Grid provides a template for documenting emergency preparedness contacts.
Tools and Templates: Risk Assessment and Planning

This section contains tools, templates, and resources that may be helpful for risk assessment and planning. Included are the:

- Emergency Preparedness Planning Checklist
- Facility-Based HVA
- Emergency Operations Plan Activation
- Essential Services Roles and Responsibilities
- HICS Documents
- Collaboration Contact Grid
**Emergency Preparedness Planning Checklist**

The Emergency Preparedness Checklist is located on the CMS Survey and Certification website. This checklist can help hospitals in emergency preparedness planning. The checklist reviews major topics that emergency preparedness programs should address, and provides information on details related to those topics. This can be an important tool for tracking progress on creating an emergency preparedness plan.


**Facility-Based HVA**

HVAs are a systematic approach to identifying potential hazards that might affect an organization. Vulnerability is determined by assessing risk associated with each hazard and analyzing assessment findings to create a prioritized comparison of hazard vulnerabilities. The vulnerability is related to both the impact on organizational and community function and the likely demands the hazard would create. The tools at this website can be used to conduct a facility-based hazard vulnerability assessment for hospitals.

[https://www.calhospitalprepare.org/hazard-vulnerability-analysis](https://www.calhospitalprepare.org/hazard-vulnerability-analysis)

**Emergency Operations Plan Activation**

The following grid is an example of the type of tool hospitals may create to document a chain of responsibility for activating emergency operations plans. Individuals selected would be responsible for assessing emergent situations and activating the emergency operations plan when appropriate.

<table>
<thead>
<tr>
<th>Individuals Responsible for Emergency Operations Plan Activation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Contact Number</td>
</tr>
<tr>
<td>Primary</td>
<td></td>
</tr>
<tr>
<td>Backup 1</td>
<td></td>
</tr>
<tr>
<td>Backup 2</td>
<td></td>
</tr>
</tbody>
</table>
**Essential Services Roles and Responsibilities**

This grid is an example of a tool hospitals may create to track roles and responsibilities for essential services during emergency events. Services identified should be essential during emergencies. Roles and responsibilities for identified services should be clearly stated, and individuals providing these services should be aware of their responsibilities. A primary and secondary point of contact should be established for each service, so that in the case of an emergency, the service can be activated and coordinated appropriately.

<table>
<thead>
<tr>
<th>Essential Services</th>
<th>Roles and Responsibilities</th>
<th>Point of Contact</th>
<th>Secondary Point of Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housekeeping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety and Security</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Additional Services if Needed)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HICS Documents
The Hospital Incident Command System organizes hospital emergency preparedness through incident command guidance. The following link leads to information on the Hospital Incident Command System, HICS documents, and HICS forms. The webpage includes information about HICS, including Frequently Asked Questions, the HICS guidebook, and a variety of templates, including job action sheets, incident planning guides, and other HICS forms.

http://hicscenter.org/SitePages/HICS%20Documents%202014.aspx
Collaboration Contact Grid

The following grid can be completed and retained for the purpose of collaborating with appropriate local, tribal, regional, state, and federal emergency preparedness partners. These contacts can be resources during emergency preparedness program development and evaluation, and during real-world emergencies. Using an all-hazards approach to emergency preparedness, hospitals should have the ability to communicate with all relevant partners, if necessary. However, during an emergency, facilities should prioritize communication with those entities with an immediate response role such as local public health, local emergency management, and their regional healthcare coalition.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Contact Name</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tribal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional: Healthcare Coalition</td>
<td>Healthcare Coalition Coordinator</td>
<td>Ann Angell/SRO</td>
<td>608-266-9422 (AA)</td>
<td><a href="mailto:ann.angell@dhs.wisconsin.gov">ann.angell@dhs.wisconsin.gov</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Leona Magnant /NERO</td>
<td>920-448-5240 (LM)</td>
<td><a href="mailto:leona.magnant@dhs.wisconsin.gov">leona.magnant@dhs.wisconsin.gov</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carol Jean Rucker/SERO</td>
<td>414-227-4563 (CJR)</td>
<td><a href="mailto:caroljean.rucker@dhs.wisconsin.gov">caroljean.rucker@dhs.wisconsin.gov</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tammy Modl /WRO</td>
<td>715-836-3030 (TM)</td>
<td><a href="mailto:tammy.modl@dhs.wisconsin.gov">tammy.modl@dhs.wisconsin.gov</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Jessica Radtke /NRO</td>
<td>715-365-2801 (JR)</td>
<td><a href="mailto:jessica.radtke@dhs.wisconsin.gov">jessica.radtke@dhs.wisconsin.gov</a></td>
</tr>
<tr>
<td>State: Division of Quality Assurance</td>
<td>Contact the appropriate BNHRC regional office.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State: Office of Emergency Preparedness and Health Care</td>
<td>DHS 24-hour Emergency Hotline</td>
<td>Answering service will direct to the correct personnel.</td>
<td>608-258-0099</td>
<td>none</td>
</tr>
<tr>
<td>Federal: CMS</td>
<td>CMS Region 5 Emergency Coordinator and CMS Region 5 Emergency Preparedness Rule POC</td>
<td><strong>Primary:</strong> Justin Pak</td>
<td></td>
<td><strong>Primary:</strong> <a href="mailto:justin.pak@cms.hhs.gov">justin.pak@cms.hhs.gov</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Secondary:</strong> Gregory Hann</td>
<td></td>
<td><strong>Secondary:</strong> <a href="mailto:gregory.hann@cms.hhs.gov">gregory.hann@cms.hhs.gov</a></td>
</tr>
<tr>
<td>Federal: ASPR</td>
<td>Secretary’s Operation Center (SOC)</td>
<td>24/7 Staffing</td>
<td>202-619-7800</td>
<td><a href="mailto:hhs.soc@hhs.gov">hhs.soc@hhs.gov</a></td>
</tr>
<tr>
<td>Federal: FEMA</td>
<td>Region V Regional Watch Center</td>
<td>24/7 Staffing</td>
<td>312-408-5365</td>
<td></td>
</tr>
</tbody>
</table>
POLICIES AND PROCEDURES

Hospitals should develop and implement emergency preparedness policies and procedures that are based on their risk assessment, emergency plan, and communication plan. These policies and procedures should be reviewed and updated at least annually. Hospitals may choose whether to incorporate emergency policies and procedures into their emergency plan or to include policies and procedures into their standard operating procedures/operations manual. However, the emergency plan and policies and procedures should always be easily accessible, and it is recommended that they be co-located.

At a minimum, the emergency preparedness policies and procedures for hospitals should address the following elements:

**Subsistence Needs**

Hospital policies and procedures should address the subsistence needs for staff and patients, including procedures for evacuation or sheltering in place. Subsistence needs may include, but are not limited to:

- Food, water, medical, and pharmaceutical supplies.
- Alternate sources of energy to maintain appropriate temperatures, emergency lighting, fire response, and sewage/waste management.

There are no set requirements for the amount of provisions that must be stored by hospitals. Hospitals should make appropriate needs assessments based on their risk assessments and the potential services, including community sheltering, they may provide in emergency events.

The *Subsistence Needs* worksheet provides questions to consider for subsistence needs policies and procedures.

**Patient and Staff Tracking**

Hospitals should develop policies and procedures that outline a system to track on-duty staff and sheltered patients that are in the hospital’s care both *during and after* an emergency. Tracking should include the location of on-duty staff and sheltered patients, including the name and location of the receiving facility/destination in the event of relocation. Information should be readily available, accurate, and shareable among officials. Hospitals are not required to track the location of patients who leave voluntarily or have been appropriately discharged, but should note this information in their medical record in case of the need for follow up.

The *Patient and Staff Tracking* worksheet provides questions to consider for patient and staff tracking policies and procedures.

**Evacuation and Sheltering in Place**

Emergency preparedness policies and procedures should include processes for safe evacuation from the hospital. Evacuation procedures should consider the treatment needs of evacuating patients, evacuation protocols for any other individuals sheltered in the hospital, responsibilities held by staff members, transportation of patients, identification of evacuation location(s), and primary and alternate means of
communication with external sources of assistance. Hospitals should consider developing triaging systems to prioritize patient evacuation if the need arises.

In certain situations, evacuation of the hospitals may not be appropriate or possible. For these situations, as identified by the facility's risk assessment, hospitals should develop policies and procedures for sheltering in place. Hospitals should develop criteria for which patients and staff would shelter in place, and identify appropriate facilities to accept patients that are transferred. Facilities should determine their policies based on the type of emergency and the types of patients, staff, volunteers, and visitors that may be on site during an emergency.

The *Evacuation and Sheltering in Place* worksheet provides questions to consider for evacuation and sheltering in place policies.

**Medical Documentation**

Emergency policies and procedures should include a system of medical documentation that is readily available while protecting the confidentiality of patient information. The system of medical documentation should support continuity of care, whether in the affected hospital or in a receiving hospital, in the event the patient is transferred. These policies and procedures should supplement existing medical record requirements and regulations. These policies and procedures should also be in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

The *Medical Documentation* worksheet provides questions to consider for medical documentation policies and procedures.

**Volunteers**

Hospital policies and procedures should address emergency staffing strategies, including the use of facility volunteers and state and federally designated health care professionals, in the event of surge needs. Hospitals may consider utilizing the Wisconsin Emergency Assistance Volunteer Registry (WEAVR) (more information is in the *Health Professions Volunteer Use* section) to recruit volunteers to meet medical surge needs. Hospitals should consider any essential privileging and credentialing processes that may become relevant in emergency situations. Policies and procedures should also include a method for contacting off-duty staff or addressing staffing shortages caused by inability of staff to report to work.

**Transfer Arrangements**

Hospital policies and procedures should include prearranged transfer agreements with other hospitals and providers to receive patients in the event of limitations or cessations of operations. These agreements may be written or contracted. Policies and procedures should also include pre-arranged transportation between facilities. The goal of such agreements should be continuity of care for patients.

Sample agreements include:

*Sample Transfer Agreement*
Sample Memorandum of Understanding

**1135 Waivers**

The hospital’s policies and procedures should include the role of the hospital in providing care and treatment at alternate sites in the event of the declaration of an 1135 waiver (a link to more information is provided below). Hospitals should collaborate with local emergency officials to organize a systemic response that ensures continuity of care even when services at their facility are severely disrupted. Policies and procedures should also address the hospital’s role in emergencies in which the President declares a major disaster or emergency and the United States Health and Human Services (HHS) Secretary declares a public health emergency. Additionally, policies and procedures should address the coordination efforts required during a declared emergency in which an 1135 waiver has been granted, and should outline the responsibilities of the hospital during the waiver period.

For purposes of waiver or modification, an emergency area and period is where and when there is: a) an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Stafford Act, and b) a public health emergency declared by the HHS Secretary.

The CMS regional office in Chicago reviews requests for Social Security Act Chapter 1135 waivers following an emergency declaration or confirmation by the State (Public) Health Officer. Requests are first submitted to the Division of Quality Assurance for review in advance of submission to the Chicago Regional Office.

1135 waiver contact for Wisconsin:
Flip Varsos, Director
DQA Bureau of Education Services and Technology
Telephone:  608-266-2055
Email:  phyllis.varsos@dhs.wisconsin.gov

See the [1135 Waiver Information](#) section for more information.
Tools and Templates: Policies and Procedures

This section contains tools, templates, and resources that may be helpful for policies and procedures for the following subjects.

Subsistence Needs

Patient and Staff Tracking

Evacuation and Sheltering in Place

Medical Documentation

Health Professions Volunteer Use

Sample Transfer Agreement

Sample Memorandum of Understanding

1135 Waiver Information
**Subsistence Needs**

Below are some questions to consider when developing policies and procedures pertaining to subsistence needs. These questions are not exhaustive; instead, they are intended to initiate and facilitate a conversation around necessary aspects of the policies and procedures.

- How many patients does your facility have on-site, on average?
- How many staff members does your facility have on-site, on average?
- How many visitors does your facility have on-site, on average?
- How long would you plan to sustain shelter-in-place?
- What supplies, in what quantities, would you need to shelter in place over a 24-hour period for each of the following categories?
  - Food
  - Water (potable)
  - Water (non-potable)
  - Medical (gowns, gloves, bedding, tubing, syringes, oxygen tanks, medical gas, etc.)
  - Pharmaceutical
  - Alternate sources of energy (maintain appropriate temperatures, emergency lighting, fire response, and sewage waste management)
- Where would you stockpile these inventories?
- Who is responsible for maintaining these emergency inventories?
- How would you access / distribute these supplies during an emergency?
- Where would you get additional supplies when your inventories begin to run low?
**Patient and Staff Tracking**

Below are some questions to consider when developing policies and procedures pertaining to patient and staff tracking. These questions are not exhaustive; instead, they are intended to initiate and facilitate a conversation around necessary aspects of the policies and procedures.

- How will the facility track the name and location of patients during an emergency? (This includes patients who are sheltered in the facility, as well as patients transferred to other locations during an evacuation.)
- How will the facility track the name and location of on-duty staff during an emergency?
- Would these tracking policies and procedures differ during an emergency versus after an emergency?
- If the means of tracking staff and patients is electronically-based, how would this be accomplished if such systems were compromised (e.g., power outage, cyberattack, etc.)?
- How is this information maintained during the emergency?
- How often is it updated?
- Which staff members are responsible for accomplishing these tasks?
- How could this information be accessible and shared with partners upon request?
Evacuation and Sheltering in Place
Below are some questions to consider when developing policies and procedures pertaining to evacuation and sheltering in place. These questions are not exhaustive; instead, they are intended to initiate and facilitate a conversation around necessary aspects of the policies and procedures.

- What criteria are used to determine whether the facility will shelter in place or evacuate during an emergency?
- Who has decision-making authority to make this determination?
- What procedures will the facility use to determine which patients can be discharged versus moved to another facility?
- What procedures will the facility use to determine the order in which patients are evacuated?
- How will the treatment needs of patients be identified and addressed during evacuations?
- What evacuation procedures will be used for non-patients, e.g., staff and visitors?
- Which staff members have what responsibilities during the execution of evacuation procedures?
- How will transport of patients be arranged?
- How will you identify appropriate facilities to receive patients?
- How will facilities ensure that primary and alternate means of communicating with external partners about evacuation are in place?
Medical Documentation

Below are some questions to consider when developing policies and procedures pertaining to medical documentation. These questions are not exhaustive; instead, they are intended to initiate and facilitate a conversation around necessary aspects of the policies and procedures.

- What systems/policies/procedures exist to provide patient medical documentation on a day-to-day basis?
- Are there changes to these systems/policies/procedures in an emergency?
- How would medical documentation be transferred during an evacuation to accompany a patient to a receiving facility?
- How are standards of confidentiality maintained?
- Where are these existing policies/procedures documented for the facility? Think about policies that have been developed to maintain compliance with HIPAA, Joint Commission, local and state law, etc.
- If electronic medical records are used, what redundant processes exist in case such systems are compromised (power outages, cyberattacks, etc.)?
- Who is responsible for activating redundant systems?
Health Professions Volunteer Use
WEAVR is the Wisconsin Emergency Assistance Volunteer Registry. WEAVR is a secure, web-based volunteer registration system for health care and behavioral health professionals. In an emergency, facilities can request that state public health officials send out a WEAVR request. Public health officials will identify appropriate individuals and contact potential volunteers. Volunteers who agree to help will be dispatched to the hospital’s location and informed of the role they need to fill. Hospitals should understand how to use WEAVR before emergency situations arise. More information about WEAVR can be found on the DHS’ WEAVR web-page:

https://www.dhs.wisconsin.gov/preparedness/weavr/index.htm

Sample Transfer Agreement
The Sample Transfer Agreement document (linked below) provides a template transfer agreement for hospitals. Hospitals can use this template or build their own based on this example. The transferring hospital and receiving facility both complete and sign this form prior to emergency events, so that in an emergency situation in which patients need to be transferred from the affected hospital, a transfer agreement is already in place. The document outlines expectations between the facilities and the terms of agreement.


Sample Memorandum of Understanding
The document provides a template for Memorandums of Understanding (MOU) along with guidance on completing the MOUs. MOUs are used to establish a mutual understanding of the roles and responsibilities of participating entities during an emergency incident. MOUs include the scope of services to be provided and reimbursement considerations. MOUs should be developed before emergency situations, so that in emergency events, a clear set of expectations exists between involved entities. This template is designed for Long-Term Care facilities, but can be adapted and modified for use by hospitals. There are three templates included in this document: one for like-type facilities, one for community partners/non-like-type facilities, and one for transportation services.

https://www.dhs.wisconsin.gov/publications/p0/p00690.pdf

1135 Waiver Information
When the President of the United States declares an emergency under the Stafford Act or National Emergencies Act, and the Health and Human Services Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is allowed to assume additional actions on top of their usual authorities. One of these actions is to waive or modify certain Medicare, Medicaid, and Children’s Health Insurance Program requirements, under section 1135 of the Social Security Act, to ensure that sufficient health care services are available to meet the needs of affected populations. The 1135 waivers may include adjustments to the conditions of participation or other certification requirements. Once an 1135 waiver is authorized at the federal level, hospitals can submit requests to their State Survey Agency (DQA) to operate under the authority of the
waiver. Hospitals should justify the use of the waiver, the expected modifications to usual standards, and the duration of the waiver use. The 1135 Waiver-At-A-Glance document (linked below) provides more detail on what 1135 waivers are, and when and how they may be implemented.

COMMUNICATION PLAN

Hospitals should develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws. This communication plan should be reviewed and updated at least annually. The communication plan should include how the facility coordinates patient care within the facility, across health care providers, and with state and local public health departments. The communication plan should also include how the facility interacts and coordinates with emergency management agencies and systems to protect patients.

If the hospital contains a Medicare-approved transplant center, a communication plan needs to be developed and disseminated between the hospitals, organ procurement organizations, and transplant programs. Transplant centers should be included in the development of their containing hospital’s communication plan. This communication plan should include the responsibilities of each facility type to ensure continuity of care.

The communication plan should include the following elements:

**Contact Information**
The communication plan should include both names and contact information for the following internal assets of the facility:

- Staff
- Entities providing services under arrangement
- Patients’ physicians
- Other hospitals and critical access hospitals
- Volunteers

The communication plan should also include contact information for the following external resources:

- Federal, state, tribal, regional, and local emergency preparedness staff
- Other identified sources of assistance

Contact information should be readily available and accessible to leadership and staff. All contact information should be accurate and current.

Sample contact grids are included for the following contact types:

*External Contact Information*
*Staff Contact Information*
*Patients’ Physicians’ Contact Information*
*Volunteer Contact Information*

**Communications**
Hospital communication plans should include primary and alternate means for communicating with their staff and federal, state, tribal, regional, and local emergency management agencies. The communication plan should include when and how alternate communication methods are used, and who uses them. Additionally, hospitals
should ensure that their selected alternate method of communication is compatible with the communication systems of those they need to contact.

A sample grid for documenting primary and alternate means of communications can be found here: Primary and Alternate Means of Communication.

**Release of Information**

Communications plans should include methods for a number of information sharing needs. Hospitals should develop a method for sharing patient information and medical documentation with other providers to maintain continuity of care. Information necessary to provide patient care should be sent with evacuated patients or be readily available for patients who are sheltered in place. When patients are transferred, hospitals should send all necessary patient information that is readily available, including patient name, DOB, allergies, current medications, medical diagnoses, current reason for admission, blood type, advance directives, and next of kin/emergency contacts.

Hospitals should have HIPAA-compliant means to release patient information to family members and others in a timely and accurate fashion, in the event of an evacuation. Additionally, hospitals should develop HIPAA-compliant means of providing general information about the condition and location of patients that are in the hospital’s care. Though HIPAA requirements are not suspended during a national or public health emergency, the privacy rule does permit certain uses and disclosures of protected health information in emergency circumstances and for disaster relief purposes.

A decision flowchart for disclosing protected health information can be found in the HIPAA Decision Flowchart.

**Hospital Information**

Hospital communication plans should include a means for providing information on the hospital’s occupancy, needs, and ability to provide assistance to others. Occupancy information may include reporting the number of patients at the hospital receiving treatment or the hospital’s occupancy percentage. A hospital’s reported needs may include shortage of provisions, assistance with evacuation, or transportation/transfer shortages. The communication plan should specifically include how the required information would be communicated.

This information should be provided to the authority with jurisdiction. The authority with jurisdiction varies by local, state, and federal emergency management structures as well as the nature of the emergency.

Hospitals can share occupancy and needs information using WiT.
Tools and Templates: Communication Plan
This section contains tools, templates, and resources that may be helpful for communication plans.

External Contact Information

Staff Contact Information

Patients’ Physicians’ Contact Information

Volunteer Contact Information

Primary and Alternate Means of Communication

HIPAA Decision Flowchart

WIT
## External Contact Information

This grid is an example of the type of tool hospitals may create to maintain information for external contacts. Hospitals should keep updated contact information so that in an emergency event, the appropriate individual can be reached in a timely fashion. The purpose for reaching out to a given contact should be included, so it is clear who should be contacted for what reason in any given situation.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Purpose for Contact</th>
<th>Contact Name/Title</th>
<th>Contact Info</th>
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<tbody>
<tr>
<td>Local Emergency Management Staff</td>
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<tr>
<td>Local Public Health Department (Emergency Preparedness)</td>
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<td>HCC</td>
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<td>State Emergency Management Staff</td>
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<td>State Public Health Department (Emergency Preparedness)</td>
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<td>State Public Health Department (DQA)</td>
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<td>Tribal Emergency Preparedness / Emergency Management</td>
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<td>Fire</td>
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<td>EMS</td>
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<td>Police</td>
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<td>Sheriff</td>
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<td>Coroner</td>
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<td>Ombudsman</td>
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<tr>
<td>Other Hospital(s)</td>
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<tr>
<td>Other Facilities w/ MOUs</td>
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<tr>
<td>Entities Providing Services</td>
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<tr>
<td>Sister Facilities</td>
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<tr>
<td>(Additional Sources of Assistance)</td>
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</table>
**Staff Contact Information**

This grid is an example of the type of tool hospitals may create to maintain contact information for staff. Hospitals should be able to contact staff during emergencies. Reasons for contact may include cancelling shifts, determining which staff are actually on duty or on site, or reaching out to staff to help with surge needs. It should be decided whether roles for staff will be adjusted or increased during emergency events, and if so, those roles should be clarified and documented.

<table>
<thead>
<tr>
<th>Name</th>
<th>Department</th>
<th>Phone</th>
<th>Email Address</th>
<th>Emergency Staffing Role</th>
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</table>
Patients' Physicians' Contact Information

This grid is an example of the type of tool hospitals may create to maintain contact information for their patients’ physicians. Hospitals should be able to contact patients’ physicians in a timely manner during emergency events. Hospitals should maintain updated contact information for physicians and include multiple ways to reach their patients’ physicians.

<table>
<thead>
<tr>
<th>Patient Physician Emergency Contact Roster</th>
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<tbody>
<tr>
<td>Name</td>
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</table>
Volunteer Contact Information
This grid is an example of the type of tool hospitals may create to maintain contact information for volunteers. Hospitals should be able to contact volunteers during emergencies. Reasons for contact may include cancelling shifts, determining which volunteers are actually on duty or on site, or reaching out to volunteers to help with surge needs. It should be decided whether roles for volunteers will be adjusted or increased during emergency events, and if so, those roles should be clarified and documented.

<table>
<thead>
<tr>
<th>Name</th>
<th>Department</th>
<th>Phone</th>
<th>Email Address</th>
<th>Emergency Staffing Role</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Primary and Alternate Means of Communication

This grid is an example of the type of tool hospitals may create to document primary and alternate means of communication with relevant individuals/partners. Hospitals should have at least two methods of communicating with staff and relevant partners. The alternate method should be easily accessible, in the event that the primary method becomes unavailable, and should be agreeable to both the hospital and the entity they are communicating with. Primary and alternate methods of communication may vary based on who the hospital is trying to contact (for example, primary and alternate methods of communication may be different for staff than they are for state emergency management staff), but should be decided and documented before emergency events occur so that communication expectations are clear in emergency events.

<table>
<thead>
<tr>
<th>Contact</th>
<th>Primary Method</th>
<th>Alternate Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td></td>
<td></td>
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<tr>
<td>Local Emergency Management Staff</td>
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<tr>
<td>Local Public Health Department (Emergency Preparedness)</td>
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<td>State Emergency Management Staff</td>
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<td>State Public Health Department (DQA)</td>
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<td>Tribal Emergency Preparedness/ Emergency Management Staff</td>
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<tr>
<td>FEMA</td>
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</tbody>
</table>
HIPAA Decision Flowchart

HIPAA is not waived in emergency events, hospitals should be aware of the need to protect patient information at all times. However, certain information can be shared during emergency events if the protected health information is disclosed for public health emergency preparedness purposes. The At-A-Glance Disclosure Decision Flowchart (linked below) can help hospitals make choices about disclosing protected health information. If there is uncertainty about the appropriateness of disclosing information, hospitals should err on the side of caution or contact appropriate authorities for guidance.

**WI Trac**

WI Trac stands for Tracking, Resources, Alerts, and Communication, and is a tool that hospitals can use to alert and communicate with each other and with emergency response partners. WI Trac can be used during emergencies, but can also be used on a day-to-day basis to communicate hospital resources. WI Trac allows hospitals to communicate their occupancy status (such as beds available) and send alerts to relevant partners. WI Trac is intended primarily for hospitals, but is also available to EMS, first responders, public health, physician offices, law enforcement, fire departments, dispatch centers, and emergency management directors. The following website provides more information about WI Trac and how to gain access to WI Trac.

https://www.dhs.wisconsin.gov/preparedness/hospital/witrac.htm

Additionally, below are some questions to consider when developing communication plans pertaining to sharing hospital information. These questions are not exhaustive; instead, they are intended to initiate and facilitate a conversation around necessary aspects of the communication plan.

- How does the facility determine which authorities to notify in the event of an emergency?
- How do the authorities vary in different types of emergency situations?
- How are occupancy levels communicated to local and state authorities during an emergency?
- How are supply and other needs communicated to local and state authorities during an emergency?
- How does the facility convey to local and state authorities their ability to help others?
- How might the means of communication differ depending on the emergency or the authorities being notified?
- What redundant means of communication exist for providing this information?
**TRAINING AND TESTING**

The hospital should develop and maintain an emergency preparedness training and testing program that is based on the risk assessments, emergency plan, policies and procedures, and communication plan. The training and testing program should be reviewed and updated at least annually.

Training should encompass the hospital’s provision of education and instruction to staff, contractors, and facility volunteers. Testing should operationalize training, and allow the hospital to evaluate the effectiveness of their training as well as the overall emergency preparedness program. Testing can include conducting drills and/or exercises to test the emergency plan and identify gaps or areas for improvement.

Training and testing can include, but is not limited to, how the hospital would communicate facility closure to required contacts, testing patient tracking, or testing transportation procedures. For hospitals with multiple locations, the training and testing program should reflect the facility-based risk assessment for each specific location.

**Training Program**

Hospitals should develop training programs that cover emergency preparedness policies and procedures. This training should be available during orientation for all new staff, individuals providing services under arrangement, and volunteers, and be consistent with their expected role in an emergency. Existing staff should also receive emergency preparedness training at least annually. Ideally, this annual training should be modified each year to reflect lessons learned from exercises and real world events in the past year and the annual emergency program review. Though all staff should receive annual training, hospitals can decide what level of training each staff member should complete each year, based on their expected responsibilities in an emergency. Hospitals may also determine that documented external training is sufficient to meet some or all of the hospital’s annual training requirements.

Training should be documented, and hospitals should be able to demonstrate staff knowledge of emergency preparedness program plans, policies, and procedures. This documentation should include the specific training completed as well as the methods used to demonstrate knowledge of the training program.

Additionally, for critical access hospitals, staff training should include prompt reporting and extinguishing of fires; protection and, where necessary, evacuation of patients, personnel, and guests: fire prevention; and cooperation with firefighting and disaster authorities.

**Testing**

Hospitals should conduct at least two exercises to test the emergency plan annually. For one exercise, hospitals should participate in a full-scale, community-based exercise. As required by this rule, full-scale exercises are defined as any operations-based exercise (drill, functional, or full-scale) that assesses a hospital's operations and its given community. This is an operations-based exercise that typically involves multiple agencies, jurisdictions, and disciplines performing functional or operational elements. **Full-scale exercises, as defined in this regulation,**
are not synonymous with full-scale exercises as defined by FEMA or Department of Homeland Security’s Homeland Security Exercise and Evaluation Program (HSEEP).

For their second exercise, hospitals can choose to conduct a second full-scale exercise that is community-based or facility-based, or conduct a tabletop exercise. If conducting a tabletop exercise, the exercise should include 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 that are designed to challenge the emergency plan.

When a community-based exercise is not available, hospitals should conduct a facility-based exercise. However, hospitals should document their attempts to participate in a community-based exercise and rationale for inability to participate. If a hospital experiences a real-world emergency that requires activation of the emergency plan, they are exempt from engaging in a full-scale, community-based exercise for one year following the actual event.

Hospitals should maintain documentation of all drills, tabletop exercises, and emergency events. Hospitals should also analyze their response to testing exercises and real world events, and revise their emergency program as appropriate. This analysis and revision can, in part, be accomplished through the completion of After Action Reports (AARs—link provided below). At a minimum, AARs should determine what was supposed to happen, what occurred, what went well, what the hospital can do differently or improve upon, and a plan with timelines for incorporating necessary improvements.

Hospitals should consider their physical location, agency, other facility responsibilities, and the needs of the community when planning or participating in exercises. Often, emergency preparedness entities, such as healthcare coalitions, may conduct annual, full-scale, community-based exercises to assess community-wide response. Hospitals should actively engage the HCCs to identify potential opportunities to participate in exercises. These exercises give hospitals the opportunity to assess their emergency plan, and better understand how they can contribute to, coordinate with, and integrate into the broader community’s response during an emergency. They also provide an opportunity to assess communication plans and engagement with external partners. Hospitals should contact their HCC to identify opportunities and assess whether participation in the HCC exercise fulfills the hospital’s CMS requirements. HCCs do not have the resources to fulfill individual hospital requirements and consequently only serve to connect hospitals to broader community engagement and coordination. Hospitals are responsible for ensuring and documenting that their participation in HCC exercises meets the requirements expected by CMS.

The following tools and templates are included:

*Exercise Design Checklist*
*Exercise Evaluation Guide*
*After Action Report/Improvement Plan Instructions and Template*
Tools and Templates: Training and Testing
This section contains tools, templates, and resources that may be helpful for training and testing.

Exercise Design Checklist

Exercise Evaluation Guide

After Action Report/Improvement Plan Instructions and Template
Exercise Design Checklist
The Exercise Design Checklist document (linked below) provides a sample checklist for designing exercises. The document leads users through the necessary steps for exercise design and can be used to document the planning and development of exercises. The first section of the checklist includes consideration of the type of exercise, the exercise scenario, the main objectives (target capabilities/critical areas) to be evaluated during the exercise, the levels of activity to be included in the exercise, who will participate in the exercise, which organizations/agencies will be involved in the exercise, and when the exercise will occur. The second section of the checklist includes consideration of communications, resources, safety and security, staff roles and responsibilities, utilities, and patient care. The following sections guide exercise designers through identifying players’ expected actions, developing a purpose statement, writing the narrative for the exercise, identifying major and detailed events in chronological order, and completing the after action report and improvement plan.

https://www.dhs.wisconsin.gov/library/exercise-design-checklist.htm

Exercise Evaluation Guide
The Exercise Evaluation Guide (linked below) is a blank document. The content and layout can be amended as is appropriate, but it is designed to help hospitals assess their exercises. The guide includes areas for evaluating numerous activities included in a single exercise. Expected observations can be entered ahead of time. After the exercise, evaluators can assess whether expectations were observed and the extent to which expectations were completed or met. Hospitals can complete this exercise evaluation guide as part of their AAR, to assess areas of strength and weakness.


After Action Report/Improvement Plan Instructions and Template
After Action Reports and Improvement Plans (IPs) are important parts of emergency preparedness testing. AARs help facilities assess their response to emergency events, whether simulated during an exercise, or real-world. AARs review the exercise design and execution, and provide an assessment of what went well and what needs to be improved upon. IPs specifically outline how and when improvements will be made to address shortcomings identified by the exercise evaluation and AAR.

The CMS AAR/IP instructions document walks through developing an AAR and IP. The document includes a purpose statement and background information on emergency preparedness. Additionally, the document contains explanations of key terms and important capabilities. It is important to note that this AAR/IP instruction document is based on the U.S. Department of Homeland Security Exercise and Evaluation Program (HSEEP). Though hospitals may choose to use HSEEP to meet exercise requirements for the CMS rule, it is essential to understand that the expectations for HSEEP and the CMS rule are not the same in regard to emergency preparedness testing. Hospitals should always ensure that their exercises and other testing activities meet the requirements of the CMS rule.
The CMS AAR/IP template document can be used to complete an AAR and IP. The document contains blank sections with instructions on how to fill out essential components in italics. The template covers the executive summary, exercise overview, exercise design summary, improvement plan, and conclusion. The template also contains five appendices: acronyms, lessons learned (optional), participant feedback summary (optional), exercise events synopsis (optional), and exercise events summary table (optional). Hospitals may use, modify, and customize this document as is appropriate for their facility. However, if a hospital wishes to conduct an exercise compliant with the Hospital Preparedness Program (HPP) and HSEEP requirements, the template sections must not be modified and each section (excluding those marked optional) must be completed entirely. Hospitals wishing to ensure compliance with the HPP and HSEEP should assess whether their testing program meets the CMS rule requirements. If hospitals determine they are not meeting conditions of participation with this template as is, they may consider completing a second AAR/IP that is compliant with the CMS regulations.


A direct file link is provided here: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/aartemplateinstructions.zip
ADDITIONAL REQUIREMENTS

Emergency and Standby Power Systems
Hospitals should implement emergency and standby power systems based on their emergency plan and policies and procedures. The following three components should be addressed:

(a) **Emergency generator location.** The generator should be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, and TIA 12–6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

(b) **Emergency generator inspection and testing.** The hospital should implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code (LSC).

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

Hospitals should continue to meet the existing provisions and requirements for their provider/supplier types under physical environment conditions of participation or any existing Life Safety Code (LSC) guidance.

Integrated Health Care Systems
If a hospital is part of a health care system consisting of multiple separately certified health care facilities that elects to have a unified and integrated emergency preparedness program, the hospital may choose to participate in the health care system’s coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program should:

- Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.
- Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered.
- Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.
- Include a unified and integrated emergency plan that meets all aforementioned requirements. The unified and integrated emergency plan should also be based on and include the following:
  - A documented community-based risk assessment, utilizing an all-hazards approach.
  - A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.
- Include integrated policies and procedures, a coordinated communication plan, and training and testing programs that meet the aforementioned requirements.

The health care system’s unified emergency preparedness program should be updated each time a facility leaves or enters the health care system’s program. The integrated program should demonstrate that each separately certified facility included in the program actively participated in the program’s development, and each facility should designate personnel to collaborate with the health care system to develop the plan. This participation should be documented. All components of the emergency preparedness program that are reviewed annually
should include all participating facilities, and each facility should be able to prove that it was involved in annual reviews and updates.

### Transplant Hospitals

If a hospital has one or more transplant centers (as defined in 42 CFR § 482.70):

- A representative from each transplant center should be included in the development and maintenance of the hospital’s emergency preparedness program.
- The hospital should develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant center, and the organ procurement organization for the DSA where the hospital is situated (unless the hospital has been granted a waiver to work with another organ procurement organization) during an emergency.
RESOURCES

CMS Survey and Certification Website

ASPR TRACIE
https://asprtracie.hhs.gov/cmsrule

Healthcare Coalitions
https://www.dhs.wisconsin.gov/preparedness/hospital/index.htm
Regional map and contacts: https://www.dhs.wisconsin.gov/preparedness/healthcare/hcc-contacts.pdf

Office of Preparedness and Emergency Health Care (OPEHC), Division of Public Health, Department of Health Services
https://www.dhs.wisconsin.gov/preparedness/index.htm

Wisconsin Emergency Management (WEM)
http://emergencymanagement.wi.gov/
**DEFINITIONS**

These definitions reflect those provided by CMS in the Interpretive Guidance for the Emergency Preparedness regulation.

**All-Hazards Approach**
An all-hazards approach is an integrated approach to emergency preparedness that focuses on identifying hazards and developing emergency preparedness capacities and capabilities that can address those as well as a wide spectrum of emergencies or disasters. This approach includes preparedness for natural, man-made, and or facility emergencies that may include but is not limited to: care-related emergencies; equipment and power failures; interruptions in communications, including cyber attacks; loss of a portion or all of a facility; and interruptions in the normal supply of essentials, such as water and food. All facilities must develop an all-hazards emergency preparedness program and plan.

**Disaster**
A hazard impact causing adverse physical, social, psychological, economic, or political effects that challenge the ability to respond rapidly and effectively. Despite a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) and change from routine management methods to an incident command/management process, the outcome is lower than expected compared with a smaller scale or lower magnitude impact (see “emergency” for important contrast between the two terms). Reference: Assistant Secretary for Preparedness and Response (ASPR) 2017-2022 Health Care Preparedness and Response Capabilities Document (ICDRM/GWU Emergency Management Glossary of Terms) (November 2016).

**Emergency**
A hazard impact causing adverse physical, social, psychological, economic, or political effects that challenge the ability to respond rapidly and effectively. It requires a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) to meet the expected outcome and commonly requires change from routine management methods to an incident command process to achieve the expected outcome (see “disaster” for important contrast between the two terms). Reference: Assistant Secretary for Preparedness and Response (ASPR) 2017-2022 Health Care Preparedness and Response Capabilities Document (ICDRM/GWU Emergency Management Glossary of Terms) (November 2016).

**Emergency/Disaster**
An event that can affect the facility internally as well as the overall target population or the community at large or community or a geographic area.

**Emergency Plan**
An emergency plan provides the framework for the emergency preparedness program. The emergency plan is developed based on facility- and community-based risk assessments that assist a facility in anticipating and addressing facility, patient, staff, and community needs and support continuity of business operations.
Emergency Preparedness Program
The Emergency Preparedness Program describes a facility’s comprehensive approach to meeting the health, safety and security needs of the facility, its staff, their patient population, and community prior to, during, and after an emergency or disaster. The program encompasses four core elements: an emergency plan that is based on a risk assessment and incorporates an all-hazards approach; policies and procedures; communication plan; and the training and testing program.

Facility-Based
We consider the term “facility-based” to mean the emergency preparedness program is specific to the facility. It includes but is not limited to hazards specific to a facility based on its geographic location; dependent patient/resident/client and community population, facility type, and potential surrounding community assets i.e., rural area versus a large metropolitan area.

Full-Scale Exercise
A full scale exercise is an operations-based exercise that typically involves multiple agencies, jurisdictions, and disciplines performing functional (for example, joint field office, emergency operation centers, etc.) and integration of operational elements involved in the response to a disaster event, i.e., “boots on the ground” response activities (for example, hospital staff treating mock patients).

Risk Assessment
The term risk assessment describes a process facilities use to assess and document potential hazards that are likely to impact their geographical region, community, facility, and patient population and identify gaps and challenges that should be considered and addressed in developing the emergency preparedness program. The term risk assessment is meant to be comprehensive and may include a variety of methods to assess and document potential hazards and their impacts. The health care industry has also referred to risk assessments as a hazard vulnerability assessment or analysis (HVA) as a type of risk assessment commonly used in the health care industry.

Staff
The term "staff" refers to all individuals that are employed directly by a facility. The phrase "individuals providing services under arrangement" means services furnished under arrangement that are subject to a written contract conforming with the requirements specified in section 1861(w) of the Social Security Act.

Table-top Exercise (TTX)
A tabletop exercise involves key personnel discussing simulated scenarios in an informal setting. TTXs can be used to assess plans, policies, and procedures. A tabletop exercise is a discussion-based exercise that involves senior staff, elected or appointed officials, and other key decision-making personnel in a group discussion centered on a hypothetical scenario. TTXs can be used to assess plans, policies, and procedures without deploying resources.
ACRONYMS

AAR/IP: After Action Report/Improvement Plan
ASC: Ambulatory Surgical Center
ASPR: Assistant Secretary for Preparedness and Response
CAH: Critical Access Hospital
CDC: Centers for Disease Control and Prevention
CfCs: Conditions for Coverage and Conditions for Certification
CMHC: Community Mental Health Center
CMS: Centers for Medicare & Medicaid Services
CoPs: Conditions of Participation
CORF: Comprehensive Outpatient Rehabilitation Facilities
DHS: Department of Homeland Security
DHHS: Department of Health and Human Services
DSA: Donation Service Area
EOP: Emergency Operations Plans
EMP: Emergency Management Plan
EP: Emergency Preparedness
ESAR–VHP: Emergency System for Advance Registration of Volunteer Health Professionals
ESF: Emergency Support Function
ESRD: End-Stage Renal Disease
FEMA: Federal Emergency Management Agency
FQHC: Federally Qualified Health Center
HHA: Home Health Agencies
HPP: Hospital Preparedness Program
HRSA: Health Resources and Services Administration
HSEEP: Homeland Security Exercise and Evaluation Program
HVA: Hazard Vulnerability Analysis or Assessment
ICFs/IID: Intermediate Care Facilities for Individuals with Intellectual Disabilities
LPHA: Local Public Health Agencies
LSC: Life Safety Code
LTC: Long-Term Care
NFs: Nursing Facilities
NFPA: National Fire Protection Association
NIMS: National Incident Management System
OPO: Organ Procurement Organization
PACE: Program for the All-Inclusive Care for the Elderly
PHEP: Public Health Emergency Preparedness
PRTF: Psychiatric Residential Treatment Facilities
RNHCIs: Religious Nonmedical Health Care Institutions
RHC: Rural Health Clinic
SNF: Skilled Nursing Facility
TJC: The Joint Commission
TRACIE: Technical Resources, Assistance Center, and Information Exchange
TTX: Tabletop Exercise
APPENDICES

Appendix A: Federal Regulation
The full text of the federal regulation can be found at:

Interpretive guidance for the federal regulation can be found at:

This appendix contains the following subsections:

Appendix A1: Federal Regulation for Hospitals

Appendix A2: Federal Regulation for Critical Access Hospitals

Appendix A3: Federal Regulation for Transplant Centers
§ 482.15 Condition of participation: Emergency preparedness.

The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:

(a) **Emergency plan.** The hospital must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:

1. Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
2. Include strategies for addressing emergency events identified by the risk assessment.
3. Address patient population, including, but not limited to, persons at risk; the type of services the hospital has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
4. Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the hospital’s efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts.

(b) **Policies and procedures.** The hospital must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

1. The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
   (i) Food, water, medical, and pharmaceutical supplies.
   (ii) Alternate sources of energy to maintain the following:
      (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
      (B) Emergency lighting.
      (C) Fire detection, extinguishing, and alarm systems.
      (D) Sewage and waste disposal.
2. A system to track the location of on-duty staff and sheltered patients in the hospital’s care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the hospital must document the specific name and location of the receiving facility or other location.
3. Safe evacuation from the hospital, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.
4. A means to shelter in place for patients, staff, and volunteers who remain in the facility.
5. A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.
6. The use of volunteers in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.
7. The development of arrangements with other hospitals and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to hospital patients.
8. The role of the hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

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

1. Names and contact information for the following:
   (i) Staff.
   (ii) Entities providing services under arrangement.
   (iii) Patients’ physicians.
   (iv) Other hospitals and CAHs
   (v) Volunteers.

2. Contact information for the following:
   (i) Federal, State, tribal, regional, and local emergency preparedness staff.
   (ii) Other sources of assistance.

3. Primary and alternate means for communicating with the following:
   (i) Hospital’s staff.
   (ii) Federal, State, tribal, regional, and local emergency management agencies.

4. A method for sharing information and medical documentation for patients under the hospital’s care, as necessary, with other health care providers to maintain the continuity of care.

5. A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).

6. A means of providing information about the general condition and location of patients under the facility’s care as permitted under 45 CFR 164.510(b)(4).

7. A means of providing information about the hospital’s occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

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

1. **Training program.** The hospital must do all of the following:
   (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
   (ii) Provide emergency preparedness training at least annually.
   (iii) Maintain documentation of the training.
   (iv) Demonstrate staff knowledge of emergency procedures.

2. **Testing.** The hospital must conduct exercises to test the emergency plan at least annually. The hospital must do all of the following:
   (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the hospital experiences an actual natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.
   (ii) Conduct an additional exercise that may include, but is not limited to the following:
      (A) A second full-scale exercise that is community-based or individual, facility based.
      (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem
statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the hospital’s response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the hospital’s emergency plan, as needed.

(e) **Emergency and standby power systems.** The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.

1. **Emergency generator location.** The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, and TIA 12–6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

2. **Emergency generator inspection and testing.** The hospital must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

3. **Emergency generator fuel.** Hospitals that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

(f) **Integrated health care systems.** If a hospital is part of a health care system consisting of multiple separately certified health care facilities that elects to have a unified and integrated emergency preparedness program, the hospital may choose to participate in the health care system’s coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must—

1. Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

2. Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered.

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

4. Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:

   (i) A documented community-based risk assessment, utilizing an all-hazards approach.

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

5. Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

(g) **Transplant hospitals.** If a hospital has one or more transplant centers (as defined in § 482.70)—

1. A representative from each transplant center must be included in the development and maintenance of the hospital’s emergency preparedness program; and

2. The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant center, and the OPO for the DSA where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency.

(h) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51.
§ 485.625 Condition of participation: Emergency preparedness.

The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness plan must include, but not be limited to, the following elements:

(a) **Emergency plan.** The CAH must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The plan must do all of the following:
   
   (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
   
   (2) Include strategies for addressing emergency events identified by the risk assessment.
   
   (3) Address patient population, including, but not limited to, persons at risk; the type of services the CAH has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
   
   (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the CAH’s efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

(b) **Policies and procedures.** The CAH must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

   (1) The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place, include, but are not limited to—
      
      (i) Food, water, medical, and pharmaceutical supplies;
      
      (ii) Alternate sources of energy to maintain:
         
         (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions;
         
         (B) Emergency lighting;
         
         (C) Fire detection, extinguishing, and alarm systems; and
         
         (D) Sewage and waste disposal.
   
   (2) A system to track the location of on-duty staff and sheltered patients in the CAH’s care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the CAH must document the specific name and location of the receiving facility or other location.
   
   (3) Safe evacuation from the CAH, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.
   
   (4) A means to shelter in place for patients, staff, and volunteers who remain in the facility.
   
   (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.
   
   (6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.
   
   (7) The development of arrangements with other CAHs or other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to CAH patients.
   
   (8) The role of the CAH under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.
(c) Communication plan. The CAH must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

1. Names and contact information for the following:
   - Staff.
   - Entities providing services under arrangement.
   - Patients’ physicians.
   - Other CAHs and hospitals.
   - Volunteers.

2. Contact information for the following:
   - Federal, State, tribal, regional, and local emergency preparedness staff.
   - Other sources of assistance.

3. Primary and alternate means for communicating with the following:
   - CAH’s staff.
   - Federal, State, tribal, regional, and local emergency management agencies.

4. A method for sharing information and medical documentation for patients under the CAH’s care, as necessary, with other health care providers to maintain the continuity of care.

5. A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).

6. A means of providing information about the general condition and location of patients under the facility’s care as permitted under 45 CFR 164.510(b)(4).

7. A means of providing information about the CAH’s occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.

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

1. Training program. The CAH must do all of the following:
   - Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
   - Provide emergency preparedness training at least annually.
   - Maintain documentation of the training.
   - Demonstrate staff knowledge of emergency procedures.

2. Testing. The CAH must conduct exercises to test the emergency plan at least annually. The CAH must do the following:
   - Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based exercise. If the CAH experiences an actual natural or man-made emergency that requires activation of the emergency plan, the CAH is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.
   - Conduct an additional exercise that may include, but is not limited to the following:
     - A second full-scale exercise that is community-based or individual, facility based.
     - A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
   - Analyze the CAH’s response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the CAH’s emergency plan, as needed.
(e) **Emergency and standby power systems.** The CAH must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.

(1) *Emergency generator location.* The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, and TIA 12–6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

(2) *Emergency generator inspection and testing.* The CAH must implement emergency power system inspection and testing requirements found in the Health Care Facilities Code, NFPA 110, and the Life Safety Code.

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

(f) **Integrated health care systems.** If a CAH is part of a health care system consisting of multiple separately certified health care facilities that elects to have a unified and integrated emergency preparedness program, the CAH may choose to participate in the health care system’s coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

(2) Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered.

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program.

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include—

   (i) A documented community-based risk assessment, utilizing an all-hazards approach.

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

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

(g) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51.
Appendix A3: Federal Regulation for Transplant Centers

§ 482.78 Condition of participation: Emergency preparedness for transplant centers.

A transplant center must be included in the emergency preparedness planning and the emergency preparedness program as set forth in § 482.15 for the hospital in which it is located. However, a transplant center is not individually responsible for the emergency preparedness requirements set forth in § 482.15.

(a) **Standard: Policies and procedures.** A transplant center must have policies and procedures that address emergency preparedness. These policies and procedures must be included in the hospital’s emergency preparedness program.

(b) **Standard: Protocols with hospital and OPO.** A transplant center must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the transplant center, the hospital in which the transplant center is operated, and the OPO designated by the Secretary, unless the hospital has an approved waiver to work with another OPO, during an emergency.
Appendix B: Emergency Preparedness Regulations Crosswalk

This crosswalk was developed by the Yale New Haven Health System Center for Emergency Preparedness and Disaster Response. This crosswalk is intended to provide a high level reference to standards provided by accrediting organizations as of October 2016. This crosswalk does not reflect standards that may have been updated since then. This crosswalk is not intended to be a comprehensive interpretation of the regulation, but a reference guide.

This appendix contains the following subsections:

Appendix B1: Hospital Emergency Preparedness Regulations Crosswalk

Appendix B2: Critical Access Hospital Emergency Preparedness Regulations Crosswalk
## Appendix B1: Hospital Emergency Preparedness Regulations Crosswalk

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Require both an emergency preparedness program and an emergency preparedness plan.</td>
<td>482.15</td>
<td>09.01.01 Emergency Safety &amp; Security</td>
<td>EP-1: Emergency Preparedness Planning</td>
<td>PE.6 SR. 1 EMERGENCY MANAGEMENT SYSTEM</td>
<td>EM.02.01.01 – General Requirements</td>
<td>12.2.3</td>
<td>12.3.2</td>
</tr>
<tr>
<td>Comply with all applicable federal, state, and local emergency preparedness requirements. The emergency plan must be reviewed and updated annually.</td>
<td>482.15</td>
<td>09.01.01 Emergency Safety &amp; Security</td>
<td>EP-1: A Coordination with Federal, State, and local emergency preparedness and health authorities EP-2: Emergency Preparedness Plan</td>
<td>EM.01.01.01 (EP 2) Evaluation</td>
<td>12.4.1</td>
<td>12.5.1</td>
<td></td>
</tr>
<tr>
<td>The emergency plan must be based on and include a documented facility-based and community-based risk assessment utilizing an all hazards approach.</td>
<td>482.15</td>
<td>09.00.02 Emergency Hazard Vulnerability Analysis (HVA)</td>
<td>EP-1: A...Risk Assessment</td>
<td>PE. 6 SR. 3 EMERGENCY MANAGEMENT</td>
<td>12.2.2.3</td>
<td>12.3.6.1</td>
<td></td>
</tr>
<tr>
<td>The emergency plan includes strategies for addressing emergency events identified by the risk assessment.</td>
<td>482.15</td>
<td>09.01.01 Emergency Safety &amp; Security</td>
<td>EP-1: B. Specific response procedures</td>
<td>PE. 6 SR. 3 EMERGENCY MANAGEMENT</td>
<td>12.5.2</td>
<td>12.5.3.1</td>
<td></td>
</tr>
<tr>
<td>The emergency plan must address the patient population including but not limited to, persons at risk, the types of services that the facility would be able to provide in an emergency; continuity of operations, including delegations of authority and succession plans.</td>
<td>482.15</td>
<td>09.01.01 Emergency Safety &amp; Security</td>
<td>EP-2: C. Emergency Preparedness Plan</td>
<td>EM.02.01.01 (EP 3, 7) General Requirements LD.01.04.01 (EP 11) Chief Executive Responsibilities</td>
<td>12.2.2.3</td>
<td>12.5.3.6.4</td>
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<td>Have a process for ensuring cooperation and collaboration with local, tribal, regional, state, or federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts.</td>
<td>482.15</td>
<td>09.01.01 Emergency Safety &amp; Security</td>
<td>EP-1: C. Emergency management and command structure</td>
<td>EM.01.01.01 (EP 3, 4, 7) Foundations for EOP EM.02.02.01 (EP 4) Communications</td>
<td>12.2.3</td>
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<td>Policies and Procedures</td>
<td>485.15</td>
<td>09.01.01 Emergency Safety &amp; Security</td>
<td>EP-2: Emergency Preparedness Plan</td>
<td>EM.02.01.01 (EP 2) General Requirements</td>
<td>12.5.3.3.5</td>
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<td>Develop and implement emergency preparedness policies and procedures based on the emergency plan and communications plan. The policies and procedures must be reviewed and updated at least annually.</td>
<td>485.15</td>
<td>09.01.01 Emergency Safety &amp; Security</td>
<td>EP-2: Emergency Preparedness Plan</td>
<td>EM.02.01.01 (EP 2) General Requirements</td>
<td>12.5.3.3.5</td>
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### Notes:
- **CMS Emergency Preparedness CoP Hospitals**: Federal regulations for hospitals.
- **Healthcare Facilities Accreditation Program**: Accreditation program for healthcare facilities.
- **Center for Improvement in Healthcare Quality (CIHQ)**: Accreditation program for healthcare facilities.
- **DNV-GL Healthcare Healthcare Accreditation Program**: Accreditation program for healthcare facilities.
- **The Joint Commission Standards**: Accreditation standards for healthcare facilities.
- **NFPA 1600**: National Fire Protection Association Standard 1600.

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### Definitions:
- **Emergency Preparedness Program**: A systematic process for preparing for, responding to, and recovering from disasters.
- **Emergency Preparedness Plan**: A written document that outlines the procedures and resources necessary to implement the emergency preparedness program.
- **EMERGENCY MANAGEMENT SYSTEM**: A comprehensive system for managing and coordinating the response to an emergency.
- **Emergency Safety & Security**: Measures taken to ensure the safety and security of patients, staff, and visitors during an emergency.
- **Emergency Hazard Vulnerability Analysis (HVA)**: A method for assessing the potential impact of hazards on a facility.
- **Emergency Command Structure**: The organizational structure used to manage an emergency response.
- **Chief Executive Responsibilities**: Leadership responsibilities in emergency preparedness.
- **Continuity of Operations**: The ability of an organization to maintain essential operations during and after a disaster.
- **Risk Assessment**: The process of identifying potential threats and vulnerabilities and assessing the likelihood and impact of an event.
- **Emergency Management Plan**: A plan that outlines the procedures and resources necessary to implement the emergency preparedness plan.

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### Additional Information:
- The crosswalk table provides a detailed comparison of regulations from CMS, CIHQ, DNV-GL, and The Joint Commission, highlighting the requirements and how they align with each other.
- The table is structured to show how federal and state regulations are interrelated and how they complement each other.
- The crosswalk is useful for healthcare facilities in understanding the comprehensive regulatory landscape and ensuring compliance with all applicable standards.
<p>| The policies and procedures must address (1) the provision of subsistence needs for staff and patients whether they evacuate or shelter in place including but not limited to (i) food, water, medical and pharmaceutical supplies (ii) alternate sources of energy to maintain: (A) temperatures to protect patient health and safety and for the safe and sanitary storage of provisions (B) emergency lighting (C) fire detection, extinguishing and alarm systems. | 482.15 (b) (1) (i-ii) A-C | 09.01.03 Emergency Utilities | EP-2: Emergency Preparedness Plan E | PE. 6. SR. 2 EMERGENCY MANAGEMENT | EM.02.02.07 (EP 5) Staff EM.02.02.09 (EP 2, 3, 4, 5, 7) Utilities EC.02.05.03 (EP 1, 3) Utilities EC.02.06.01 Other Physical Environment Requirements | 12.5.3.3.6.2 (7) (8) 12.5.3.3.6.5 12.5.3.3.6.6 |
| The policies and procedures must address...(D) sewage and waste disposal. | 482.15 (b) (ii) (D) | EP-2: Emergency Preparedness Plan L EP-2: Emergency Preparedness Plan M | EC.02.02.01 (All EP) Hazardous Materials and Waste IC.02.02.01 (EP 3) Medical Equipment, Devices, and Supplies | EM.02.02.03 (EP 9) Resources and Assets EM.02.02.11 (EP 8) Patients | 12.5.3.3.6.2 (7) (8) 12.5.3.3.6.5 12.5.3.3.6.6 |
| Develops a system to track the location of on-duty staff and sheltered patients in the facility’s care during an emergency. If on-duty staff or sheltered patients are relocated during the emergency the hospital must document the specific name and location of the receiving facility or other location. | 482.15 (b) 2 | 09.01.10 Emergency Evacuation 11.04.01 Written Fire Control Plans | PE. 6 EMERGENCY MANAGEMENT SYSTEM SR. 7 | EM.02.02.03 (EP 9) Resources and Assets EM.02.02.11 (EP 3) Patients | 12.5.3.3.6.1 (3) (4) 12.5.3.3.6.2 (7) 12.5.3.3.6.4 (1) (6) (7) (8) 12.5.3.3.6.8 |
| Have policies and procedures in place to ensure the safe evacuation from the facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation locations; and primary and alternate means of communication with external sources of assistance. | 482.15 (b) 3 | 09.01.10 Emergency Evacuation 09.01.02 Emergency Supplies | PE. 6 EMERGENCY MANAGEMENT SYSTEM SR. 7 | EM.02.02.03 (EP 9) Resources and Assets EM.02.02.11 (EP 3) Patients | 12.5.3.3.3 12.5.3.3.6 |
| Have a means to shelter in place for patients, staff, and volunteers who remain in the facility. | 482.15 (b) 4 | 09.01.10 Emergency Evacuation 09.01.02 Emergency Supplies | PE. 6 EMERGENCY MANAGEMENT SYSTEM SR. 7 | EM.02.02.03 (EP 1-6) Resources and Assets | 12.5.3.3.3 12.5.3.3.6 |
| Have a system of medical documentation that preserves patient information, protects the confidentiality of patient information, and secures and maintains availability of records. | 482.15 (b) 5 | 03.01.17 Emergency Privileges 03.01.18 Temporary Privileges | PE. 6 SR. 4 EMERGENCY MANAGEMENT MS. 13 SR. 4 TEMPORARY CLINICAL PRIVILEGES | EM.02.02.07 (EP 9) Staff EM.02.02.13 (All EP’s) Volunteers EM.02.02.15 (All EP’s) Volunteer Practitioners MS.01.01.01 (EP 14) Medical | 4.7.2 12.5.3.3.6.1 (4) |
| Have policies and procedures in place to address the use of volunteers in an emergency and other emergency staffing strategies, including the process and role for integration of state or federally designated health care professionals to address surge needs during an emergency. | 482.15 (b) 6 | 03.01.17 Emergency Privileges 03.01.18 Temporary Privileges | PE. 6 SR. 4 EMERGENCY MANAGEMENT MS. 13 SR. 4 TEMPORARY CLINICAL PRIVILEGES | EM.02.02.07 (EP 9) Staff EM.02.02.13 (All EP’s) Volunteers EM.02.02.15 (All EP’s) Volunteer Practitioners MS.01.01.01 (EP 14) Medical | 6.9.1.2 12.5.3.4.5 |
|---|---|---|---|---|---|---|---|
| The development of arrangements with other hospitals and providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to hospital patients. | 482.15 (b) 7 | 09.01.01 Emergency Safety &amp; Security | PE. 6 SR. 3 EMERGENCY MANAGEMENT | EM.02.02.03 (EP 9) Resources and Assets | 6.9.1.2 |
| Policies and procedures to address the role of the hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Act, for the provision of care and treatment at an alternative care site (ACS) identified by emergency management officials. | 482.15 (b) 8 | 09.01.01 Emergency Safety &amp; Security | EM.02.01.01 (EP 7) General Requirements |
| Communication Plan | Be required to develop and maintain an emergency preparedness communication plan that complies with local, state, and federal law and required to review and update the communication plan at least annually. | 482.15 (c) | 09.01.07 Emergency Communications | EP-2 Emergency Preparedness Plan F | PE. 6 SR. 1 EMERGENCY MANAGEMENT | EM.02.02.01 (All EPs) General Requirements | 6.4 | 12.5.3.3.6.1 |
| As part of its communication plan include in its plan names and contact information for staff; entities providing services under arrangement; patients' physicians; other hospitals and CAHs; and volunteers. | 482.15 (c) 1 | 09.01.07 Emergency Communications | EP-2 Emergency Preparedness Plan I | EM.02.02.01 (EP 1, 2, 7, 8, 9, 10) Communication | 6.4.1 | 12.5.3.3.6.1 (6) |
| Require contact information for federal, state, tribal, regional, or local emergency preparedness staff and other sources of assistance. | 482.15 (c) 2 | 09.01.07 Emergency Communications | EP-2 Emergency Preparedness Plan F | EM.02.02.01 (EP 3-13) General Requirements | 6.4.1 | 12.5.3.3.6.1 (6) |
| Include primary and alternate means for communicating with hospital staff and federal, state, tribal, regional, and local emergency management agencies. | 482.15 (c) 3 | 09.01.07 Emergency Communications | EP-2 Emergency Preparedness Plan F | EM.02.02.01 (EP 14) General Requirements | 6.4.1 | 12.5.3.3.6.1 |
| Include a method for sharing information and medical documentation for patients under the hospital's care, as necessary, with other health care providers to maintain continuity of care. | 482.15 (c) 4 | 09.01.07 Emergency Communications | EP-2 Emergency Preparedness Plan F | EM.02.02.01 (EP 11, 12) General Requirements | 6.5.3.3.6.1 (4) |
| Have a means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510. | 482.15 (c) 5 | 09.01.07 Emergency Communications | EP-2 Emergency Preparedness Plan F | EM.02.02.01 (EP 5, 12) General Requirements | 6.4.1 | 12.5.3.3.6.1 (4) |
| Have a means of providing information about the general condition and location of patients under the facility's care, as permitted under 45 CFR 164.510(b)(4). | 482.15 (c) 6 | 09.01.07 Emergency Communications | EP-2 Emergency Preparedness Plan F | EM.02.02.01 (EP 5, 6, 12) General Requirements | 6.4.1 | 12.5.3.3.6.1 (4) |
| Have a means of providing information about the hospital's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee. | 482.15 (c) 7 | 09.01.07 Emergency Communications | EP-2 Emergency Preparedness Plan F | EM.02.02.01 (EP 4) General Requirements | 6.4.1 | 12.5.3.3.6.1 (2) (6) |
| Training and Testing | Develop and maintain an emergency preparedness training and testing program based on the emergency plan, risk assessment, policies and procedures, and communication | 482.15 (d) | 09.02.02 Emergency Education | HR-2: Orientation of staff | Staffing Management SM. 4 ORIENTATION | HR.01.04.01 (EP 1, 2, 3) Orientation | 7.1 | 12.3.3.10 |
|-----------------------------------------|----------------------|---------------------------------------------|--------------------------------------------------|------------------|------------------------------|----------|--------|
| plan. The training and testing program must be reviewed and updated at least annually. | 482.15 (d) 1 | 09.02.02 Emergency Education | EP-4 Testing of the Emergency Preparedness Plan | Staffing Management SM. 4 SR. ORIENTATION | HR.01.04.01 (EP 1, 2, 3) Orientation | EM.03.01.03 (EP 1) Evaluation | 7.1 | 12.3.10 |
| Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement and volunteers consistent with their expected roles. Provide this training annually and maintain documentation of all emergency preparedness training along with demonstration of staff knowledge of emergency procedures. | 482.15 (d) 2 | 09.02.01 Emergency Exercises | EP-4 Testing of the Emergency Preparedness Plan | PE. 6 SR. 4 EMERGENCY MANAGEMENT | EM.03.01.03 Evaluation | 8.1.1 | 8.5.1 | 12.3.10 |
| Conduct exercises to test the emergency plan at least annually. | 482.15 (d) 2 | 09.02.01 Emergency Exercises | EP-4 Testing of the Emergency Preparedness Plan | PE. 6 EMERGENCY MANAGEMENT SYSTEM SR. 4 | EM.03.01.03 (EP 4, 5) Evaluation | 12.3.2 |
| Participate in a full scale exercise that is community-based or when community-based exercise is not available, individual, facility-based. | | | PE. 6 EMERGENCY MANAGEMENT | | EM.03.01.03 (EP 1) Evaluation | 12.3.2 |
| If the facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual facility based full-scale exercise for one year following the onset of the actual event. | 482.15 (d) 2 | 09.02.01 Emergency Exercises | PE. 6 SR. 4 EMERGENCY MANAGEMENT | EM.03.01.03 Evaluation | 12.3.3.2 |
| Conduct a second exercise that may include but is not limited to a second full-scale exercise that is individual, facility-based; a tabletop exercise that includes a group discussion led by a facilitator using a narrated, clinically relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge the emergency plan. | 482.15 (d) 2 | 09.02.01 Emergency Exercises | PE. 6 EMERGENCY MANAGEMENT SYSTEM SR. 4 | EM.03.01.03 Evaluation | 12.3.3.2 |
| Analyze the response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the facility emergency plan as needed. | 482.15 (d) 2 | 09.02.01 Emergency Exercises | EP-4 Testing of the Emergency Preparedness Plan | PE. 6 EMERGENCY MANAGEMENT SYSTEM SR. 4c | EM.03.01.03 (EP 6–16) Evaluation | 12.3.2 |
| Emergency and Standby Power Systems | | | | | | | | 12.3.2 |
| The hospital must implement emergency and standby power systems based on the emergency plan and the policies and procedures. | 482.15 (e) | | | | EM.02.02.09 (EP 8) | EC.02.05.07 (EP 7) Note that this requirement is to run this test every 36 months, not every 12 as the Rule states | 12.3.2 |
| Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code, Life Safety Code, and NFPA 110, when a new structure is built or when an existing structure or building is renovated. | 482.15 (e) 1 | | PE. 6 SR. 2 EMERGENCY MANAGEMENT | EC.02.05.03 (All EP’s) Utilities | EM.02.02.09 (All EP’s) Utilities | Section 3-4 |</p>
<table>
<thead>
<tr>
<th>Emergency generator inspection and testing. The facility must implement emergency power system inspection and testing requirements found in the Health Care Facilities</th>
<th>482.15 (e) 2</th>
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<th>PE. 6 SR. 2 EMERGENCY MANAGEMENT</th>
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<th>EC.02.05.07 (EP 7) Utilities</th>
<th>EM.02.02.09 (EP 8) Utilities</th>
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<td>Hospitals</td>
<td>482.15 (e) 3</td>
<td>09.01.03 Emergency Utilities</td>
<td>CE-13 Testing of Emergency Power Generators</td>
<td>PE. 6 SR. 2 EMERGENCY MANAGEMENT</td>
<td>EM.02.02.09 (EP 2, 5, 8) Utilities</td>
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<td><strong>Integrated Healthcare Systems</strong></td>
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<td>If the facility is part of a health care system consisting of multiple separately certified health care facilities that elects to have a unified and integrated emergency preparedness program, the facility may choose to participate in such a program.</td>
<td>482.15 (f)</td>
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<td>Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.</td>
<td>482.15 (f) 1</td>
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<td>The unified and integrated emergency preparedness program must be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations and services offered.</td>
<td>482.15 (f) 2</td>
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<td>Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance.</td>
<td>482.15 (f) 3</td>
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<td>Include a unified and integrated emergency plan that meets all standards of paragraphs (a) (2), (3), and (4) of this section.</td>
<td>482.15 (f) 4</td>
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<td>The plan must be based on a community risk assessment using an all hazards approach with each separately certified facility within the health system having a documented individual facility based risk assessment.</td>
<td>482.15 (f) 5</td>
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<td><strong>Transplant Center</strong></td>
<td>482.68</td>
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<td>A transplant center located within a hospital that has a Medicare provider agreement must meet the conditions of participation specified in 482.72 through 482.104 in order to be granted approval from CMS to provide transplant services.</td>
<td>482.68 (a)</td>
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<td>Unless specified otherwise, the conditions of participation at 482.72 through 482.104 apply to heart, heart lung, intestine, kidney, liver, lung, and pancreas centers.</td>
<td>482.68 (b)</td>
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<td>In addition to meeting the conditions of participation specified in §§ 482.72 through 482.104, a transplant center must also meet the conditions of participation in §§ 482.1 through 482.57, except for § 482.15.</td>
<td>482.68 (b)</td>
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<td>A transplant center must be included in the emergency</td>
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### CMS Emergency Preparedness CoP

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<td>preparedness planning and the emergency preparedness program as set forth in § 482.15 for the hospital in which it is located. However, a transplant center is not individually responsible for the emergency preparedness requirements set forth in § 482.15.</td>
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<td>Policies and procedures. A transplant center must have policies and procedures that address emergency preparedness. These policies and procedures must be included in the hospital's emergency preparedness program.</td>
<td>482.78 (a)</td>
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<td>Standard: Protocols with hospital and OPO. A transplant center must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the transplant center, the hospital in which the transplant center is operated, and the OPO designated by the Secretary, unless the hospital has an approved waiver to work with another OPO, during an emergency.</td>
<td>482.78 (b)</td>
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# Appendix B2: Critical Access Hospital Emergency Preparedness Regulations Crosswalk

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<td>Require both an emergency preparedness program and an emergency preparedness plan.</td>
<td>485.625</td>
<td>17.01.01 Emergency Safety &amp; Security</td>
<td>PE.6 SR. 1 EMERGENCY MANAGEMENT SYSTEM</td>
<td>EM.02.01.01 – General Requirements</td>
<td>12.2.2.3</td>
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<td>Emergency Plan</td>
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<td>Comply with all applicable federal, state, and local emergency preparedness requirements. The emergency plan must be reviewed and updated annually.</td>
<td>485.625 (a)</td>
<td>17.00.02 Emergency Hazard Vulnerability Analysis (HVA)</td>
<td></td>
<td>EM.02.01.01 General Requirements EM.03.01.01 (EP 2) Evaluation</td>
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<td>The emergency plan must be based on and include a documented facility-based and community-based risk assessment utilizing an all hazards approach.</td>
<td>485.625 (a) 1</td>
<td>02.01.00 Additional Required Policies 17.00.02 Emergency Hazard Vulnerability Analysis (HVA)</td>
<td>PE. 6 SR. 3 EMERGENCY MANAGEMENT</td>
<td>EM.01.01.01 (EP 2, 3, 5) – Foundation for the Emergency Operations Plan EM.03.01.01 (EP 1)</td>
<td>4.4.2</td>
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<td>The emergency plan includes strategies for addressing emergency events identified by the risk assessment.</td>
<td>485.625 (a) 2</td>
<td>17.00.02 Emergency Hazard Vulnerability Analysis (HVA)</td>
<td>PE. 6 SR. 3 EMERGENCY MANAGEMENT</td>
<td>EM.01.01.01 (EP 5, 6) – Foundation for the Emergency Operations Plan</td>
<td>5.1.5</td>
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<td>The emergency plan must address the patient population including but not limited to, persons at risk, the types of services that the facility would be able to provide in an emergency; continuity of operations, including delegations of authority and succession plans.</td>
<td>485.625 (a) 3</td>
<td>17.01.01 Emergency Safety &amp; Security 17.01.08 Incident Command Center</td>
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<td>EM.02.01.01 (EP 3, 7, 8) Communications</td>
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<td>Have a process for ensuring cooperation and collaboration with local, tribal, regional, state, or federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts.</td>
<td>485.625 (a) 4</td>
<td>17.00.02 Emergency Hazard Vulnerability Analysis (HVA)</td>
<td></td>
<td>EM.01.01.01 (EP 7) Foundations for EOP EM.02.02.01 (EP 4) Communications</td>
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<td>Develop and implement emergency preparedness policies and procedures based on the emergency plan and communications plan. The policies and procedures must be reviewed and updated at least annually.</td>
<td>485.625 (b)</td>
<td>17.01.01 Emergency Safety &amp; Security</td>
<td></td>
<td>EM.02.01.01 (EP 2) General Requirements</td>
<td>12.5.3.3</td>
<td>12.5.3.6.1</td>
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<td>12.5.3.6.1</td>
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<td>The policies and procedures must address (1) the provision of subsistence needs for staff and patients whether they evacuate or shelter in place including but not limited to (i) food, water, medical and pharmaceutical supplies (ii) alternate sources of energy to maintain: (A) temperatures to protect patient health and safety and for the safe and sanitary storage of provisions (B) emergency lighting (C) fire detection, extinguishing and alarm systems.</td>
<td>485.625 (b) 1</td>
<td>06.03.01 Dietary Emergency Preparedness Plan 17.1.1 Emergency Safety &amp; Security 17.1.2 Emergency Supplies 17.01.03 Emergency Utilities 17.01.06 Emergency Nutritional Services</td>
<td>PE. 6. SR. 2 EMERGENCY MANAGEMENT</td>
<td>EM.02.02.07 (EP 5) Staff EM.02.02.09 (EP 2, 3, 4, 5, 7) Utilities EC.02.05.03 (EP 1, 3) Utilities</td>
<td>12.5.3.6.2</td>
<td>12.5.3.6.4</td>
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<td>Critical Access Hospitals</td>
<td>485.625 (b) 1 ii D</td>
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<td>EC.02.02.01 (All EP) Hazardous Materials and Waste</td>
<td>12.5.3.3.6.2</td>
<td>12.5.3.3.6.4 (7) (8) 12.5.3.3.6.5 12.5.3.3.6.6</td>
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<tr>
<td>The policies and procedures must address...sewage and waste disposal.</td>
<td>485.625 (b) 2 17.01.01 Emergency Safety &amp; Security 17.01.10 Emergency Evacuation</td>
<td>PE. 6 SR. 1 EMERGENCY MANAGEMENT SYSTEM</td>
<td>EM.02.02.03 (EP 9) Resources and Assets EM.02.02.11 (EP 8) Patients</td>
<td>12.5.3.3.6.4 (9)</td>
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<td>Develops a system to track the location of on-duty staff and sheltered patients in the facility’s care during an emergency. If on-duty staff or sheltered patients are relocated during the emergency the hospital must document the specific name and location of the receiving facility or other location.</td>
<td>485.625 (b) 3 17.01.01 Emergency Safety &amp; Security 17.01.11 Volunteer Management</td>
<td>PE. 6 SR. 4 EMERGENCY MANAGEMENT</td>
<td>EM.02.02.03 (EP 1-6) Resources and Assets EM.02.02.11 (EP 3) Patients</td>
<td>12.5.3.3.3 12.5.3.3.6</td>
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<td>Have policies and procedures in place to ensure the safe evacuation from the facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation locations; and primary and alternate means of communication with external sources of assistance.</td>
<td>485.625 (b) 4 17.01.10 Emergency Evacuation</td>
<td>PE. 6 SR. 3 EMERGENCY MANAGEMENT</td>
<td>EM.02.02.03 (EP 9) Resources and Assets</td>
<td>4.7.2</td>
<td>12.5.3.3.6.1 (4) 12.5.3.3.6.2 (7) 12.5.3.3.6.4 (1) (6) (7) (8) (9) 12.5.3.3.6.8</td>
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<td>Have a means to shelter in place for patients, staff, and volunteers who remain in the facility.</td>
<td>485.625 (b) 5 05.01.15 Emergency Privileges 17.01.11 Volunteer Management</td>
<td>PE. 6 SR. 4 EMERGENCY MANAGEMENT</td>
<td>EM.02.02.07 (EP 9) Staff EM.02.02.13 (All EP’s) Volunteers EM.02.02.15 (All EP’s) Volunteer Practitioners</td>
<td>6.9.1.2</td>
<td>12.5.3.4.5</td>
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<td>Have a system of medical documentation that preserves patient information, protects the confidentiality of patient information, and secures and maintains availability of records.</td>
<td>485.625 (b) 6 17.01.01 Emergency Safety &amp; Security NOTE- it is assumed that the EOP would be activated when 1135 Waivers are in effect and the EOP would provide guidance related to ACS</td>
<td>PE. 6 SR. 1 EMERGENCY MANAGEMENT</td>
<td>EM.02.01.01 (EP 7) General Requirements</td>
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<td>Policies and procedures to address the role of the hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Act, for the provision of care and treatment at an alternative care site (ACS) identified by emergency management officials.</td>
<td>485.625 (b) 7 17.01.01 Emergency Safety &amp; Security Communications</td>
<td>PE. 6 SR. 3 EMERGENCY MANAGEMENT</td>
<td>EM.02.02.01 (All EPs) General Requirements</td>
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<td>Communication Plan</td>
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<td>Be required to develop and maintain an emergency preparedness communication plan that complies with local, state, and federal law and required to review and update the communication plan at least annually.</td>
<td>485.625 (C) 17.01.01 Emergency Safety &amp; Security 17.01.07 Emergency Communications</td>
<td>PE. 6 SR. 1 EMERGENCY MANAGEMENT</td>
<td>EM.02.02.01 (EP 1, 2, 7, 8, 9, 10) Communication</td>
<td>6.4</td>
<td>12.5.3.3.6.1</td>
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<td>As part of its communication plan include in its plan names and contact information for staff; entities providing services under arrangement;</td>
<td>485.625 (C) 17.01.01 Emergency Safety &amp; Security</td>
<td>EM.02.02.01 (EP 1, 2, 7, 8, 9, 10) Communication</td>
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<td>patients’ physicians; other hospitals and CAHs; and volunteers.</td>
<td>17.01.07 Emergency Communications</td>
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<td>Require contact information for federal, state, tribal, regional, or local emergency preparedness staff and other sources of assistance.</td>
<td>485.625 (C) 2 ii-ii</td>
<td>17.01.07 Emergency Communications</td>
<td>EM.02.02.01 (All EPs) General Requirements</td>
<td>6.4.1</td>
<td>12.5.3.3.6.1 (6)</td>
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<td>Include primary and alternate means for communicating with CAH staff and federal, state, tribal, regional, and local emergency management agencies.</td>
<td>485.625 (C) 3</td>
<td>17.01.01 Emergency Safety &amp; Security</td>
<td>EM.02.02.01 (EP 14) General Requirements</td>
<td>6.4.1</td>
<td>12.5.3.3.6.1</td>
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<td>Include a method for sharing information and medical documentation for patients under the hospital’s care, as necessary, with other health care providers to maintain continuity of care.</td>
<td>485.625 (C) 4</td>
<td>EM.02.02.01 (EP 11, 12) General Requirements</td>
<td>6.4.1</td>
<td>12.5.3.3.6.1 (4)</td>
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<td>Have a means, in the event of an evacuation, to release patient information as permitted under 45 CFR § 164.510.</td>
<td>485.625 (C) 5</td>
<td>EM.02.02.01 (EP 5, 12) General Requirements</td>
<td>6.4.1</td>
<td>12.5.3.3.6.1 (4)</td>
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<td>Have a means of providing information about the general condition and location of patients under the facility’s care, as permitted under 45 CFR § 164.510(b)(4).</td>
<td>485.625 (C) 6</td>
<td>EM.02.02.01 (EP 5, 6, 12) General Requirements</td>
<td>6.4.1</td>
<td>12.5.3.3.6.1 (4)</td>
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<td>Have a means of providing information about the hospital’s occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the incident command center, or designee.</td>
<td>485.625 (C) 7</td>
<td>EM.02.02.01 (EP 4) General Requirements</td>
<td>6.4.1</td>
<td>12.5.3.3.6.1 (2) (6)</td>
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### Training and Testing

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<td>Develop and maintain an emergency preparedness training and testing program based on the emergency plan, risk assessment, policies and procedures, and communication plan. The training and testing program must be reviewed and updated at least annually.</td>
<td>485.625 (D)</td>
<td>17.02.02 Emergency Education</td>
<td>Staffing Management SM. 4 ORIENTATION</td>
<td>HR.01.04.01 (EP 1, 2, 3) Orientation EM.02.02.07 (EP 7) Staff EM.03.01.03 (EP 1) Evaluation</td>
<td>7.1</td>
<td>12.3.3.10</td>
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<td>Provide initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing on-site services under arrangement and volunteers consistent with their expected roles. Provide this training annually and maintain documentation of all emergency preparedness training along with demonstration of staff knowledge of emergency procedures.</td>
<td>485.625 (D) 1 i-iv</td>
<td>17.02.02 Emergency Education</td>
<td>Staffing Management SM. 4 ORIENTATION</td>
<td>HR.01.04.01 (EP 1, 2, 3) Orientation EM.02.02.07 (EP 7) Staff EM.03.01.03 (EP 1) Evaluation</td>
<td>7.1</td>
<td>12.3.3.10</td>
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<td>Conduct exercises to test the emergency plan at least annually.</td>
<td>485.625 (D) 2</td>
<td>17.02.01 Emergency Exercises</td>
<td>PE. 6 SR. 4 EMERGENCY MANAGEMENT</td>
<td>EM.03.01.03 Evaluation</td>
<td>7.1</td>
<td>12.3.10</td>
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<td>Participate in a full scale exercise that is community based or when community-based exercise is not available, individual, facility-based.</td>
<td>485.625 (D) 2 i</td>
<td>17.02.01 Emergency Exercises</td>
<td>PE. 6 SR. 4 EMERGENCY MANAGEMENT</td>
<td>EM.03.01.03 (EP 4, 5) Evaluation</td>
<td>8.1.1</td>
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<td>If the facility experiences an actual natural or manmade emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual facility-based, full-scale exercise for one year following the onset of the actual event.</td>
<td>485.625 (D) 2 i</td>
<td>17.02.01 Emergency Exercises</td>
<td>PE. 6 SR. 4 EMERGENCY MANAGEMENT</td>
<td>EM.03.01.03 (EP 1) Evaluation</td>
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<td>Conduct a second exercise that may include but is not limited to a second full-scale exercise that is individual, facility based; a tabletop exercise that includes a group discussion led by a facilitator using a narrated, clinically relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge the emergency plan.</td>
<td>485.625 (D) 2 ii</td>
<td>17.02.01 Emergency Exercises</td>
<td>PE. 6 SR. 4 EMERGENCY MANAGEMENT</td>
<td>EM.03.01.03 (EP 1) Evaluation</td>
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### CMS Emergency Preparedness CoP

**Critical Access Hospitals**

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#### Analyze the response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the facility emergency plan as needed.

485.625 (D) 2 iii 17.02.01 Emergency Exercises PE. 6 EMERGENCY MANAGEMENT EM.03.01.03 (EP 6-16) Evaluation 12.3.3.2

#### Emergency and Standby Power Systems

The hospital must implement emergency and standby power systems based on the emergency plan and the policies and procedures.

485.625 (E)

Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code, Life Safety Code, and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

485.625 (E) 1 03.06.02 Emergency Power Electrical System PE. 6 SR. 2 EMERGENCY MANAGEMENT EC.02.05.03 (All EP's) Utilities EM.02.02.09 (All EP's) Utilities

Emergency generator inspection and testing. The facility must implement emergency power system inspection and testing requirements found in the Health Care Facilities Code, NFPA 110, and the Life Safety Code.

485.625 (E) 2 03.06.04 Plant Equipment & Systems - Maintenance PE. 6 SR. 2 EMERGENCY MANAGEMENT EC.02.05.07 (EP 7) Utilities EM.02.02.09 (EP 8) Utilities

Emergency Generator Fuel. Hospitals that maintain an on-site fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

485.625 (E) 3 17.01.03 Emergency Utilities PE. 6 SR. 2 EMERGENCY MANAGEMENT EM.02.02.09 (EP 2, 5, 8) Utilities

#### Integrated Healthcare Systems

If the facility is part of a health care system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the facility may choose to participate in such a program.

485.625 (F)

Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

485.625 (F) 1

The unified and integrated emergency preparedness program must be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations and services offered.

485.625 (F) 2

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

485.625 (F) 3

Include a unified and integrated emergency plan that meets all standards of paragraphs (a) (2), (3), and (4) of this section.

485.625 (F) 4

The plan must be based on a community risk assessment using an all hazards approach with each separately certified facility within the health system having a documented individual facility-based risk assessment.

485.625 (F) 5 EM.01.01.01 (EP 2) Foundation for the EOP