March 10, 2022

Emergency Preparedness

Updates to Survey Guidance for Home Health and Hospice

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Home Health & Hospice Emergency Preparedness Learning Objectives

- Understand the Conditions of Participation for Emergency Preparedness
- Review Updated Guidance for Emergency Preparedness – Appendix Z of the State Operations Manual (SOM)
- Describe Steps to Ensure Emergency Preparedness Compliance

§484.102 – HOME HEALTH EMERGENCY PREPAREDNESS

§418.113 – HOSPICE EMERGENCY PREPAREDNESS

Emergency Preparedness Rule

The **Emergency Preparedness (EP) Rule was finalized in 2016** and is based primarily off of the hospital emergency preparedness Condition of Participation (CoP) as a general guide for the remaining providers and suppliers, then tailored to address the differences and or unique needs of the other providers and suppliers.

The requirements are focused on three key essentials necessary for maintaining access to healthcare during disasters or emergencies:

1. Safeguarding Human Resources
2. Maintaining Business Continuity
3. Protecting Physical Resources.

Emergency Preparedness Rule

- CMS feels the successful adoption of these emergency preparedness requirements will enable all providers and suppliers wherever they are located to better anticipate and plan for needs, rapidly respond as a facility, as well as integrate with local public health and emergency management agencies and healthcare coalitions' response activities and rapidly recover following the disaster.
- The State Operations Manual (SOM) – **Appendix Z** for emergency preparedness was developed to provide consistent interpretive guidance and survey procedures within a single document due to the individual regulations for each specific provider and supplier sharing a majority of standard provisions for EP.

Emergency Preparedness Rule

In **February of 2019** CMS added **"Emerging Infectious Diseases"(EIDs)** to the **definition of the "All-Hazards"** approach to be included in the EP risk assessment.

- CMS determined it was critical for facilities to include planning for infectious diseases within their EP program stating that in light of events such as the Ebola Virus and Zika, facilities should consider preparedness and infection prevention within their "All-Hazards" approach covering both natural and man-made disasters.
- The regulation includes that a **comprehensive approach** to meeting the health & safety needs of a patient population should encompass the elements for emergency preparedness planning based on the **"All-Hazards"** definition and specific to the location of the facility.
  - 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.

Emergency Preparedness Rule

On **September 30, 2019**, CMS revised the requirements for all providers and suppliers for Emergency Preparedness within the Burden Reduction Final Rule (84 FR 51732).

- Removal of the requirement to document efforts to contact local, tribal, regional, state, and federal EP officials and documentation of participation in collaborative and cooperative planning efforts.
- Revised the requirement for reviewing/updating the EP program to every 2 years from annually.
- Revised the requirement for staff Training on the EP program to every 2 years from annually.
  - Training is required at time of hire and if the emergency plan is significantly updated.
- Revised Testing Exercise requirements was added, allowing an exemption to the testing requirements during or after an actual emergency.
  - If a provider experiences an actual natural or man-made emergency that requires activation of their emergency plan, 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.

Updated Guidance for Emergency Preparedness

On **March 26, 2021**, CMS issued a memorandum (QSO-21-15) providing updated guidance (Appendix Z) for Emergency Preparedness for All Providers.

https://www.cms.gov/files/document/qso-21-15-all.pdf

The Conditions of Participation for the Emergency Preparedness requirements did not change due to the pandemic.

CMS did expand the Guidelines based on best practices, lessons learned, and planning considerations for emerging infectious diseases (EIDs) in light of the COVID-19 Public Health Emergency.

Updated Guidance for Emergency Preparedness

The Updated Guidance for EP included:

- Providers need to be able to identify and manage emerging infectious disease (EID) as part of their emergency preparedness plan.
  - *It is important that Agencies review their EP program in depth to ensure it sufficiently meets the agency's needs in dealing with emerging infectious disease (EID) such as the Ebola Virus, Zika and the Coronavirus.*
- Expectations were clarified surrounding documentation of the EP program.
- Additional guidance/considerations for EID planning for personal protective equipment (PPE).
- The Guidance included planning considerations for potential patient surges & staffing needs.

Updated Guidance for Emergency Preparedness

The Updated Guidance for EP included the following:

- Facilities need to monitor the CDC and other public health agencies **during Public Health Emergencies (PHEs)**, which may issue event-specific guidance and recommendations to healthcare workers.
- Added guidance on risk assessment/planning considerations during EIDs outbreaks.
- Expanded guidance & added clarifications related to alternate care sites and 1135 Waivers.
- Revised guidance related to training/testing of the EP program as the Burden Reduction Rule extensively changed these requirements, especially for outpatient providers.
- Provided clarification related to testing exercise exemptions when a provider/supplier experiences an actual emergency event.

Updated Guidance for Emergency Preparedness

June 21, 2021, CMS released Updated Guidance related to Emergency Preparedness – Exercise Exemption based on A Facility's Activation of their Emergency Plan.

*Revised to provide additional guidance and clarification due to the continued public health emergency (PHE)

https://www.cms.gov/files/document/qso-20-41-all-revised-06212021.pdf

Emergency Preparedness Rule

- Home Health and Hospice agencies must comply with all applicable Federal, State, and local emergency preparedness requirements.
- All agencies must establish and maintain an Emergency Preparedness (EP) program that meets the requirements of this section.
- The EP program must include a comprehensive approach to meeting the health & safety needs of patients with EP based on an “All Hazards” approach specific to the location of the Home Health or Hospice Agency.
- EP Interpretive Guidelines E-001 – CoPs 418.113 Hospice/484.102 Home Health (E tags)

  (There are no corresponding G or L tags for Emergency Preparedness)

Emergency Preparedness

Elements to the Emergency Preparedness Required by CMS

- Standard (a) Emergency Plan – Risk Assessment and Planning
- Standard (b) Policies and Procedures
- Standard (c) Communication Plan
- Standard (d) Training and Testing
- Standard (e) Integrated Healthcare Systems

RISK ASSESSMENT & PLANNING

§ 418.113 – Hospice and
§ 484.102 – Home Health
Emergency Preparedness
Standard- (a) Emergency Plan

Emergency Preparedness Standard - (a) Emergency Plan

(A) Emergency Plan - The Agency must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years. The plan must:

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 that would affect the agency's ability to provide care.
3. Address patient population, including, but not limited to, persons at-risk; the type of services the agency is able to provide in an emergency; and continuity of operations, including delegations of authority and succession plan.
4. Include a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' and efforts to maintain an integrated response during a disaster or emergency.
   - *While the responsibility for ensuring a coordinated disaster preparedness response lies upon the state and local emergency planning authorities, the agencies must collaborate in planning for an integrated emergency response.*

Emergency Preparedness
Standard - (a) Emergency Plan

The **Emergency Plan** is part of the EP program and includes:

- Conducting facility-based and community-based risk assessments, utilizing an all-hazards approach.
- Addressing the needs of an agency's patient population.
- Identifies the **continuity of business operations** which will provide support during an actual emergency.
- Supports, guides, and ensures an agency's ability to collaborate with local emergency preparedness officials.

Emergency Preparedness
Standard - (a) Emergency Plan

Essential Services and Continuity of Care

- Business continuity is the agency's ability to continue operations or services related to patient care and to ensure patient safety and quality of care is continued in an emergency event.
- To accomplish this, during EID outbreaks, you may have to update your agency facility protocols to protect the health and safety of patients, such as isolation and personal protective equipment (PPE) measures.
- Since contractors and suppliers may be subject to the same hardships as the community they serve, there are no guarantees in the event of a disaster that the contractor would be able to fulfill their duties. Therefore, the emergency plan should reflect contingency planning.

Emergency Preparedness
Standard - (a) Emergency Plan

Risk Assessments Using All-Hazards Approach

- The risk assessment is not required to be a specific format, but it must include pandemics and EIDs, unforeseen widespread communicable diseases, as well as natural and man-made disasters. A risk assessment is facility and community-based and considers an agency's patient population and vulnerabilities.
- For PHE's, such as a pandemic, planning should include a process to evaluate the facility's needs based on the specific characteristics of an EID that includes things we have done during COVID-19, such as, the need for PPE, considerations for screening and/or testing patients and staff, transfers, or discharges of patients; physical environment, including but not limited to changes needed for distancing, quarantine, and masking.
- At-risk populations, in the event of EIDs and communicable diseases, may also include older adults and people of any age with underlying medical conditions or who are immunocompromised, in which exposure may place them at higher risk for severe illnesses.

Emergency Preparedness
Standard - (a) Emergency Plan

Emerging Infectious Diseases (EIDs)

- EID's are a potential threat which can impact the agency operations and continuity of care and should be considered when developing the emergency plan.
- Adding EID's as part of the agency's risk assessment ensures that agencies consider having infection prevention personnel involved in the planning, development and revisions to the emergency preparedness program.
- EID's may be localized to a certain community or be widespread (as seen with the COVID-19 PHE); therefore, plans for coordination with local, state, and federal officials are essential.
- Examples of EIDs:
  - Potentially infectious Bio-Hazardous Waste
  - Bioterrorism
  - Pandemic Flu
  - Highly Communicable Diseases (such as Ebola, Zika Virus, SARS, COVID-19, or SARS-CoV-2)

Emergency Preparedness Standard - (a) Emergency Plan

For Public Health Emergencies, such as EIDs or pandemics:

Consider risk assessments to include the needs of the patient population in relation to a communicable or emerging infectious disease outbreak.

Planning should include a process to evaluate the agency's needs based on the specific characteristics of an EID that includes, but is not limited to:

- Influx in need for PPE;
- Considerations for screening patients and visitors; which may also include testing considerations for staff, visitors and patients for infectious diseases;
- Transfers and discharges of patients;
- Home-based healthcare settings;
- Physical Environment, including but not limited to changes needed for distancing, isolation, or capacity/surge

Emergency Preparedness Standard - (a) Emergency Plan

Surge & Staffing

- The emergency plan must address the types of services that the agency would be able to provide in an emergency.
- The emergency plan must identify which staff would assume specific roles in another's absence through succession planning and delegations of authority.
- Agency's may have a general plan which outlines the roles and responsibilities of the different individuals (e.g. incident commander, public information officer, patient liaison, etc.) and refers to those individuals by their titles.
- If an agency chooses to follow a process without individual name identification, the individual serving in the role during the time of the survey should be able to describe their role and responsibility during an emergency.
- The emergency plan should also include ways the agency will respond to identified patient needs that cannot be addressed by agency services in an emergency.

Emergency Preparedness Standard - (a) Emergency Plan

Cooperation and Collaboration:

- The agency must have a process to engage in collaborative planning for an integrated emergency response.
- Every detail of the cooperation and collaboration process is not required to be documented in writing, but it is expected that the agency has documented sufficient details to support verification of the process.
- Agencies are expected to engage and coordinate with their local healthcare systems (including any emergency-related Alternate Care Sites), and their local and state health departments, and federal agency staff and also encouraged to engage with their healthcare coalitions, as applicable.
- Coordination should be pre-planned and facility management should know the state and local emergency contacts.

Policies & Procedures

§ 484.102 – Home Health
Emergency Preparedness
Standard- (b) Policies and Procedures

Home Health -Emergency Preparedness Standard- (b) Policies and Procedures

The HHA must develop & implement EP policies & procedures, based on the emergency plan, risk assessment, and the communication plan. The policies and procedures must be reviewed and *updated at least every 2 years*.

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

(b)(1) ***The plans for the HHA's patients*** during a natural or man-made disaster. ***Individual plans for each patient must be included as part of the comprehensive patient assessment***, which must be conducted according to the provisions at § 484.55.

- HHAs must include policies and procedures in its emergency plan for ensuring all patients have an **individualized plan** in the event of an emergency. That plan must be included as part of the patient's comprehensive assessment.

Home Health-Standard(b)(1)-Policies and Procedures

Individualized Patient EP Plans

- Discussions to develop individualized EP plans may include potential disasters that the patient may face within the home such as fire hazards, flooding, and tornados, ***and EIDs***; and how and when a patient is to contact local emergency officials.
- Discussions should occur with the patient, the patient's care providers, patient representative, or any person involved in the patient's clinical care to educate them on measures to improve the patient's safety.

The individualized emergency plan should be in writing and may be as simple as a detailed emergency card to be kept with the patient.

Home Health-Standard(b)(1)-Policies and Procedures

Individualized Patient EP Plans

Examples:

- Patient is disaster code 2 as she lives at home with spouse who is available around the clock to assist in an emergency.
- Patient and spouse have an adequate supply of emergency canned/dry foods, bottled water as well as a 15-day supply of patient medications.
- Patient and spouse instructed in limiting contact with others, wearing mask, s/s COVID-19 and are to inform HHA if pt develops symptoms. In the event symptoms develop or possible exposure occurs, the patient's physician will be notified.

HHA personnel should document that these discussions occurred **and** keep a copy of the individualized emergency plan in the patient's file as well as provide a copy to the patient and/or their caregiver.

HHAs should consider potential contingency operations within their policies.

Home Health -Standard(b)(1)
Policies and Procedures

Individualized Patient EP Plans

Considerations:

- How will the HHA ensure the appropriate discipline/staff perform the required initial and comprehensive assessments when access to patient's homes may be hindered due to an emergency?

Some contingency plans may include requests for Section 1135(b) emergency waiver flexibility during a declared public health emergency (requiring CMS pre-approval prior to use).

HHAs are encouraged to plan ahead for the potential use of alternative staffing options/professions, acting in accordance with their state scope of practice laws.

Policies & Procedures

§ 418.113 – Hospice Emergency Preparedness Standard- (b) Policies and Procedures

Hospice -Standard(b)(1)-Policies and Procedures

The Hospice Agency must develop & implement EP policies & procedures, based on the emergency plan, risk assessment, and the communication plan.

The policies and procedures must be *reviewed and updated at least every 2 years*.

- At a minimum, the policies and procedures must address the following:
- (b) (1) Procedures to follow up with on duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency.

The hospice must inform State and local officials of any on-duty staff or patients that they are unable to contact.

Hospice -Standard(b)(1)-Policies and Procedures

- Hospices have the flexibility to determine how best to develop these policies and procedures.
- 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.

HOME-BASED HOSPICE PROVIDERS STANDARD (B)(2)

- Standard (B)(2) -Home Based hospices are required to inform State and local emergency preparedness officials of the need for patient evacuations.
- 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.
- Clinical care needs should include, but are not limited to:
- –Whether or not the patient is mobile.
- –What type of life-saving equipment does the patient require?
- –Is the life-saving equipment able to be transported? (E.g., Battery operated, transportable, condition of equipment, etc.)
- –Does the patient have special needs? (E.g., electricity-dependent, communication challenges, language barriers, intellectual disabilities, special dietary needs, etc.)
- –Is the patient a person under investigation (PUI), suspected exposure to or a confirmed case for any communicable diseases?

IN-PATIENT HOSPICE PROVIDERS

- The CoPs require Inpatient Hospices to have policies and procedures that address the provision of subsistence needs for hospice employees and patients whether they evacuate or shelter in place.
- Inpatient Hospices must be able to provide for adequate subsistence for all patients and staff for the duration of an emergency or until all its patients have been evacuated and its operations cease.
- Hospices have flexibility in identifying their individual subsistence needs that would be required during an emergency.
- Inpatient providers must ensure that they have policies and procedures that address food, water, medical and pharmaceutical needs during an emergency, regardless of whether they evacuate or not.

POLICIES AND PROCEDURES – HOSPICE INPATIENT FACILITY ONLY

§418.113(B)(6) The following are additional requirements for hospice-operated inpatient care facilities only.

- The Hospice Policies and Procedures Must address the following:

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

A. Food, water, medical and pharmaceutical supplies

B. Alternate sources of energy to maintain the following:

1)Temperatures to protect patient health/safety & safe/sanitary storage of provisions.

2)Emergency lighting.

3)Fire detection, extinguishing, and alarm systems.

C. Sewage and waste disposal

Hospice -Standard(b)(1)-Policies and Procedures

Hospices must develop policies and procedures:

- That address the use of hospice employees in an emergency and the hospices' potential surge needs; hospices should give consideration to their roles during a natural disasters and emerging infectious diseases outbreaks or pandemics.
- Depending on the type of emergency, to maintain the continuity of services to hospice patients and should account for variability in the services which they provide-including planning considerations for inpatient versus outpatient hospices and that in a given emergency either setting may need to transfer patients to different healthcare settings based on needs.
- Which address the requirement to follow up with on duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency.

Hospice -Standard(b)(1)-Policies and Procedures

The policies and procedures should include considerations such as but not limited to:

- Staffing shortages;
- Staff ability to provide safe care, to include any potential needs such as PPE;
- Care needs of the patients-inpatient or in home-based settings and potential equipment needs;
- Screening phone calls prior to arrival & questions prior to entry into a home
- Ways to decontaminate equipment & procedures to limit equipment taken into homes

The policies and procedures should outline the timeframes for check-in with the facility's designated individual (e.g. staff check-in's every 2 or 4 hours while on shift, and every 8 while off-duty).

Hospices should work with their state and local officials to determine how to coordinate the reporting of staff or patients who cannot be contacted.

Hospices should also account for contingency planning in the event that some staff are unaccounted for and how this relates to providing patient care.

Home Health and Hospice
Standard- (b)(2) - Policies and Procedures

Patient and Staff Communication in EP

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

- These 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.
- EIDs- need to communicate if the patient is a person under investigation (PUI), suspected exposure to or a confirmed case for any communicable diseases.
- Since such policies and procedures include protected health information of patients, agencies must also ensure they are in compliance with HIPAA Rules.
- Agencies should work with their state and local officials to determine how to coordinate the reporting of staff or patients who cannot be contacted.

Home Health and Hospice
Standard- (b)(2) - Policies and Procedures

Patient and Staff Communication in EP

- The agency should provide emergency officials with the appropriate information to facilitate the patient's evacuation and transportation. This should include, but is not limited to, the following:
  - Whether or not the patient is mobile.
  - What type of life-saving equipment does the patient require?
  - Is the life-saving equipment able to be transported? (E.g., Battery operated, transportable, condition of equipment, etc.)
  - Does the patient have special needs? (E.g., electricity-dependent, communication challenges, language barriers, intellectual disabilities, special dietary needs, etc.)
  - Is the patient a person under investigation (PUI), suspected exposure to or a confirmed case for any communicable diseases?
- Agencies should also account for contingency planning in the event that some staff are unaccounted for and how this relates to providing patient care.
- An agency's policies and procedures should outline a contingency plan in the event patients require evacuation but are unable to be transferred due to a community-wide impacted emergency.

Home Health Standard- (b)(3) Policies and Procedures

Patient and Staff Communication in EP

(b)(3) Home Health - The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event there is an interruption in services during or due to an emergency.

- The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact.
- During an emergency, if a patient requires care that is beyond the capabilities of the HHA, there is an expectation that care of the patient would be rearranged or suspended for a period of time, as most HHAs in general would not necessarily transfer patients to other HHAs during an emergency.
- HHAs policies and procedures should clearly outline what surrounding facilities it has a transfer arrangement with to ensure patient care is continued.

Home Health Standard- (b)(3) Policies and Procedures

Patient and Staff Communication in EP

The policies and procedures should outline timelines for transferring patients and under what conditions patients would need to move.

- For instance, if the emergency is anticipated to have one or two days of disruption and does not pose an immediate threat to patient health or safety (in which then the HHA should immediately transfer the patient); the HHA may rearrange services, whereas if a disaster is anticipated to last over one week or more, the HHA may need to initiate transfer of a patient as soon as possible. The policies and procedures should address these events.

The HHAs' policies and procedures must address what actions would be required due to the inability to make contact with staff or patients and reporting capabilities to the local and State emergency officials

Home Health Standard- (b)(3) Policies and Procedures

Patient and Staff Communication in EP

- The HHA policies and procedures should outline the timeframes for check-in with the HHA's designated individual (e.g. staff check-in's every 2 or 4 hours while on shift, and every 8 while off-duty).
- HHAs should account for contingency planning in the event that some staff are unaccounted for and how this relates to providing patient care.

Home Health and Hospice Standard(b)- Policies and Procedures

(b)(3) Hospice - **(b)(4) Home Health** - A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

(b)(4) Hospice - **(b)(5) Home Health** - 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.

(b)(5) Hospice - 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.

- Prearranged transfer agreements

Home Health and Hospice
Standard(b)- Policies and Procedures

Surge Planning:

- While it is not possible to predict every scenario which could result in surge situations, agencies must have policies and procedures which include emergency staffing strategies and plan for emergencies.
- Agencies must have policies which address their ability to respond to a surge in patients.
- These policies and procedures must be aligned with an agency's risk assessment and should include planning for EIDs.

Surge Planning Considerations:

- Instructing patients to use available advice lines, patient portals, and/or on-line self-assessment tools;
- Call options to speak to an office/clinical staff and identify staff who will conduct telephonic interactions with patients;
- Development of protocols so that staff can triage and assess patients quickly;
- Determine algorithms to identify which patients can be managed by telephone & advised to stay home, and which patients will need to be sent for emergency care or go to a facility.

Home Health and Hospice
Standard- (b) Policies and Procedures – Volunteers

Volunteers – Medical and Non-medical

- During an emergency, an agency may also need to accept volunteer support from individuals with varying levels of skills and training.
- The agency must have policies and procedures in place to facilitate this support.
- While not required to use volunteers as part of their plans to supplement or increase staffing during an emergency, an agency must have policies and procedures to address plans for emergency staffing needs.
- If agencies use volunteers as part of their emergency staffing strategy, policies and procedures should clearly outline what type of volunteers would be accepted during an emergency and what role these volunteers might play.

Communication Plan

418.113 - Hospice
484.102-Home Health
Emergency Preparedness
Standard (c) – *Communication Plan*

418.113 – Hospice - Emergency Preparedness Standard - (c) Communication Plan

(c) Communication Plan - The Hospice 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 every 2 years.

The communication plan must include all of the following:

(c)(1) Names and contact information for the following:

- (i) Hospice Employees
- (ii) Entities providing services under arrangement
- (iii) Patients' physicians
- (iv) Other Hospices

484.102 – Home Health - Emergency Preparedness Standard - (c) Communication Plan

(c) Communication Plan - The HHA 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 every 2 years.

The communication plan must include all of the following:

(c)(1) Names and contact information for the following:

- (i) Staff
- (ii) Entities providing services under arrangement
- (iii) Patients' physicians
- (iv) Volunteers

484.102 – Home Health - Emergency Preparedness Standard - (c) Communication Plan

- An agency must have the contact information for those individuals and entities outlined within the standard.
- The requirement to have contact information for “other facilities” requires a provider or supplier to have the contact information for another provider or supplier of the same type as itself.
- Agencies have discretion in the formatting of this information, but it should be readily available and accessible to leadership, the individual(s) designated as the emergency preparedness coordinator or person(s) responsible for the agency’s emergency preparedness program and management during an emergency event.
- Agencies 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.

484.102 – Home Health - Emergency Preparedness Standard - (c) Communication Plan

Specific for Home Health Agencies:

- The contact information should also include patient's physicians or allowed practitioners.
- Each patient's written plan of care must specify the care and services necessary to meet the patient specific needs identified in the comprehensive assessment.
- Additional practitioners at HHAs should also be notified to reflect the interdisciplinary, coordinated approach to home health care delivery consistent with the HHA regulations.

Home Health and Hospice Emergency Preparedness Standard - (c) Communication Plan

(c)(2) Contact information for the following:

- (i) Federal, State, tribal, regional, and local emergency preparedness staff.
- (ii) Other sources of assistance.

NOTE: Even though the communications plan must include contact information, it does not specifically require the agency to have an individual contact for emergency management agencies.

(c)(3) Primary and alternate means for communicating with the following:

- (i) Agency Staff
- (ii) Federal, State, tribal, regional, and local emergency management agencies.

(c)(4) A method for sharing information/medical documentation for patients under the agency's care, as necessary, with other health care providers to maintain the continuity of care.

Home Health and Hospice Emergency Preparedness Standard - (c) Communication Plan

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

- **(c)(5) Home Health** - 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).

- **(c)(6) Home Health** - A means of providing information about the HHA's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

Home Health and Hospice Emergency Preparedness Standard - (c) Communication Plan

- The Agency 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.
- The Agency should not delay patient transfers during an emergency to assemble all patient reports, tests, etc. to send with the patient. However, agency's should send all necessary patient information that is readily available and should include at least:
  - The patient's name, age, DOB, allergies, current medications, medical diagnoses, blood type, advance directives and next of kin/emergency contacts.
  - There is no specified means (such as paper or electronic) for how facilities are to share the required information.

Home Health and Hospice Emergency Preparedness Standard - (c) Communication Plan

HIPAA requirements are not suspended during a national or public health emergency. However, the HIPAA Privacy Rule specifically permits certain uses/disclosures of protected health information in emergency circumstances and for disaster relief purposes.

Section 164.510 **"Uses and disclosures requiring an opportunity for the individual to agree to or to object,"** is part of the "Standards for Privacy of Individually Identifiable Health Information," commonly known as **"The Privacy Rule."**

HIPAA Privacy Regulations at 45 CFR 164.510(b)(4), **"Use and disclosures for disaster relief purposes,"** establishes requirements for disclosing patient information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts for purposes of notifying family members, personal representatives, or certain others of the patient's location or general condition.

Home Health and Hospice Emergency Preparedness Standard - (c) Communication Plan

Reporting of an Agency's Needs

- In small community emergency disasters, reporting the agency's needs will be coordinated through established processes to report directly to local and state emergency officials.
  - Reporting needs may include but are not limited to: shortages in PPE; need to evacuate or transfer patients; requests for assistance in transport; temporarily loss of part or all facility function; and staffing shortages.
- In large scale emergency disasters or pandemics, reporting of needs specific to an agency may be altered by local, state and federal public health and emergency management officials due to the potential volume of requests.
  - It is recommended that agencies verify their reporting requirements with their local Incident Command Structures or State Agencies.

Home Health and Hospice Emergency Preparedness Standard - (c) Communication Plan

Reporting of an Agency's Ability to Provide Assistance

- During widespread disasters, reporting an agency's ability to provide assistance is critical within a community.
- Pre-planning and collaborating with emergency officials before an emergency to determine what assistance may be necessary directly supports surge planning within a community.
- During widespread disasters, agencies may be required to report the following to local officials:
  - Ability to care for patients requiring transfer from different healthcare settings;
  - Availability of PPE;
  - Availability of staff who may be able to assist in a mass casualty incident

Training and Testing

418.113-Hospice
484.102-Home Health
Emergency Preparedness
Standard -(d) *Training and Testing*

Home Health and Hospice Emergency Preparedness Standard - (d) Training and Testing

(d) Training and Testing- The Agency 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 every 2 years.

Home Health and Hospice Emergency Preparedness Standard - (d) Training and Testing

Training and Testing Program- General

The Training & Testing Program as specified in this requirement must be documented, reviewed, and updated; and reflect the risks identified in the agency's risk assessment included in the emergency plan.

- **Example:** An Agency that identifies flooding as a risk should also include policies & procedures in their emergency plan for closing or evacuating their agency and include these in their training and testing program. This would include, but is not limited to:
  - Training/Testing on how the agency will communicate the closure of the agency
  - Testing patient tracking systems and testing transportation procedures for safely moving patients to other facilities.
  - If the agency has multiple locations the training/testing program must reflect the risk assessment for each location.

Home Health and Hospice Emergency Preparedness Standard - (d) Training and Testing

Training Component

- Training refers to an agency's responsibility to provide education and instruction to staff, contractors, and volunteers to ensure all individuals are aware of the emergency preparedness program.
- The agency must have a process outlined within its emergency preparedness program which encompasses staff and volunteer training complementing the risk assessment.
- Training for staff should at a minimum include training related to the agency's policies and procedures.
- Agencies must maintain documentation of the training so that surveyors are able to clearly identify staff training and testing conducted.

Home Health Emergency Preparedness Standard - (d)(1) Training and Testing

(d)(1) Training Program- The Home Health Agency Must do **ALL** of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, and individuals providing services under arrangement, consistent with their expected roles.

(ii) Provide emergency preparedness training at least every 2 years.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

(v) If the emergency preparedness policies and procedures are significantly updated, the HHA must conduct training on the updated policies and procedures.

Hospice Emergency Preparedness Standard - (d)(1) Training and Testing

(d)(1) Training Program- The Hospice Agency Must do **ALL** of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, 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 every 2 years.

(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including non-employee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

(v) Maintain documentation of the training.

(vi) If the emergency preparedness policies and procedures are significantly updated, the Hospice must conduct training on the updated policies and procedures.

Home Health and Hospice Emergency Preparedness Standard - (d)(1) Training and Testing

- Agencies are required to provide **initial training** in emergency preparedness policies and procedures that are consistent with staff roles in an emergency to all new and existing staff, individuals providing services under arrangement, and volunteers.
- Initial Training provided by the agency must be based on the agency's risk assessment policies, procedures, and communication plan.
- Initial Training Should mirror the agency's emergency plan and include staff training on procedures that are relevant to the hazards identified.
- After the initial training for staff, agencies must provide training on their own emergency plan at least every 2 years.
- The documentation must include the specific training completed as well as the methods used for demonstrating knowledge of the training program.

Home Health and Hospice Emergency Preparedness Standard - (d)(1) Training and Testing

- **Training should include:**
  - Individual-based response activities in the event of a natural disasters, such as what the process is for staff in the event of a forecasted hurricane.
  - Policies and Procedures on how to shelter-in-place or evacuate.
  - How the facility manages the continuity of care to its patient population, such as triage processes and transfer/discharge during mass casualty or surge events.
- **Home Health and Hospice Agencies:**
  - Must be able to demonstrate additional training when the emergency plan is significantly updated.
  - Are not required to retrain staff on the entire emergency plan but can choose to train staff on the new or revised element of the emergency preparedness program
  - Must maintain documentation of the initial and subsequent (at least every 2 years) 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.

Home Health and Hospice Emergency Preparedness Standard - (d)(2) Training and Testing

Testing Component

- Agencies are required to conduct one testing exercise annually, at least every two years the exercise must be a full-scale exercise.
- Testing includes conducting drills and/or exercises to test the emergency plan to identify gaps and areas for improvement.
- Agencies should establish a process which includes participation of all staff in testing exercises over a period of time.
- Agencies should test their exercises according to how they would respond to an actual emergency.
- Surveyors are to assess if the training and testing program are based on the agency's risk assessment and has incorporated its PP and communication plan within the required training and testing exercises.

Home Health and Hospice Emergency Preparedness Standard - (d)(2) Training and Testing

(d)(2)Testing: The Agency must conduct exercises to test the emergency plan at least annually. The Agency must do the following:

(i)Participate in a full-scale exercise that is community-based; or

- (A)When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.
- (B)If the Agency experiences an actual natural or man-made emergency that requires activation of the emergency plan, the Agency is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event

Home Health and Hospice Emergency Preparedness Standard - (d) Training and Testing

(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale exercise or functional exercise is conducted, that may include, but is not limited to the following:

- (ii)(A) A second full-scale exercise that is community-based or facility-based functional exercise; or
- (ii)(B) A mock disaster drill; or
- (ii)(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

HHA and Hospices- (iii) Analyze the agency's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

Hospice Emergency Preparedness Standard Testing

Home-based Hospices MUST conduct ONE testing exercise Annually

And

Hospice Inpatient Units MUST conduct TWO testing exercises annually.

HOSPICE IPU – TWO TESTING EXERCISES ANNUALLY

(i) Participate in an annual full-scale exercise that is community-based; or

A. When a community-based exercise is not accessible, conduct an annual Individual facility based functional exercise; or

B. If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community-based or facility-based functional exercise following the onset of the emergency event.

HOSPICE IPU – TWO TESTING EXERCISES ANNUALLY

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

A. A second full-scale exercise that is community-based or a facility-based functional exercise; or
B. B.A mock disaster drill; or
C. C.A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

EMERGENCY PREPAREDNESS – PARTICIPATION IN TESTING

PARTICIPATION IN TESTING

- The regulations do not specify a minimum number of staff, or the roles of staff that must participate in the exercises.
- Agencies should review which staff members participated in the previous exercise and include those who did not participate in the subsequent exercises to ensure all staff members have an opportunity to participate and gain insight and knowledge.

Emergency Preparedness – QSO-20-41-All

June 21, 2021, CMS released Updated Guidance related to Emergency Preparedness – Exercise Exemption based on A Facility's Activation of their Emergency Plan.

*Revised to provide additional guidance and clarifications due to the continued public health emergency (PHE)

https://www.cms.gov/files/document/qso-20-41-all-revised-06212021.pdf

EP Testing Exemption and Guidance

Requirement & Guidance: **All** Home Health and Hospice agencies must conduct a **full-scale exercise** (or individual facility-based exercise when a full-scale is not available) every 2 years pursuant to standard (d)(2) of their respective "Emergency Preparedness" regulation **and** in opposite years conduct any one of the **"exercises of choice,"** which include another full-scale or individual facility-based functional exercise, tabletop exercise, workshop, or mock drill.

The Exemption Clause: In the event a Home Health or Hospice agency activates its emergency plan due to an actual emergency, the agency would be exempt from engaging in the Next required community-based full-scale exercise or individual facility-based functional exercise following the onset of the emergency event.

Agency's must be able to demonstrate, through written documentation, that they activated their emergency plan.

The **intent** is to ensure that agencies conduct ***at least one exercise per year.***

EP Testing Exemption and Guidance

CMS requires Agencies to conduct an exercise of choice every two years opposite the year of the full-scale or facility-based functional exercise.

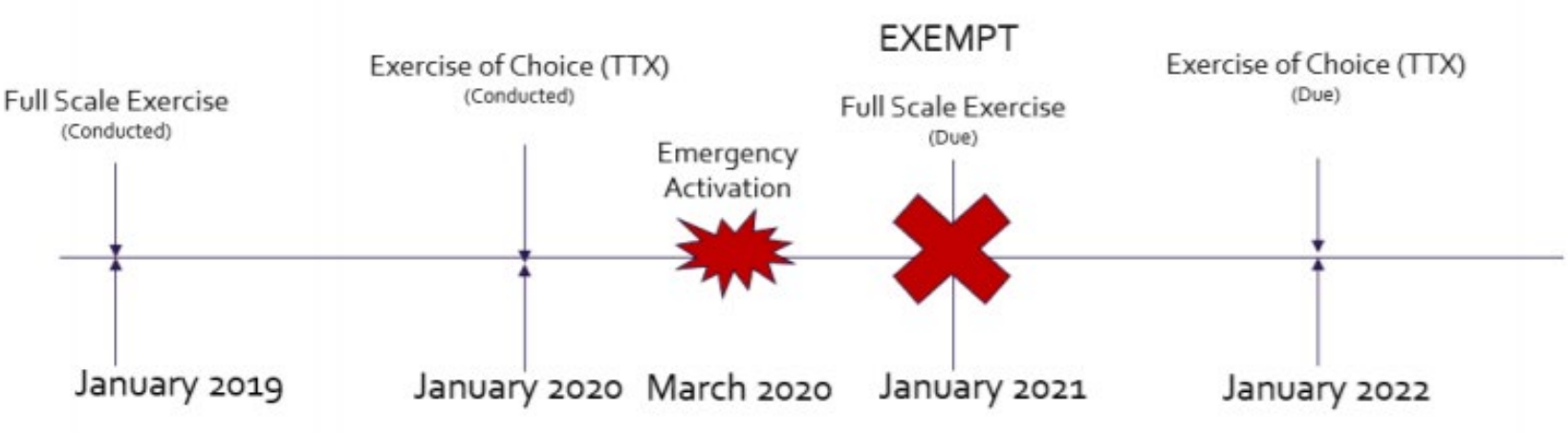
For the “exercise of choice,” facilities must conduct one of the testing exercises below:

- Another full-scale exercise;
- Individual-facility-based functional exercise;
- Mock disaster drill; or
- A tabletop exercise or workshop.

Testing Scenario # 1

Agency conducted a full-scale exercise in January 2019 and a table-top exercise for January 2020 (opposite year). In March 2020, the agency activates its emergency preparedness plan due to the COVID-19 Public Health Emergency (PHE).

The agency is exempt from the next scheduled exercise (January 2021 full-scale exercise). It would then be required to complete their opposite year exercise of choice by January 2022.



Reference: CMS Center for Clinical Standards and Quality/Quality, Safety & Oversight Group/ Revised June 21, 2021/ Ref: QSO-20-41-ALL

Testing Scenario # 2

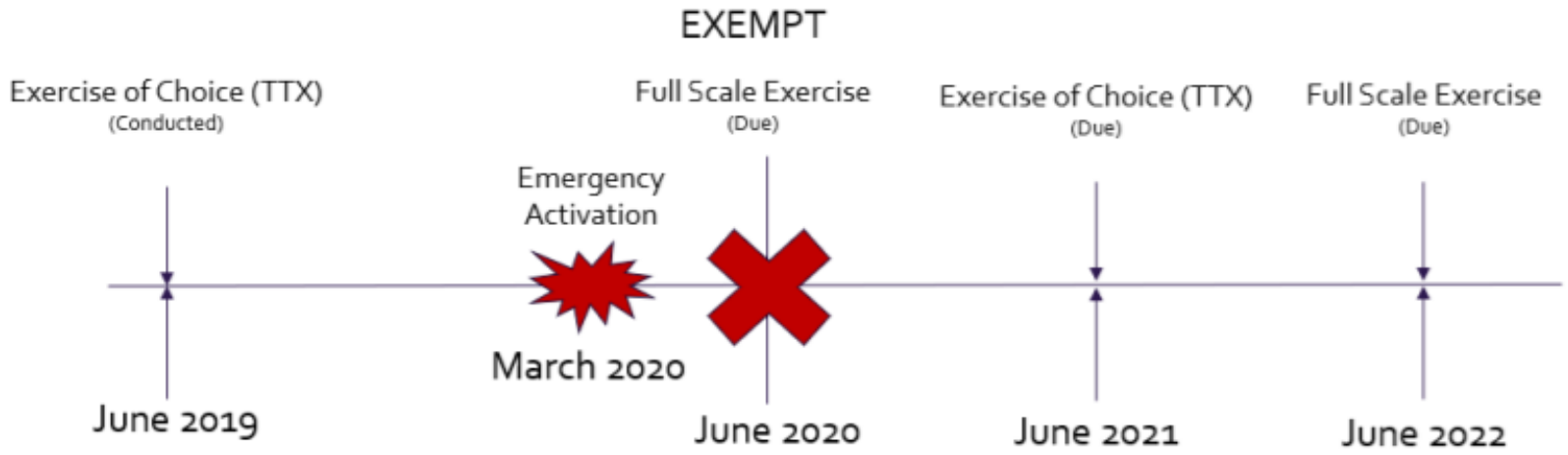
Agency conducted a table-top exercise in January 2019 as the exercise of choice and conducted a full-scale exercise in January 2020. In March 2020, the agency activates its emergency preparedness program due to the COVID-19 PHE.

The agency is exempt from the January 2022 full-scale exercise for that “annual year”. However, the facility must conduct its exercise of choice by January 2021, and again in January 2023

Testing Scenario # 3

Agency conducted a table-top exercise in June 2019 (based on its annual cycle). It is scheduled to conduct a full-scale exercise in June 2020. In March 2020, the agency activates its emergency preparedness program due to the COVID-19 PHE.

The agency is exempt from the June 2020 scheduled full-scale exercise for that “annual year” and is required to complete an exercise of choice in June 2021, and a following full-scale exercise in June 2022. It is exempt from its next required full-scale or individual facility-based exercise which would have been in June 2020.



Reference: CMS Center for Clinical Standards and Quality/Quality, Safety & Oversight Group/ Revised June 21, 2021/ Ref: QSO-20-41-ALL

Exemption Based on Actual Emergency Guidance

- Agencies must document that they had activated their emergency program based on an actual emergency.
- Documentation may include, but is not limited to:
  - A section 1135 waiver issued to the facility (time limited and event-specific);
  - documentation alerting staff of the emergency;
  - documentation of facility closures;
  - meeting minutes which addressed the time and event specific information.
- Agencies must also have completed an after-action review and integrated corrective actions into their emergency preparedness program
- It is recommended that Agencies retain, at a minimum, the past 2 cycles (4 years) of emergency testing exercise documentation.
- This would allow surveyors to assess compliance on the cycle of testing required.

Integrated Healthcare Systems

418.113 - Hospice
484.102-Home Health
Emergency Preparedness
Standard-(e) Integrated Healthcare Systems

Home Health and Hospice Emergency Preparedness Standard-(e) Integrated Healthcare Systems

(E) Integrated health care systems - If a Home Health or Hospice agency 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 Agency 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.

Home Health and Hospice Emergency Preparedness Standard-(e) Integrated Healthcare Systems

(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 all of 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.

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Thank You For Participating!

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