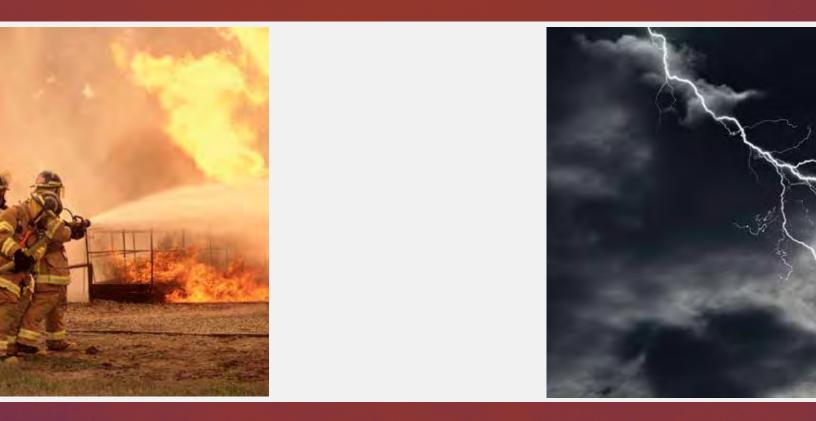# EMERGENCY PREPAREDNESS

FOR HOSPICE PROVIDERS

National Hospice and Palliative Care Organization

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Table of Contents

Section I - Introduction

Hospice care is an interdisciplinary palliative care approach that focuses on symptom management rather than curative treatment for a terminally ill patient. Hospice palliative care improves the quality of life for patients and their families who face the problems associated with terminal illness by preventing and relieving suffering through early identification, assessment, and treatment of pain and other issues. Hospices use an interdisciplinary team to provide medical, social, physical, emotional, and spiritual services through the use of a broad spectrum of caregivers while allowing the patient to remain in their home environment and maintain his or her dignity (The Centers for Medicare and Medicaid Services, 2016).

Hospices are unique health care providers because they serve patients and their families in a wide variety of settings. Hospice patients receive care in whatever setting they call home which could be their private residence, a nursing home, an assisted living facility, or even a recreational vehicle, as long as such locations are determined to be the patient's place of residence. Hospice patients may also be served in inpatient facilities operated by the hospice. It is important that hospice providers understand how to interact with their community emergency preparedness resources and how it connects to the federal disaster response system before disaster strikes (CMS, 2016).

Prior to the posting of *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* (CMS-3178-F), the federal hospice regulations required provisions requiring hospice inpatient facilities to have a written disaster preparedness plan that is periodically rehearsed with hospice employees, with procedures to be followed in the event of an internal or external disaster, and procedures for the care of casualties (patients and staff) arising from such disasters. This requirement, which was limited in scope, was found at § 418.110(c)(1)(ii) under ''Standard: Physical environment.'' The new Condition of Participation '§418.113, Emergency preparedness' groups include requirements that apply to all hospice providers at §418.113(b)(1) through § 418.113(b)(5) followed by requirements at §418.113(b)(6) that apply only to hospice inpatient care facilities (CMS, 2016).

Why a new regulation?

During a disaster, a hospice must be ready to continue cares for patients who do not require hospitalization or cannot be admitted into overwhelmed health care facilities. Depleted supplies, personnel shortages, and other challenges during times of crisis may strain an agency's ability to address their patients' needs. Thorough preparedness planning is essential for ensuring that the needs of patients and caregivers are met in the most effective and professional manner possible.

The Centers for Medicare & Medicaid Services (CMS), issued *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* ([CMS-3178-F](#)) with an **implementation date of November 15, 2017.** This final rule establishes national emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers to ensure that they adequately plan for both natural and man-made disasters, and coordinate with federal, state, tribal, regional, and local emergency preparedness systems. It also ensures that providers are adequately prepared to meet the needs of patients and families during disasters and emergency* situations. Disasters can disrupt the environment of health care and change the demand for health care services. Regulatory requirements make it necessary that health care providers and suppliers ensure that emergency management is integrated into their daily operation and culture (CMS, 2016).

*In this regulatory guidance, CMS defines "emergency" or "disaster" as an event affecting the overall target population or the community at large that precipitates the declaration of a state of emergency at a local, state, regional, or national level by an authorized public official such as a governor, the Secretary of the Department of Health and Human Services (HHS), or the President of the United States (CMS, 2016).

After CMS conducted an extensive review of emergency preparedness guidance from multiple agencies of the federal government, they concluded that current emergency preparedness regulatory requirements were not comprehensive enough to address the complexities of actual emergencies. Specifically, the requirements did not address the need for:

(1) communication to coordinate with other systems of care within local jurisdictions (for example. cities, counties) or states;

(2) contingency planning; and

(3) training of personnel

Additionally, through analysis of written reports, articles, and studies, as well as their continuing discussion with representatives from the federal, state, and local levels and with various stakeholders, CMS believed that in the event of a disaster, health care providers across the nation would not have the necessary emergency planning and preparation in place to adequately protect the health and safety of their patients. Underlying this problem was the pressing need for a more consistent regulatory approach that would ensure that providers and suppliers nationwide are required to plan for and respond to emergencies and disasters that directly impact patients, families, and their communities (CMS, 2016).

CMS determined that the regulatory potpourri of federal, state, local laws and guidelines, and accrediting organization emergency preparedness standards, did not meet what was required for health care providers to be adequately prepared for a disaster. Thus, the new emergency preparedness requirements establish a comprehensive, consistent, flexible, and dynamic regulatory approach to emergency preparedness and response that incorporates the lessons learned from the past, combined with the proven best practices of the present (CMS, 2016).

Section II - Getting to Know the Disaster Response System
(Federal, State, Local)

There are different types of disaster threats and they can be categorized as acts of nature or humans. Natural disasters include earthquakes, tornadoes, floods, fires, hurricanes, or an infectious disease outbreak. Manmade disasters can include industrial accidents, shootings, terrorism, and incidents of mass violence. These types of traumatic events threaten humanity and may cause loss of life and property. They may also prompt evacuations from certain areas and overwhelm behavioral health resources in the affected communities. The federal government has structure and resources for response and management of all types of disaster threats that reach into state and local communities (Disaster Assistance, 2016). It is important to understand the disaster response system and how your local and state governments interface with the federal disaster response system.

Disasters always occur locally, thus the people in the area where the event occurs and their local governments and voluntary agencies are the first to have to handle the outcomes. The local government maintains control of all resources used in the response and recovery efforts, regardless of the source of those resources. Local governments plan and prepare for this role with the support of the State and Federal governments. A local jurisdiction may seek assistance from their State government in a disaster situation; but, keep in mind that the State government may have many local jurisdictions requesting aid at the same time. Most emergencies are managed at the local level, without assistance from the State or the Federal government and only a small number result in a request for Federal assistance. State governments serve as liaisons for the local jurisdictions if Federal disaster assistance is needed as local governments cannot directly access Federal programs (Federal Emergency Management Agency, 2014).

★★★★★★★★★★

www.DisasterAssistance.gov provides information about types of disasters and resources about specific disasters

★★★★★★★★★★

The Federal government becomes the source for resources when a disaster is so severe that the local governments and the State governments together cannot provide the needed resources. The Federal Emergency Management Agency (FEMA) is the Federal agency that coordinates the activation and implementation of the Federal Response Plan (FRP), so the States work with FEMA to access Federal programs and support. The FRP defines how the resources of Federal agencies and the American Red Cross will coordinate to provide immediate response assistance to a state (FEMA, 2014).

Sequence of a Disaster Response

A. Local disaster response includes:
    1. Acting as the primary "first provider" of emergency response services.
    2. Activating the Emergency Operations Center (EOC) and Emergency Management Plan.
    3. Coordinating the response with public and private organizations and agencies.
    4. Updating the State Emergency Management Agency regularly by providing reports.
    5. Activating response agreements with State and Federal departments or agencies.

6. Proclaiming a local state of emergency to authorize:
    a. Using local resources;
    b. Expending local funds; and
    c. Waiving the usual bidding process for goods and services.
7. Requesting the State Emergency Management Agency to provide State and/or Federal assistance (FEMA, 2014).

B. State disaster response includes:
    1. Monitoring the situation.
    2. Reviewing and evaluating local updates, response efforts, and requests for assistance.
    3. Activating the State EOC to coordinate available State assistance.
    4. Determining if Federal assistance is needed.
    5. Declaring a state of emergency by the Governor that:
        a. Activates the State Disaster Preparedness Plan;
        b. Activates the use of State assistance or resources;

    Note: A Governor can declare a statewide state of emergency or designate specific counties or local jurisdictions.

    6. Initiates the process for requesting Federal assistance (FEMA, 2014).

C. Federal disaster response includes:

    Federal disaster response is managed through the Incident Command System (ICS). The ICS is designed to enable effective and efficient local and national incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. The ICS includes procedures to select and form temporary management hierarchies to control funds, personnel, facilities, equipment, and communications. The role of the ICS is to meet the needs of a jurisdiction to assist them coping with disasters of any type or complexity (i.e. it expands or contracts as needed) (FEMA, 2016). During an emergency or disaster, the Federal disaster response includes:

    1. Communicating with State and local governments to identify:
        a. Destruction to individuals, farms, and businesses, public agencies, special districts, and private nonprofit organizations;
        b. Potential relief activities that can occur during repairs and before another disaster.
    2. Approving or denying requests for Federal assistance.
    3. Activating the measures outlined in the Federal Response Plan.
    4. Establishing an Emergency Support Team (EST) to monitor disaster response and operations from Washington, D. C.
    5. Identifying necessary Emergency Support Functions (ESF) to respond to the disaster (FEMA, 2014).

All about Federal 1135 Waivers

An 1135 Waiver is an allowance under section 1135 of the Social Security Act (SSA) and relaxes regulatory requirements in a disaster area or during an emergency situation. An 1135 Waiver can be requested by a State or individual provider when:

- The U.S. President declares a major disaster or an emergency under the Stafford Act or an emergency under the National Emergencies Act, and
- The U.S. Department of Health and Human Services (HHS) Secretary declares a public health emergency. The Secretary is authorized to take certain actions in addition to his or her regular authorities under section 1135 of the Social Security Act (Public Health Emergency, 2013).

The Secretary may waive or moderate certain Medicare, Medicaid, Children's Health Insurance Program (CHIP) and Health Insurance Portability and Accountability Act (HIPAA) requirements as necessary to ensure sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act (SSA) programs to the maximum extent feasible in an emergency area during an emergency period. Providers of these services, in good faith, who are unable to comply with certain statutory requirements are reimbursed and exempted from sanctions for noncompliance other than fraud or abuse (PHE, 2013). The Waiver usually ends when the emergency response ends, or 60 days from the date the waiver or modification is first published unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period (CMS, 2009).

The 1135 Waiver allows only regulations that govern provision of care to be waived or modified, not conditions of payment. For example, hospice requirements for a face-to face encounter cannot be waived by an 1135 Waiver because it is considered to be condition of payment. A face-to-face encounter must occur no more than 30 days prior to the start of the third benefit period and 30 days prior to any subsequent benefit periods thereafter. Therefore, the hospice face-to-face requirement cannot be waived under Section 1135 of the Act. If the emergency causes a provider to expect to be unable to meet these timeframes, that provider should contact their CMS Regional Office to allow for tracking and completion of this encounter as soon as conditions allow (CMS, 2013a).

Conditions of care provision that may be waived or modified under the 1135 Waiver include:

- Certain conditions of participation certification requirements, program participation or similar requirements for individual health care providers or types of health care providers;
- Requirements that physicians and other health care professionals hold licenses in the state in which they provide services if they have a license from another state (and are not affirmatively barred from practice in that state or any state in the emergency area) for purposes of Medicare, Medicaid, and CHIP reimbursement only;
- Deadlines and time tables for performance of required activities to allow timing of such deadlines to be modified;
- Sanctions and penalties arising from noncompliance with HIPAA privacy regulations relating to:
    - Obtaining a patient's agreement to speak with family members or friends
    - Honoring a patient's request to opt out of the facility directory

- o Distributing a notice of privacy practices
- o Honoring the patient's right to request privacy restrictions or confidential communications (PHE, 2013)

The waiver of HIPAA requirements is effective only if actions under the waiver do not discriminate on the basis of a patient's source of payment or ability to pay (PHE, 2013).

The 1135 Waiver allowance does not expand beyond the designated "emergency area," which is defined as the area in which there has been both a Stafford Act or National Emergencies Act declaration and a public health emergency declaration. However, Medicare does allow for certain limited flexibilities outside the scope of the 1135 waiver, and some of these flexibilities may be extended to areas beyond the confirmed emergency area (CMS, 2013b).

More Information about the 1135 Waiver

- [Additional Emergency and Disaster-Related Policies and Procedures](#) (CMS)
- [Requesting an 1135 Waiver](#) (CMS)
- [Authority To Waive Requirements During National Emergencies](#) (SSA)

Section III - Action Steps for Regulatory Compliance

Every provider type under Medicare must comply with the new regulatory requirements under this final rule, so hospice providers should not feel that they are alone in preparing for compliance. In fact, a hospice may not even need to reinvent the wheel depending on the local community's current resources. The first Federal disaster relief was in a Congressional Act of 1803 which provided assistance to a New Hampshire town following an extensive fire (FEMA, n.d.). Comprehensive, timely planning provides the foundation for effective emergency management. The response to an emergency can impact an entire community and can involve numerous medical and public health entities, including health care provider systems, public health departments, emergency medical services, medical laboratories, individual health practitioners, and medical support services (CMS, 2015).

Federal, State, County (Parish) and local governments as well as a wide array of businesses and a variety of professional organizations have been developing disaster plans for a very long time. There is a universe of well-developed plans and tools available. If the hospice provider approaches compliance with a "create from scratch" attitude, a lot of time and energy can be wasted, and a provider may be likely to miss some of the insights and best practices that have been researched, developed, and proven over the last few hundred years. It is important to keep in mind when planning for disaster response that it does not matter what type of disaster strikes, the response the provider takes is generally going to be the same. Also, bear in mind that there is forewarning related to many natural disasters, which is the first step for any provider to prepare and plan to ensure optimal patient care.

During a disaster or emergency, a coordinated response is essential. The CMS states that comprehensive emergency management includes the following phases:

- **Hazard Identification:** Health care providers should make every effort to include any potential hazards that could affect the facility directly and indirectly for the particular area where it is located. Indirect hazards could affect the community, but not the provider, and as a result interrupt necessary utilities, supplies or staffing.
- **Hazard Mitigation:** Hazard mitigation includes action taken to eliminate or reduce the probability of the event, or reduce its severity or consequences, either prior to or following a disaster or emergency.
    - The emergency plan should include mitigation processes for both residents and staff.
    - Mitigation details should address care for the hospice facility, and how the facility will educate staff in protecting themselves in the likelihood of an emergency.
    - Comprehensive hazard mitigation efforts, including staff education, will aid in reducing staffs' vulnerability to potential hazards.
    - These activities precede any imminent or post-impact timeframe and are considered part of the response.
- **Preparedness:** Preparedness includes developing a plan to address how the provider will meet the needs of patients and residents if essential services break down because of a disaster. A completed preparedness plan will be the product of a review of the basic facility information,

hazard analysis and an examination of the provider's ability to continue providing care and services during an emergency. It also includes training staff on their role in the emergency plan, testing the plan, and revising the plan as needed.

- **Response:** Activities immediately before (for an impending threat), during and after a hazard impact must address the immediate and short-term effects of the emergency.
- **Recovery:** Activities and programs implemented during and after response are designed to return the hospice facility to its usual state or a "new normal."

The Regulations - § 418.113 Condition of Participation: Emergency preparedness.

The regulatory requirements in the federal Conditions of Participation (CoP) at **§**418.110 related to emergency preparedness have been amended by removing the blue italicized paragraph below and moving all requirements to §418.113 Condition of participation: Emergency preparedness.

§418.110 Condition of participation: Hospices that provide inpatient care directly.

(c) *Standard: Physical environment.* The hospice must maintain a safe physical environment free of hazards for patients, staff, and visitors.

    (1)   Safety management.
The hospice must address real or potential threats to the health and safety of the patients, others, and property.

    (ii) The hospice must have a written disaster preparedness plan in effect for managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. The plan must be periodically reviewed and rehearsed with staff (including non-employee staff) with special emphasis placed on carrying out the procedures necessary to protect patients and others.

This new CoP addresses all regulatory requirements for hospice providers including requirements for providers who own their own inpatient hospice facility. The hospice must establish and maintain an emergency preparedness program that meets the outlined requirements and they must comply with all applicable Federal and State emergency preparedness requirements. The emergency preparedness program must include, but not be limited to, the following provisions illustrated in the figure below:

(a) Risk assessment and planning	**(b) Policies and procedures**
(c) Communication plan	**(d) Training and testing**

Emergency preparedness program

There is an additional provision (e) that provides guidance and outlines requirements for hospice providers that are part of an integrated healthcare system.

NHPCO has added the following emergency preparedness standard to the NHPCO Standards of Practice for Hospice Programs under CES 11: Clinical Excellence and Safety (CES).

Standard:

CES 11 The hospice develops, implements, and evaluates a plan for emergency preparedness, which includes the development of policies and procedures, a communication plan, and training and testing program and that is evaluated and rehearsed annually.

> **CES 11.1** The hospice performs facility-based and community-based risk assessments, utilizing an all-hazards approach to determine areas of vulnerability for disaster response.
>
> **CES 11.2** The hospice has a written emergency preparedness plan that provides for the continuation of services in the event of an emergency or disaster. The emergency preparedness plan minimally addresses:
>
> 1. Policies and procedures that address staffing, provision of patient services, evacuation, sheltering in place, safeguard of supplies, maintenance of clinical records, and collaboration with other community providers;
> 2. Strategies for addressing emergency events identified by the risk assessment;
> 3. A plan for the management of consequences from power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care;
> 4. The types of services the hospice has the ability to provide in an emergency;
> 5. Continuity of operations, including delegations of authority and succession plans;
> 6. Processes for 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; and
> 7. Documentation of collaboration and participation with local, tribal, regional, state, or federal emergency preparedness officials', when applicable, in planning efforts.
>
> **CES 11.3** The hospice develops and maintains a communication plan that is updated annually. The communication plan minimally addresses:
>
> 1. Contact information (primary and alternate) for hospice staff, contractors, and federal, state, tribal, regional, and local emergency preparedness staff;
> 2. A process for sharing hospice patient information and clinical documentation, as necessary, with other health care providers to maintain the continuity of care;
> 3. A process to furnish patient information and disclose information about the general condition and location of patients under a hospice's care as permitted under the Health Insurance Portability and Accountability Act , in the event of an evacuation; and
> 4. A process to provide information about a hospice's inpatient unit occupancy, needs, and its ability to provide assistance to emergency preparedness officials.
>
> **CES 11.4** Training and testing on the hospice's emergency preparedness plan, communication plan, and related policies and procedures is provided to all new and existing hospice employees,

and individuals providing services under a contractual arrangement with the hospice at least annually. The training and testing program minimally addresses:

1. Staff knowledge of emergency procedures;
2. Documentation of all emergency preparedness training;
3. Exercises to test the emergency plan that include participation in a full-scale exercise that is community- or facility-based, as well as facilitation of an additional activity that may include a second full-scale exercise or a tabletop exercise; and
4. Documentation of testing and lessons learned.

CES 11.5 The hospice is integrated into the broader community network and is prepared to respond to broader community needs as a result of a natural or civil disaster (e.g., relocation options for patients, requests for bereavement services, increased referrals).

Practice Examples:

- The hospice creates and regularly updates a telephone tree, using mobile telephones as necessary, to facilitate communication with the staff during an emergency.

- The hospice reviews the emergency preparedness plan with all new employees, volunteers, and contracted staff during initial orientation and annually thereafter.

- The hospice considers preparation for multiple disasters (e.g., multiple storms or extended utility loss*).*

- The hospice has an internal plan related to its involvement in the greater community related to its role in response to a natural or civil disaster.

- The hospice completes a debriefing after any activation of the emergency preparedness plan to assess the need for revision to the plan for increased effectiveness in future events.

- The hospice has a crisis communication plan for communicating internally with staff and volunteers and externally with the media.

- The hospice participates annually in a state-wide or country-wide drill that includes triaging patient needs in an emergency.

The information in this section provides discussion of the regulatory requirements, issues for consideration, and resources for compliance for each provision in the CoP.

Provision (a) Emergency plan

The hospice 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, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.
3. Address patient population, including, but not limited to, the type of services the hospice has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
4. Include a process to locate patients to assess their safety status.
5. Include a process for 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 hospice's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts (CMS, 2016).

Planning is a continuous process for optimal emergency preparedness. The regulations require a hospice to develop an emergency plan for their response to the disaster, including personnel who will be involved and other resources. Once a plan has been developed, staff members who have a responsibility in the response should be educated and trained about their role before, during, and after the response. Planning is a collaborative effort and requires participation from many parties (Centers for Disease Control and Prevention, 2016).

Resources and Links to Risk Assessment Tools:
TRACIE

Hospice providers can convene a new committee or expand an existing committee (e.g., the quality improvement, compliance committee, etc…) to include physicians and clinical, administrative, purchasing, information technology (IT), maintenance personnel and other staff as needed in your organization. The key is that it must be to use a multidisciplinary approach. Include staff from all areas of operations that will be affected by a disaster, as this will build stakeholder support in the planning process. Responsibilities among committee members should be delegated to avoid staff members from feeling overwhelmed (CDC, 2016).

Emergency Plan Development

There are several types of hospice providers taking care of patients in their community, including independent providers, providers who are part of a larger agency or health care system or chain, and providers who may be part of a public health department. Providers who have links to larger entities can use an established emergency plan and customize it for compliance with the requirements in §418.113 Condition of Participation: Emergency preparedness.

Independent providers should look to their community to see what emergency preparedness plans may already be in place before building a plan from the ground up. Consider the public health department as a resource to help develop the emergency plan. The

existing plan created by the health department may be able to be customized for the hospice. A hospice may also want to consider looking to other independent hospice providers in the community to collaborate on development of an emergency plan. Remember, competitors are not competitors during a disaster.

The Risk Assessment

A hospice provider can choose their risk assessment tool. The tool should readily identify community-based hazards and vulnerabilities that hospice operations could encounter. The risk assessment is required to be completed for homecare hospice providers, as well as those providers who own a hospice inpatient facility. Hospice providers who own a hospice inpatient facility need to complete a risk assessment that is specific to that environment of care. There are different issues related to disaster or emergency event risks for an inpatient facility than there are for providers who only provide care to patient in a home setting.

Once again, look to the community for help in determining which risk assessment tools to be used. Community fire departments, public health departments, etc. have been assessing risks for years. A hospice may consider meeting with a community partner to identify what risk assessment tool they use and how they use the outcomes in developing and updating their emergency plan.

Steps in Risk Assessment

Step 1	Identify risks and hazards	Step 2	Select risks to address	Step 3	Develop a plan to address selected risks

1. **Identify risks and hazards**
    - A risk assessment identifies potential hazards in your community and analyzes what could happen if a hazard occurs.
    - For each hazard identified, there are many possible scenarios that could unfold depending on timing, magnitude and location of the hazard.
    - Completing an optional business impact analysis (BIA) allows an organization to determine the potential impact resulting from the interruption of time sensitive or critical business processes. (completion of a BIA is not a hospice regulatory requirement)

    Types of Hazards

    Below is a list to guide a hazard assessment.   This list, while lengthy, may not be comprehensive of all local hazards.   Programs should consult their local emergency management systems to ensure that they are familiar will all local hazards.

Examples of hazards could include:

- Natural events
    - Pandemic/epidemic
    - Hurricanes
    - Earthquakes
    - Tornados/severe weather
    - Ice/snow storms
    - Temperature extremes
    - Floods
    - Temperature extremes
    - Floods
    - Wildfires
    - Drought
    - Landslide
    - Tsunami/Tidal Wave
    - Volcanic Eruptions
- Infrastructure events
    - Power Outage
    - Road closures, travel interruption
    - Natural gas leak
    - Dam failure
    - Water or sewer systems failure
    - Communications systems fail
    - IT systems failure
    - Structure fire/loss of use of offices
- Industrial incidents
    - Toxic spill, train, factory, refinery
    - Nuclear release
- Mass casualty events
    - Plane, train, or car crash
    - Building collapse
- Criminal incidents
    - Terrorism (Conventional, nuclear, biological)
    - Bomb threat
    - Hostage situation/ abduction
- Social disturbance
    - Labor actions, Transit strike
    - Civil unrest/riots
    - Unexpected school closures

2. **Select risks to address**
    - A risk assessment may identify twenty potential hazards for a specific area, but a provider needs to prioritize these risks by asking the following questions:
        - What disaster scenarios have happened in the past?
        - What disaster scenarios are the most likely to happen?
        - What disaster scenarios would be the most damaging or disruptive to operations?
    - Planning for the top 3-4 risks is less overwhelming than planning for twenty potential risks
    - Evaluate risk assessment outcomes from local and state entities such as a county health department or hospital system. Reviewing outcomes from other healthcare entities can help you validate that the outcomes of your risk assessment are on target.

See Appendix A - Assessing the Hazard

This resource provides a series of questions about characteristics of hazards. The answers to these questions will help programs prioritize their planning as well as identify similarities between hazards.

3. Develop a plan

Find the issues/challenges first – don't jump to solutions. Facilitate multidisciplinary brainstorming sessions within the organization to identify what the issues and challenges may be. For example, how will the organization communicate with staff if phone systems are down? How will staff that utilizes public transportation be available to work? What happens if gas stations cannot pump gas and staff needs gas for their cars? Be creative in brainstorming to identify all possible issues.

It is also important to use other resources and get involved in the community's public health emergency planning efforts or meetings to target potential partners. Developing connections with public health entities, hospitals, home health agencies, and emergency management systems may generate valuable resources in a disaster situation. A hospice may discover that some of these organizations may or may not have resources to provide support during a public health emergency. FEMA developed fundamental principles of community emergency planning which appear in the publication, "Emergency Management: Principles and Practice for Local Government" (Waugh, 2007). FEMA recommends pre-impact planning and improvisation depending on the course of the disaster. These principles are outlined in the box below.

> **FEMA's Fundamental Principles of Community Emergency Planning**
> - Emergency planners should anticipate both active and passive resistance to the planning process and develop strategies to manage these obstacles.
> - Pre-impact planning should address all hazards to which the community is exposed.
> - Pre-impact planning should elicit participation, commitment, and clearly defined agreement among all response organizations.
> - Pre-impact planning should be based upon accurate assumptions about the threat, typical human behavior in disasters, and likely support from external sources such as state and federal agencies.
> - EOPs Emergency Operating Procedures should identify the types of emergency response actions that are most likely to be appropriate, but encourage improvisation based on continuing emergency assessment.
> - Emergency planning should address the linkage of emergency response to disaster recovery and hazard mitigation.
> - Pre-impact planning should provide for training and evaluating the emergency response organization at all levels—individual, team, department, and community.
> - Emergency planning should be recognized as a continuing process (Waugh, 2007).

Hospice providers should initiate discussions with other providers about hospice response to a public health emergency and how a hospice may be helpful. There may be a need for crisis/grief counseling for first responders or other health care professionals. Hospice may be able to help with that. Simultaneously, a hospice should discuss their expectations of other providers during a response. Developing relationships with other hospice, long-term, home health, or hospice care facilities or providers, locally and regionally is another resource for support during a disaster.

<u>Alternative Office Location</u>

How will the hospice operations and staff be affected if your office location is affected by the disaster or emergency situation? Part of the planning process is to determine an alternative base of operations if the hospice office is compromised during a disaster. All staff should be trained about the alternative location of business as well as their role in operationalizing the location. Also consider the information technology (IT) requirements and utilization and protection of remote server locations.

<u>Vendor Management</u>

It is recommended that hospices cultivate relationships with more than one vendor for supplies and resources the organization will need during an emergency situation, which includes consideration of operational continuity and the ability to be a sustainable resource during an emergency. Determine how the vendor will prioritize delivery of supplies during an emergency and what priority the hospice organization will be given. Understanding limitations of service upfront will allow you to assess the need to find other vendors.

Weather-related and other disasters can make it difficult for DME companies and other vendors to provide their usual services. A supplier's ability to respond to a crisis depends not only on the gravity of the situation, but also on the vendor's capacity. Hospices are well served by working together with suppliers to ensure that there is as little disruption in service as possible during a crisis. Medication and oxygen delivery is a key area of vendor management (National Hospice and Palliative Care Organization, 2005).

Backup power presents another logistical challenge for hospices. Since generators often run on diesel fuel, hospices need to ensure that they have enough of a fuel supply to keep their generators running. Hospices should consider making arrangements with their diesel fuel supplier for the delivery of additional fuel if a power outage lasts longer than a predetermined window of time. If the arrangements are made beforehand, then all that's needed is a phone call to activate the plan (NHPCO, 2005).

Issues for Consideration:
- It takes time to make contacts and set up meetings, so you should take this into consideration and be realistic related to your planning timeline. And yes, you need to develop a definite planning timeline!
- Remember that planning is part of a continuous quality assessment performance improvement process; there is no start or finish. Compliance with **§**418.113 Condition of participation: Emergency preparedness for the **November 15, 2017** effective date is a perfect quality assessment performance improvement (QAPI) project.
- The only way to ask for assistance or offer your assistance before, during, or after an emergency situation is to communicate with others. Identify sources for information, and appoint capable staff to receive and interpret it on behalf of the organization.

- Keep an up-to-date contact list of community partners and vendors.
- Consider and plan for staff that will work from home during an emergency situation and identify the communication equipment and computer support they may require.

Provision (b) Policies and Procedures

A hospice provider must develop and implement emergency preparedness policies and procedures, based on their risk assessment and communication plan. The policies and procedures must be reviewed and updated at least annually, and the provider must be able to provide documented evidence of a review and update. Minimally, 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.**

  Hospice providers are responsible for patient care before, during, and after a disaster and must ensure that they have a plan in place to determine each patient's location at all of those time points. Lessons learned from the hurricanes in the Gulf States revealed that some providers, despite having patient-related information backed up to computer databases within or outside of the state in which the disaster occurred, could not access the information in a timely manner. Hospice staff plays a key role in reaching out to patients to establish their status and needs. Hospice staff must know their responsibility while on duty and off duty during a disaster or emergency to enhance the response of hospice operations. Making connections prior to a disaster or emergency ensures that this information is delivered to the right State and local officials. Establish an incident command center within the organization, assign roles to staff, and develop a chart listing the roles (i.e. operations chief, logistics chief, etc...)

- **Procedures to inform State and local officials about hospice 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.**

  During any crisis, a hospice's first response typically is to prioritize the hospice. Providers must have (a) a tool to prioritize patient care from most to least critical and (b) a method to identify patients requiring evacuation during a disaster. Implementing these systems allows for easy identification of high risk patients and communication of their needs to the local emergency manager. An example of a patient risk categorization tool follows:

  - *Level I: High Priority*. Patients who require uninterrupted services because they are the most vulnerable. In the case of a disaster or emergency, every possible effort must be made to see this patient. The patient's condition is unpredictable and deteriorating.
  - *Level II: Moderate Priority*. The patient's symptoms are managed at this time and services may be postponed and replaced with telephone contact without detriment to the patient.

- *Level III: Low Priority*. The patient's symptoms are managed at this time and they have access to informal support to provide care. The patient can safely miss a scheduled visit if basic care is provided by family members, other informal support, or by the patient himself.

Factors for Categorizing Patients

- Whether or not a patient has a caregiver and support system.
- Assign every patient a risk categorization at admission and update every 15 days (or as frequently as the patient condition requires) as part of the update to the patient's comprehensive assessment and plan of care. Assign and update patient risk at every interdisciplinary team meeting.
- Educate patients and families about the patient risk categorization and what care they can expect to receive during a disaster based on the assignment of risk.
- Monitor the process at predetermined time points throughout the year and as part of emergency preparedness program evaluation and testing.

- **A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.**
  More than one million paper medical records were lost during Hurricane Katrina in 2005, which presented significant challenges in providing care to patients (Dimick, 2008). While there has be significant progress within healthcare related to electronic medical records (EMR) over the past decade, measures still need to be implemented to protect, preserve, and secure patient information. The capacity to exchange medical information is vital during an emergency response and improves the outcome for everyone.
  - Electronic medical records (EMR):
    - It is recommended that a provider who utilizes an electronic database consider backing up its computer system with a secondary source. It is recommended to use the other drive or remote location that stores the backups in order to perform a restore.
    - Prevent information gaps with regular backups.
    - Prioritize critical data for protection.
    - Test your system periodically.
    - Even with EMR, consider downtime paperwork, and a minimum level set for paper forms.
  - Paper clinical records:
    - Providers who utilize paper clinical records need to develop a plan to protect the information from destruction.
    - Identify vital records and information for protection and move them offsite from disaster risk.

- o Test your system periodically.
- Ensure that all personal health information of your patients (whether paper of electronic) is secured and shared only for treatment, payment, or health care operations per the HIPAA Privacy Rule.

- **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.**

  Planning for staffing needs is part of overall disaster planning. Staffing needs will depend on a host of variables that could include:

  - Patient census
  - Patient risk categorization
  - Robustness of current staffing
  - Staff ability to travel to home patients or an inpatient facility
  - The magnitude of the disaster.

  Hospice providers should map out a staffing strategy based on all possible variables. Providers should develop a staffing contingency plan and should not rely on only their staff for assistance during an emergency response. Remember, your staff may be caught up in the thick of the disaster themselves, or they may be caring for their own family who may be involved.

  The federal hospice Conditions of Participation at §418.64 (Core services) require a hospice provider to routinely provide substantially all core services directly by hospice employees. These services include physician services, nursing services, medical social services, and counseling (bereavement, spiritual, and dietary). Non-core hospice services may be contracted at any time and include hospice aides, therapists, and homemakers. These services must be also provided in a manner consistent with acceptable standards of practice (CMS, 2015). There is allowance in the federal hospice Conditions of Participation for a hospice provider to enter a written contractual arrangement for core services during extraordinary or other non-routine circumstances such as unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care.

  > *§418.64 - A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. A hospice may also enter into a written arrangement with another Medicare certified hospice program for the provision of core services to supplement hospice employee/staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include: unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary*

situations that interrupt patient care; and temporary travel of a patient outside of the hospice's service area (CMS, 2015).

<u>Tips for Staffing Strategies</u>

- Negotiate staffing contracts before the threat of a disaster for core and non-core hospice services as part of your emergency preparedness planning process.
- Determine which of your staff will be available during a disaster response to help you develop a staffing contingency plan.
- Update your staffing plan for disaster response on a regular basis. As staff changes, so should your staffing contingency plan.
- Educate your staff regularly about expectations and their responsibilities during a disaster response.
- Look outside of the hospice industry when planning for emergency staffing.
- Share your staff availability and plan with your emergency coordinator management or public health officials and determine if there would be available support from state and federally designated health care professionals for your patients.

- **The development of arrangements with other hospices and other providers to receive patients in the event of limitations or cessation of operations to ensure the continuity of services to hospice patients.**
  Hospice providers who own and run a Medicare certified inpatient unit or state licensed hospice residence must have a plan in place in the event the facility is not able to continue to house and care for patients related to a disaster. Providers should seek contractual relationships with other hospice or healthcare providers to ensure continuity of palliative end of life care services to hospice patients if there is a limitation or cessation of operations related to a disaster. Negotiate contractual agreements and relationships before the threat of a disaster as part of your emergency preparedness planning process.

- **There are specific policy requirements for hospice-operated inpatient care facilities which are very straightforward and address a hospice provider's ability to ensure that their patients and staff are taken care of during an emergency response.**
  Policy issues that must be minimally addressed include the following:
  i. <u>A means to shelter in place</u> for patients and hospice employees who remain in the hospice.
      o Sheltering in place is a precaution aimed at keeping people safe while remaining indoors in the same place when a disaster strikes. Planning for sheltering in place includes ensuring enough supplies for patients as well as staff.
  ii. <u>Safe evacuation from the hospice</u>, 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.

- Hospice providers will need to be at the table during the planning stage with local emergency response coordinators management or public health officials to understand the evacuation and transport process for patients in the community and advocate for the needs of those hospice and palliative care patients.
- Determining how and when your patients will be evacuated or eligible for transportation from a disaster area during a disaster is too late.

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:
- Food, water, and medical supplies to include oxygen.
- Alternate sources of energy to maintain the following:
  - Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
  - Emergency lighting.
  - Fire detection, extinguishing, and alarm systems.
- Sewage and waste disposal.

iv. The role of the hospice 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. (See the Getting to Know the Disaster Response System Federal, State, local section of this resource for an explanation of the 1135 Waiver)

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.

Note: CMS issued a final rule (CMS-3277-F) in May 2016 that updated health care facilities' fire protection guidelines to improve protections for all Medicare beneficiaries in facilities from fire including patients in hospice inpatient facilities. This final rule incorporates updated provisions of the National Fire Protection Association's (NFPA) 2012 edition of the Life Safety Code (LSC) as well as provisions of the NFPA's 2012 edition of the Health Care Facilities Code. The compliance date for this final rule was **July 5, 2016**.

NFPA Resources:

- Emergency Preparedness
- List of NFPA codes & standards
- Emergency Preparedness Requirements - A User's Guide - This free resource was designed by NFPA to help providers to gain familiarity with the CMS requirements for emergency preparedness.

Red Cross Shelter-in-Place Supplies Checklist for facilities

Issues for Consideration

- It is critical that providers develop a relationship with the emergency response coordinators locally to ensure that their patients are recognized and included in a community's emergency response plan.
- Conduct regular assessments of the facility to ensure optimal functioning for patients and staff in the event that sheltering in place is a need.
- Develop a sheltering in place plan that addresses care for patients and consideration for staff. The Red Cross has a comprehensive shelter-in-place supplies checklist for facilities.
- Prepare to shelter in place or evacuate patients and staff prior to a disaster depending upon the threat. Communicate with local emergency responders to keep updated about the community's ability to safeguard their citizens.
- Providers should also educate and provide written information to their patients and families about:
    - their emergency policy preparedness policies and what to expect from the hospice during an emergency or disaster
    - what to do in the event of an emergency or disaster
    - how to be prepared for an emergency or disaster

Education with patients and family is vital throughout the provision of hospice services. Providers need to determine such information as where a patient can go to shelter during an emergency or disaster, if a county requires individuals to pre-register for a shelter, and what the patient can take when they go to the shelter.

See Appendix B – Resources for Patients and Families

Provision (c) Communication Plan

A hospice provider must develop and maintain an emergency preparedness communication plan that complies with both Federal and State law and must be reviewed and updated at least annually. The communication plan must include all of the following components:

(1) Names and contact information for the following:
   i. Hospice employees.
   ii. Entities providing services under arrangement.
   iii. Patients' physicians.
   iv. Other hospices.

Providers are already required to maintain a list of current hospice staff and vendors/contractors providing services under arrangement for state/federal survey purposes. Current listings of your patient's physicians and the other hospice providers in your service area are an addition to the information that will not only aid in a disaster situation, but will be required during a Medicare survey

and should be added to survey readiness materials. Spreadsheets work well for tracking information if your EMR cannot produce accurate lists. Providers should also determine if their after-hours answering service has the ability to provide service from another site if they cannot continue service in the current site.

Access NHPCO's [Survey Readiness Compliance Resources](#) including a checklist of survey ready information

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

Find a **[State Department of Public Health](#)**

   Hospice providers will need to maintain a list of staff contact information for Federal, State, tribal, regional, and local emergency preparedness staff as part of disaster readiness resources and survey Medicare readiness materials. FEMA provides a link to [State Emergency Management Agencies](#) in the United States. Providers will need to reach out into their community to determine the local and regional contacts for emergency preparedness staff. The local public health department is a good first stop!

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

   What would a provider do if the organization could not communicate with staff and patients during a disaster or emergency? Part of risk assessment and planning is communication, not only with staff and patients but with local disaster responders. Providers will need to plan for alternative methods of communication and in what order the methods will be implemented. For example, the first line of communication is landline phones, then cell phones, followed by text, etc…. Ensure staff knows what methods of communication will be used during a disaster or emergency and in which order. Providers should also consider alternative methods of communication such as:

- Texting - Text messages require far less bandwidth than phone calls and will still work as they operate on a parallel network to cell phones.
- Email and social media **-** Email and social media are hosted on a network of global servers which gives it remarkable fault tolerance. It's easy to post Facebook or Twitter messages as a backup to the backup in case of an emergency.
- Phone Booths **–** if the ability to text, email, or access social media is not an option, phone booths may still exist in some areas and most of them are on landlines, which are characteristically reliable. There are even apps online that provide locations of phone booths. Change is required, so ensure staff has change to pay for calls.

- HAM Radio - ham radio is another great 'out of the box' communication solution. Your average five watt handset can achieve 10+ miles of range on flat ground, using a repeater (Adam, 2013).

(4) A method for sharing information and medical documentation for patients under the hospice's care, as necessary, with other health care providers to ensure continuity of care.

(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510* (45 CFR 164.510 - *Uses and disclosures requiring an opportunity for the individual to agree or to object*).

> **164.510 - A covered entity may use or disclose protected health information, provided that the individual is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the use or disclosure, in accordance with the applicable requirements of this section. The covered entity may orally inform the individual of and obtain the individual's oral agreement or objection to a use or disclosure.*

Resource: Crisis and Emergency Risk Communication (Manual): Second Edition

(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) (45 CFR 164.510(b)(4) - *Uses and disclosures for disaster relief purposes*)

(7) 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.

Can a Hospice Share Patient Information?

Providers and health plans covered by the HIPAA Privacy Rule can share patient information for treatment, payment, and operations without patient authorization. Even if a state law is stricter than HIPAA and requires authorization prior to disclosing PHI for treatment, any personal health information necessary for treatment may be shared in an emergency without authorization. This includes sharing patient information with legal or chartered disaster relief organizations without patient permission if obtaining permission interferes with emergency response. Sharing patient information for the purpose of treatment includes:

- Sharing information with other providers (including hospitals and clinics)
- Referring patients for treatment (including connecting patients with available providers in areas where the patients have relocated)
- Coordinating patient care with others (such as emergency relief workers or others that can help in finding patients appropriate health services)

Providers can also share patient information to the extent necessary to seek payment for these health care services. In addition, patient information, including location, general condition, or death, can be shared as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the individual's care. Verbal permission to share information should be obtained from patients/ individuals, when possible. However, if the individual is debilitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest (US Department of Health and Human Services, 2005).

If the patient is in imminent danger, providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public -- consistent with applicable law and the provider's standards of ethical conduct. Hospice facilities who maintain a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and general condition (HHS, 2005).

Note: HIPAA Breach Laws still apply during a disaster or emergency, and breaches must be reported to the US Department of Health and Human Services, Office for Civil Rights per regulatory guidelines.

Methods of Sharing Information

How hospice providers share patient information during a disaster or emergency depends on their method of clinical record keeping. Providers that utilize an EMR can share information electronically using encryption to safeguard the information in transit. Providers who document on paper clinical records can fax copies to their designated recipient. How patient information is shared is dependent upon the "what if's" as a disaster unfolds and part of the planning process is determining how the hospice will meet patient needs, even if they are no longer the primary care provider.

Provision (d) Training and Testing

Regulations require hospice providers to develop and maintain training and testing programs that must be reviewed and updated at least annually (CMS, 2016). Training and testing identifies the areas of a provider's emergency plan, policies and procedures, and communication plan that require revision. Depending on the size and available resources of the hospice, testing may be the most challenging standard to implement and evidence compliance. Once again, providers are not alone and are encouraged to look to their community for established resources and exercises for testing their emergency plan. Remember! Providers never want to be exchanging business cards during an actual disaster.

The Training Program

The following are training requirements for the hospice:

1. Initial training in emergency preparedness policies and procedures must be provided to all new and existing hospice staff, and individuals who provide services under arrangement in context of their role in hospice operations.
2. Ensure that hospice employees can demonstrate knowledge of emergency procedures.
3. Provide emergency preparedness training at least annually to all hospice staff.
4. 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.
5. Maintain documentation of all emergency preparedness training.
6. Regulatory update information as staff changes.

The key to compliance in this standard is not only completing the training about the emergency plan, policies and procedures, and communication plan, but being able to produce documentation that evidences each staff member is knowledge and competent about all the components of the plan and particularly in relation to their role in hospice operations. Evidence of training can be maintained at the hospice provider's discretion, but should be organized and readily accessible. Documentation of training for individuals who provide services under arrangement should be organized and readily accessible and most likely separate from hospice staff documentation.

Testing the Emergency program

The hospice must conduct **two exercises** to test the emergency plan annually. Hospice providers must do the following to demonstrate compliance:

| Participate in full scale community based exercise | A second full scale exercise or table top exercise | Analyze response and document the event |

1. Participate in a full-scale exercise that is community-based or when a community based exercise is not accessible, an individual, facility-based.

2. 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. Remember, table top exercise should be lifelike and realistic.
3. Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the hospice's emergency plan, as needed.

Exception: If the hospice experiences an actual natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in a community or individual, facility-based mock disaster drill for **1 year following the onset of the actual event** (CMS, 2016). The analysis outlined below should take place after the actual emergency to determine any changes needed to future responses.

Participation in simulated public health emergency exercises allows a hospice provider to determine if, and ensure that, they understand their role and responsibilities during a disaster or emergency. By reaching out into the community to determine emergency preparedness resources that already exist, providers can secure a place at the table during a full scale exercise. By the time a hospice provider reaches this stage, the emergency preparedness state and local staff and community participants know about:

- hospice patients and their needs
- hospice provider needs during a disaster or emergency
- how hospice staff can help during a disaster or emergency

Documentation of the exercise should encompass but is not limited to the following:

- The scope of the disaster or emergency
- The hospice patient population affected and their status
- How the emergency and communication plans were implemented and guided by applicable policies and procedures
- Identified areas of strength in the implementation (What went well?)
- Identified areas for performance improvement in the implementation (What did not go well?)
- Unexpected issues
- Staff response

> **FEMA's [Emergency Planning Exercises web page](#) offers free, downloadable table top exercises for the private sector to review, share and use**

Post Exercise Analysis

After each exercise, whether a community based mock drill or a table top implementation of the emergency plan, a post exercise analysis should be completed. Comparing actual response by the

hospice to the simulated emergency will help identify areas of strengths as well as response gaps. The hospice can uses this information in developing a performance improvement plan (CMS, 2016). The analysis of the response should be completed by the same multidisciplinary group that contributed to the development of the emergency plan, policies and procedures, and communication plan. After the analysis is complete, the plan should be revised to include recommendations for improvement, and the process starts again.

<u>**Lessons Learned**</u>

Disaster or emergency situations are a reminder of how crucial it is to have a disaster plan in place, to review it periodically, and to follow it in the midst of a crisis. The more practice a hospice team has with the disaster plan, the better prepared they will be to handle a crisis situation and continue to provide hospice care. Hospices professionals who have weathered disasters agree on two significant points. First, communicating with staff, patients, families and the community before, during, and after a crisis is key. Second, it is essential to have a good, working disaster plan in place. Even with the plan, however, hospices need to be prepared for the unexpected. For example, it's easy to forget that most phones today rely on electricity, and are useless during an outage. Having an inexpensive plug-in phone makes sense for hospices, as well as patients and families. Developing a plan and going over it frequently helps staff develop instincts and awareness that will serve them well during emergency situations. The final lesson learned is to always debrief shortly after the crisis is over. The debrief is an opportunity to talk about what went well and what did not, to discuss situations that had not been anticipated, and to recognize the dedication and commitment of staff who went the extra mile. After the debrief, the disaster plan should be amended as necessary and recirculated among staff, so all can be prepared for future crises (NHPCO, 2005).

Provision (e) Integrated Healthcare Systems

If a hospice 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 hospice may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do 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 outlined in provision (a). 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 provision (b), a coordinated communication plan and training and testing programs that meet the requirements of provisions (c) and (d) (CMS, 2016).

See Appendix C – Provider Resources

Measuring Compliance

Appendix D includes a standalone compliance checklist for hospice providers to measure their compliance with the emergency preparedness requirements. NHPCO has also updated the CoP Audit Tool with the regulatory requirements in **§**418.113 Condition of participation: Emergency preparedness.

See Appendix D – Emergency preparedness compliance checklist

Continuing Information

Providers should also monitor CMS Survey & Certification group communication and the NHPCO Emergency Preparedness webpage for updates.

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Appendices

Appendix A

Assessing the Hazard

The answers to these questions will help programs prioritize their planning as well as identify similarities between hazards. The following bullet points are the initial set of assessment factors.

- Probability of the hazard occurring

- Proximity of the hazard, to service area in general and specific locations.

- Degree of advance warning

    o None – earthquake, industrial accident

    o Some – tornado, wildfire, flood

    o 24+ hours – hurricane, labor action

- Duration of the immediate hazard/threat

- Will there be secondary hazards? (Downed power lines, contaminated water, personal safety)

- Geographic scope of the hazard, how widespread is the expected impact? (local, regional, state, etc.)

- Are communications systems likely to be disrupted?

- Extent of damage to infrastructure. What systems will be damaged or destroyed and how long will it take for the damage to be repaired. (communications, electricity, water/sewer, roads/bridges, rail, airports, IT, other utilities)

- Impact on the health care system, will the hazard push the system beyond surge capacity?

- What other business partners will be unavailable or operating in a diminished or overwhelmed capacity? (Suppliers, medical transport, nursing facilities, IT vendors, hospitals)

- Are health care workers more likely to be victims?

- Will hospice & palliative care staff need to be caregivers for their own families?

- Could the hazard lead to an evacuation? If an evacuation is ordered how soon will staff and patients be able to return?

- Will the hazard involve quarantine or shelter in place

- Impact on the ability to travel to patients

- Broader economic impact, did the incident sharply curtail the economic vitality of the community in which the hospice/palliative care program operates?

- Demographic impact. Will the incident cause major demographic changes that will:

    o Impact the patient base and census of the provider?

    o Impact the pool of available staff?

Appendix B

Resources for Patients and Families

Centers for Disease Control and Prevention

- Emergency Preparedness and You
- Make a Plan

American Red Cross

- Prepare for Emergencies
- Create Your Emergency Plan in Just 3 Steps
- Emergency Preparedness Checklist
- Tools and Resources Library

Ready.gov

- Build an Emergency Supply Kit
- Plan to Protect Yourself & Your Family

Federal Emergency Management Agency (FEMA)

- Family Emergency Planning Guide
- Free Publications
  - o Ready Materials Order Form

National Disaster Education Coalition

- Family Disaster Plan

Appendix C

Provider Resources

Center for Medicare and Medicaid Services (CMS)

- Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers – Final Rule
- General Resources for Emergency Preparedness [PDF, 38KB]
- EP Rule - Table Requirements by Provider Type [PDF, 126KB]
- OCR Emergency Preparedness HIPPA Disclose [PDF, 30KB]
- Emergency Preparedness Checklist for All Providers [PDF, 109KB]
- Emergency Preparedness Checklist Recommended Tool For Effective Health Care Facility Planning
- Facility Transfer Agreement - Example [PDF, 56KB]
- Frequently Asked Questions (FAQs) Round One [PDF, 312KB]
- Frequently Asked Questions (FAQs) Round Two [PDF, 32KB]
- CMS Survey & Certification- Emergency Preparedness Regulation Guidance

U.S. Department of Health and Human Services

- Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers
- Emergency Preparedness
- ASPR Technical Resources Assistance Center and Information Exchange (ASPR TRACIE)

  TRACIE is an information gateway that connects public health and medical professionals with the emergency preparedness, response and recovery information that they need. ASPR TRACIE can help you quickly identify resources to get your planning started, build on the experience of your colleagues, prioritize activities for the future, make smart decisions, find training, and get answers to your questions.
- Can health care information be shared in a severe disaster?
- HIPAA and Disasters: What Emergency Professionals Need to Know

Federal Emergency Management Agency (FEMA)

- FEMA's Emergency Planning Exercises web page offers free, downloadable table top exercises for the private sector to review, share and use.
- National Preparedness
- Disaster Sequence of Events
- Free Publications
  - Ready Materials Order Form

Centers for Disease Control and Prevention

- Office of Public Health Preparedness and Response
- Clinician Resources
- Crisis and Emergency Risk Communication (Manual): Second Edition (2014)

National Fire Protection Association (NFPA)

- Emergency Preparedness
- List of NFPA codes & standards
- Emergency Preparedness Requirements - A User's Guide - This free resource was designed by NFPA to help providers to gain familiarity with the CMS requirements for emergency preparedness.

American Red Cross

- Workplaces and Organizations
- Shelter-in-Place Supplies Checklist for facilities

Ready.gov

- Business Impact Analysis (BIA)
- Workplace Plans
- Preparedness Planning for Your Business
- Business Continuity Planning Suite

U.S. Small Business Administration

- Emergency preparedness

Appendix D
Hospice Emergency Preparedness CoP Compliance Checklist

Regulatory Requirements	Are you compliant?		Actions required for compliance	Responsible party	Added to QAPI program?		Target compliance date	Complete date
	Yes	No			Yes	No		
Provision (a) Emergency plan								
Emergency plan developed, maintained, reviewed, and updated at least annually.								
Plan is based on and includes based a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.								
Plan includes 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.								
Plan addresses patient population, including, but not limited to, the type of services the hospice has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.								
Plan includes a process for 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 hospice's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.								

Regulatory Requirements	Are you compliant?		Actions required for compliance	Responsible party	Added to QAPI program?		Target compliance date	Complete date
	Yes	No			Yes	No		
Provision (b) Policies and procedures								
Emergency preparedness policies and procedures are developed based on the emergency plan, risk assessment, and the communication.								
The policies and procedures must be reviewed and updated at least annually.								
Procedures are developed 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 has a process to inform State and local officials of any on-duty staff or patients that they are unable to contact.								
Procedures developed to inform State and local officials about hospice 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.								
A system of medical documentation exists that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.								
The use of hospice employees in emergency and other emergency staffing strategies, includes the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.								

Regulatory Requirements	Are you compliant?		Actions required for compliance	Responsible party	Added to QAPI program?		Target compliance date	Complete date
	Yes	No			Yes	No		
The hospice has developed arrangements with other hospices and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to hospice patients.								
Policy and Procedure requirements for hospice-operated inpatient care facilities only:								
• 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:								
• Food, water, medical, and pharmaceutical supplies.								
• Alternate sources of energy to maintain the following:								
▪ Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.								
▪ Emergency lighting.								
▪ Fire detection, extinguishing, and alarm systems.								
▪ Sewage and waste disposal.								
The role of the hospice under a waiver 1135 of the Act, in the provision of care and treatment at an alternate care site is identified by emergency management officials.								

Regulatory Requirements	Are you compliant?		Actions required for compliance	Responsible party	Added to QAPI program?		Target compliance date	Complete date
	Yes	No			Yes	No		
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.								

See next page for Provision (c) Communication plan

Regulatory Requirements	Are you compliant?		Actions required for compliance	Responsible party	Added to QAPI program?		Target compliance date	Complete date
	Yes	No			Yes	No		
Provision (c) Communication plan								
The hospice has developed and maintains an emergency preparedness communication plan that complies with Federal, State, and local laws.								
(1) Names and contact information for the following:								
(i) Hospice employees.								
(ii) Entities providing services under arrangement.								
(iii) Patients' physicians.								
(iv) Other hospices.								
(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) Hospice's employees.								
(ii) Federal, State, tribal, regional, and local emergency management agencies.								
(4) A method for sharing information and medical documentation for patients under the hospice'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).								

Regulatory Requirements	Are you compliant?		Actions required for compliance	Responsible party	Added to QAPI program?		Target compliance date	Complete date
	Yes	No			Yes	No		
Provision (d) Training and testing								
The training and testing program is reviewed and updated at least annually.								
(1) Training program. 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 annually.								
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.								
v. Maintain documentation of all emergency preparedness training.								
(2) Testing. The hospice must conduct exercises to test the emergency plan at least annually.								

Regulatory Requirements	Are you compliant?		Actions required for compliance	Responsible party	Added to QAPI program?		Target compliance date	Complete date
	Yes	No			Yes	No		
i. Participation in a full-scale exercise that is community-based or when a community based exercise is not accessible, an individual, facility-based. If the hospice experiences an actual natural or man-made emergency that requires activation of the emergency plan.								
★ **Is the hospice exempt?** The hospice 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 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.								
iii. Analyze response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the hospice's emergency plan, as needed.								

Regulatory Requirements	Are you compliant?		Actions required for compliance	Responsible party	Added to QAPI program?		Target compliance date	Complete date
	Yes	No			Yes	No		
Provision (e) Integrated healthcare system								
A hospice may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do the following:								
• 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.								
• 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.								
Includes integrated policies and procedures, a coordinated communication plan, and training and testing programs that meet hospice requirements.								