Hospice Emergency Preparedness: Applicable E-tags and Excerpts from the Interpretive Guidelines

(Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.)

Tag	Condition of Participation	Interpretive Guideline Notes	Implementation Notes
E001	The facility must comply with all applicable Federal, State and local emergency preparedness requirements. The facility must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:	• Program must be reviewed biennially. • The term "comprehensive" in this requirement is to ensure that facilities do not only choose one potential emergency that may occur in their area, but rather consider a multitude of events and be able to demonstrate that they have considered this during their development of the emergency preparedness plan	• Program must be written • Maintain evidence of the biennial review (i.e. meeting minutes, date of review, etc.)
	Emergency Plan		
E004	The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every two years (biennially).	• Bienniall review must be documented to include the date of the review and any updates made to the emergency plan based on the review • The format of the emergency preparedness plan that a facility uses is at its discretion • The plan provides the framework, which includes conducting facility-based and community-based risk assessments that will assist a facility in addressing the needs of their patient populations, along with identifying the continuity of business operations which will provide support during an actual emergency • This approach is specific to the location of the facility and considers particular hazards most likely to occur in the surrounding area. These include, but are not limited to: ƒ Natural disasters ƒ Man-made disasters ƒ Facility-based disasters that include but are not limited to: – Care-related emergencies – Equipment and utility failures, including but not limited to power, water, gas, etc. – Interruptions in communication, including cyber-attacks – Loss of all or portion of a facility – Interruptions to the normal supply of essential resources, such as water, food, fuel (heating, cooking, and generators), and in some cases, medications and medical supplies (including medical gases, if applicable) – Emerging Infectious Diseases (EID) such as Influenza, Ebola, Zika Virus and others. • When evaluating potential interruptions to the normal supply of essential services, the facility should take into account the likely durations of such interruptions. Arrangements or contracts to re-establish essential utility services during an emergency should describe the timeframe within which the contractor is required to initiate services after the start of the emergency, how they will be procured and delivered in the facility's local area, and that the contractor will continue to supply the essential items throughout and to the end of emergencies of varying duration	• Document the date of the review and updates that were made to the plan based on the review • These EIDs may require modifications to facility protocols to protect the health and safety of patients, such as isolation and personal protective equipment (PPE) measures. • The biennial review includes a review of the emergency plan, policies and procedures, communication plan, and training and testing program. CMS expects that providers will update their program more frequently as needed (for example, if staff changes occur or lessons-learned are acquired from a real-life event or exercise).

Tag	Condition of Participation	Interpretive Guideline Notes	Implementation Notes
E006	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, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.	• Facilities may rely on a community-based risk assessment developed by other entities, such as public health agencies, emergency management agencies, and regional health care coalitions or in conjunction with conducting its own facility-based assessment. If this approach is used, facilities are expected to have a copy of the community-based risk assessment and to work with the entity that developed it to ensure that the facility's emergency plan is in alignment • Hospices must include contingencies for managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care	Both the facility-based and community-based risk assessments must be documented
E007	The plan must do all of the following: (3) Address patient/client population, including, but not limited to, the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.	• Patients with limited mobility should be included • Continuity of operations planning generally considers elements such as: essential personnel, essential functions, critical resources, vital records and IT data protection, alternate facility identification and location, and financial resources	Include in plan: • Specify facility's patient populations and their unique vulnerabilities during an emergency event; • Services the facility would be able to provide during an emergency; • How the facility plans to continue operations during an emergency; • Delegations of authority and succession plans.
E009	The plan must do all of the following: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.	• The facility must include this integrated response process in its emergency plan • Facilities are encouraged to participate in a healthcare coalition as it may provide assistance in planning and addressing broader community needs that may also be supported by local health department and emergency management resources	CMS Emergency Preparedness Rule Webpage This site has many updated resources in the Downloads section of the page including a link to Health Care Coalitions and sample forms.
Policies and Procedures			
E0013	(b) Policies and procedures. Facilities must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least biennially.		

Tag	Condition of Participation	Interpretive Guideline Notes	Implementation Notes
E0015	*The following are additional requirements for hospice-operated inpatient care facilities only.* The policies and procedures must address the following: The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: • Food, water, medical and pharmaceutical supplies • Alternate sources of energy to maintain the following: ƒ Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. ƒ Emergency lighting. ƒ Fire detection, extinguishing, and alarm systems. ƒ Sewage and waste disposal.	• This specific standard does not require facilities to have or install generators or any other specific type of energy source. It is up to the facility to determine what it needs; however, if it determines it needs a generator then the LSC applies • Facilities are not required to upgrade their alternate energy source or electrical systems, but after review of their risk assessment may find it prudent to make modifications. Regardless of the alternate sources of energy a facility chooses to utilize, it must be in accordance with local and state laws, manufacturer requirements, as well as applicable LSC requirements • Facilities must establish policies and procedures that determine how required heating and cooling of their facility will be maintained during an emergency situation, as necessary, if there were a loss of the primary power source. Facilities are not required to heat and cool the entire building evenly, but must ensure safe temperatures are maintained in those areas deemed necessary to protect patients, other people who are in the facility, and for provisions stored in the facility during the course of an emergency, as determined by the facility risk assessment. If unable to meet the temperature needs, a facility should have a relocation/evacuation plan (that may include internal relocation, relocation to other buildings on the campus or full evacuation). The relocation/evacuation should take place in a timely manner so as not to expose patients and residents to unsafe temperatures • If a facility risk assessment determines the best way to maintain temperatures, emergency lighting, fire detection and extinguishing systems and sewage and waste disposal would be through the use of a portable and mobile generator, rather than a permanent generator, then the LSC provisions such as generator testing, maintenance, etc. outlined under the NFPA guidelines requirements would not be applicable, except for NFPA 70 - National Electrical Code • When inpatient facilities determine their supply needs, they are expected to consider the possibility that volunteers, visitors, and individuals from the community may arrive at the facility to offer assistance or seek shelter	Consider storage for necessary items and ensure rotation of stock, as necessary.

E0016	At a minimum, the policies and procedures must address the following: Procedures to follow up with on duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The hospice must inform State and local officials of any on-duty staff or patients that they are unable to contact.	• For administrative purposes, all hospices should already have some mechanism in place to keep track of patients and staff contact information. • The information regarding patient services that are needed during or after an interruption in their services and on-duty staff and patients that were not able to be contacted must be readily available, accurate, and shareable among officials within and across the emergency response system, as needed, in the interest of the patient.	
E0018	At a minimum, the policies and procedures must address the following: A system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the facility must document the specific name and location of the receiving facility or other location		

Tag	Condition of Participation	Interpretive Guideline Notes	Implementation Notes
E0018	At a minimum, the policies and procedures must address the following: *The following are additional requirements for hospice-operated inpatient care facilities only* (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.		
E0019	At a minimum, the policies and procedures must address the following *The following is applicable to homebound hospice patients only* The procedures to inform State and local emergency preparedness officials about patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment.	Policies and procedures must address when and how this information is communicated to emergency officials and also include the clinical care needed for these patients	
E0020	At a minimum, the policies and procedures must address the following *The following is applicable to hospice-operated inpatient care facilities only* Safe evacuation from the facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance		

Tag	Condition of Participation	Interpretive Guideline Notes	Implementation Notes
E0022	At a minimum, the policies and procedures must address the following *The following are additional requirements for hospice-operated inpatient care facilities only.* A means to shelter in place for patients, hospice employees who remain in the hospice.	Facilities are expected to include in their policies and procedures the criteria for determining which patients and staff would be sheltered in place	
E0023	At a minimum, the policies and procedures must address the following A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records	In addition to any existing requirements for patient records found in existing laws, under this standard, facilities are required to ensure that patient records are secure and readily available to support continuity of care during emergency	
E0024	At a minimum, the policies and procedures must address the following: The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency		
E0025	At a minimum, the policies and procedures must address the following The development of arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.	Facilities are required to have policies and procedures which include prearranged transfer agreements, which may include written agreements or contracted arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients	
E0026	At a minimum, the policies and procedures must address the following The role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.	• Facilities must develop and implement policies and procedures that describe its role in providing care at alternate care sites during emergencies • Facility's policies and procedures must specifically address the facility's role in emergencies where the President declares a major disaster or emergency • Facilities policies and procedures should address what coordination efforts are required during a declared emergency • Facilities should also have in place policies and procedures which address emergency situations in which a declaration was not made and where an 1135 waiver may not be applicable, such as during a disaster affecting the single facility. In this case, policies and procedures should address potential transfers of patients; timelines of patients at alternate facilities, etc.	For additional 1135 Waiver information, the S&G Emergency Preparedness Website has resources.

Tag	Condition of Participation	Interpretive Guideline Notes	Implementation Notes
Communication Plan			
E0029	(c) The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least bienially.	• Facilities must have a written emergency communication plan that contains how the facility coordinates patient care within the facility, across healthcare providers, and with state and local public health departments • The plan must be reviewed biennially and updated as necessary • Facilities in rural or remote areas with limited connectivity to communication methodologies such as the Internet, World Wide Web, or cellular capabilities need to ensure their communication plan addresses how they would communicate and comply with this requirement in the absence of these communication methodologies	• Optional communication methods facilities may consider include satellite phones, radios and short-wave radios. • Maintain evidence of biennial review of the plan
E0030	The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. (v) Volunteers	• Facilities have discretion in the formatting of this information, however it should be readily available and accessible to leadership and staff during an emergency event. Facilities which utilize electronic data storage should be able to provide evidence of data back-up with hard copies or demonstrate capability to reproduce contact lists or access this data during emergencies • All contact information must be reviewed and updated as necessary and at least biennially • Facilities must update contact information for incoming new staff and departing staff throughout the year and any other changes to information for those individuals and entities on the contact list	Maintain evidence of biennial review and update of the contact information
E0031	The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance.	• Facilities have discretion in the formatting of this information, however it should be readily available and accessible to leadership during an emergency event • Facilities are encouraged but not required to maintain these contact lists both in electronic format and hard-copy format in the event that network systems to retrieve electronic files are not accessible • All contact information must be reviewed and updated at least biennially	

Tag	Condition of Participation	Interpretive Guideline Notes	Implementation Notes
E0032	The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) facility staff. (ii) Federal, State, tribal, regional, and local emergency management agencies.	• It is expected that facilities would consider pagers, cellular telephones, radio transceivers (that is, walkie-talkies), and various other radio devices such as the NOAA Weather Radio and Amateur Radio Operators' (HAM Radio) systems, as well as satellite telephone communications systems • We recognize that some facilities, especially in remote areas, may have difficulty using some communication systems, such as cellular phones, even in non-emergency situations, which should be outlined within their risk assessment and addressed within the communications plan. It is expected these facilities would address such challenges when establishing and maintaining a well-designed communication system that will function during an emergency • The communication plan should include procedures regarding when and how alternate communication methods are used, and who uses them, ensuring these systems are compatible with their systems • Facilities may seek information about the National Communication System (NCS), which offers a wide range of National Security and Emergency Preparedness communications services, the Government Non-emergency Telecommunications Services (GETS), the Telecommunications Service Priority (TSP) Program, Wireless Priority Service (WPS), and SHARES. Other communication methods could include, but are not limited to, satellite phones, radio, and short-wave radio. The Radio Amateur Civil Emergency Services (RACES) is an integral part of emergency management operations	
E0033	The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). OR (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).	• Such a system must ensure that information necessary to provide patient care is sent with an evacuated patient to the next care provider and would also be readily available for patients being sheltered in place. While the regulation does not specify timelines for delivering patient care information, facilities are expected to provide patient care information to receiving facilities during an evacuation, within a timeframe that allows for effective patient treatment and continuity of care • Facilities are also required to have a means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510 and a means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4) • HIPAA requirements are not suspended during a national or public health emergency. However, the HIPAA Privacy Rule specifically permits certain uses and disclosures of protected health information in emergency circumstances and for disaster relief purposes	

Tag	Condition of Participation	Interpretive Guideline Notes	Implementation Notes
E0034	The communication plan must include all of the following: *The following are additional requirements for hospice-operated inpatient care facilities only.* A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee	• Occupancy reporting is considered, but not limited to, reporting the number of patients currently at the facility receiving treatment and care or the facility's occupancy percentage • We are not prescribing the means that facilities must use in disseminating the required information. However, facilities should include in its communication plan, a process to communicate the required information	
Training and Testing			
E0036	(d) Training and testing. The facility must develop and maintain an emergency preparedness training and testing program that is based on the emergen- cy 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 biennialy.	• Training refers to a facility's responsibility to provide education and instruction to staff, contractors, and facility volunteers to ensure all individuals are aware of the emergency preparedness program • Testing is the concept in which training is operationalized and the facility is able to evaluate the effectiveness of the training as well as the overall emergency preparedness program • Testing includes conducting drills and/or exercises to test the emergency plan to identify gaps and areas for improvement	Maintain documentation of the biennial review and updates.
E0037	Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least biennially, after the initial training is provided AND provide additional training if the emergency plan is significantly updated (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.	• Facilities are required to provide initial training in emergency preparedness policies and procedures that are consistent with their roles in an emergency to all new and existing staff, individuals providing services under arrangement, and volunteers • In the case of facilities with multiple locations, such as multi-campus hospitals, staff, individuals providing services under arrangement, or volunteers should be provided initial training at their specific location and when they are assigned to a new location • Ideally, training should be modified each year, incorporating any lessons learned from the most recent exercises, real-life emergencies that occurred in the last year and during the bienniall review of the facility's emergency program • Facilities must maintain documentation of the biennial training for all staff. The documentation must include the specific training completed as well as the methods used for demonstrating knowledge of the training program • Facilities have flexibility in ways to demonstrate staff knowledge of emergency procedures • Facilities must maintain documentation that training was completed and that staff are knowledgeable of emergency procedures	Orientation should include this training and ensure that orientation is also provided when an individual is assigned to a new location.

Tag	Condition of Participation	Interpretive Guideline Notes	Implementation Notes
E0039	Testing. The facility must conduct exercises to test the emergency plan. Inpatient unit hospices 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, facil- ity-based exercise. If the facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise of the hospice's choice. This may include, but is not limited to the following: (a) A second full-scale exercise that is community-based or individual, facility-based. (b) An individual facility-based functional exercise, a drill, or a tabletop exercise or workshop that included a group discussion led by a facilitator (c) Freestanding/home-based hospices and home health agencies, must conduct one testing exercise annually. i. Either a community-based full-scale exercise (if available) OR ii. Conduct an individual facility-based functional exercise every other year (iii) In the opposite years, outpatient providers can conduct the testing exercise of their choice which may include either a community-based full-scale exercise (if available), an individual, facility-based functional exercise, a drill, or a tabletop exercise or workshop that includes a group discussion led by a facilitator. (a) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the facility's emergency plan, as needed.	• For the purposes of this requirement, a full scale exercise is defined and accepted as any operations-based exercise (drill, functional, or full-scale exercise) that assesses a facility's functional capabilities by simulating a response to an emergency that would impact the facility's operations and their given community • A full-scale exercise is also an operations-based exercise that typically involves multiple agencies, jurisdictions, and disciplines performing functional or operational elements • Facilities are expected to contact their local and state agencies and healthcare coalitions, where appropriate, to determine if an opportunity exists and determine if their participation would fulfill this requirement. In doing so, they are expected to document the date, the personnel and the agency or healthcare coalition that they contacted • Facilities are encouraged to engage with their area Health Care Coalitions (HCC) (partnerships between healthcare, public health, EMS, and emergency management) to explore integrated opportunities • Facilities that are not able to identify a full-scale community-based exercise, can instead fulfill this part of their requirement by either conducting an individual facility-based exercise, documenting an emergency that required them to fully activate their emergency plan, or by conducting a smaller community-based exercise with other nearby facilities • Facilities that conduct an individual facility-based exercise will need to demonstrate how it addresses any risk(s) identified in its risk assessment • If a provider experiences an actual natural or man-made emergency that requires activation of their emergency plan, inpatient and outpatient providers will be exempt from their next required full-scale community-based exercise or individual, facility-based functional exercise following the onset of the actual event. An organization's communication plan is part of their emergency plan, as is coordination with other community emergency preparedness officials (for example, emergency management and public health), and CMS expects that these elements, along with the completion of a corrective action plan, are part of the activation of their emergency plan. • Each facility is responsible for documenting their compliance and ensuring that this information is available for review at any time for a period of no less than three (3) years. Facilities should also document the lessons learned following their tabletop and full-scale exercises and real-life emergencies and demonstrate that they have incorporated any necessary improvements in their emergency preparedness program	

Tag	Condition of Participation	Interpretive Guideline Notes	Implementation Notes
E0042	(e) Integrated healthcare systems. If a facility is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the facility may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following: (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following: (i) A documented community-based risk assessment, utilizing an all-hazards approach. (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.	• If a healthcare system elects to have a unified emergency preparedness program, the integrated program must demonstrate that each separately certified facility within the system that elected to participate in the system's integrated program actively participated in the development of the program. Therefore, each facility should designate personnel who will collaborate with the healthcare system to develop the plan. The unified and integrated plan should include documentation that verifies each facility participated in the development of the plan • Compliance with the emergency preparedness requirements is the individual responsibility of each separately certified facility	