4C. Emergency Preparedness for Hospice

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Emergency Preparedness Learning Objectives

- Understand the Conditions of Participation (CoP) for Emergency Preparedness (EP)
- Describe Steps to Ensure Emergency Preparedness (EP) Compliance and Survey Readiness
Resources

State Operations Manual (SOM) Appendix M: Guidance to Surveyors: Hospice (Rev. 210, 03/03/23)

State Operations Manual (SOM) – Appendix Z: Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance (Rev. 204, Issued: 04-16-21)


§418.113 – HOSPICE EMERGENCY PREPAREDNESS
The requirements of the EP Rule 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.

EP requirements were developed to enable all providers and suppliers wherever they are located to:

- Better anticipate and plan for needs
- Rapidly respond as a facility
- Integrate with local public health and emergency management agencies and healthcare coalitions’ response activities
- Rapidly recover following the disaster.
Emergency Preparedness Rule

- All hospices 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 Hospice Agency.
- EP Interpretive Guidelines E-001 – CoPs 418.113 Hospice

(There are no corresponding L tags for Emergency Preparedness)

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Hospice Emergency Preparedness
RISK ASSESSMENT & PLANNING

§ 418.113 – Hospice Emergency Plan

Hospice Emergency Preparedness

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**.

Hospice Emergency Preparedness

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 a hospice’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

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

Hospice Emergency Preparedness

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.
- Hospice’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 a hospice 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 hospice 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.

▪ Hospices 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.

Hospice Emergency Preparedness

Policies & Procedures

§ 418.113 – Hospice Emergency Preparedness Standard- (b) Policies and Procedures
Hospice - Standard (b)(1) - Policies and Procedures

The hospice 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, if 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 Emergency Preparedness

− 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.
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 consider their roles during a natural disaster and EID 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 in an 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, if there is an interruption in services during or due to an emergency.

Hospice Emergency Preparedness

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.
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 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 include the clinical care needed for these patients.
- Since such policies and procedures include protected health information of patients, agencies must also ensure they comply 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.

Hospice Emergency Preparedness

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

Patient and Staff Communication in EP

- The hospice 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?
Hospice Standard(b)- Policies and Procedures

Policies and procedures should address/include:

- The hospice has a **system of medical documentation** that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

- 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.

- 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

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**Hospice Emergency Preparedness**

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**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**.
- Hospices 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.
Volunteers – Medical and Non-medical
- During an emergency, a hospice 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 the hospice uses 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.
418.113 – Hospice - Emergency Preparedness Standard - (c) Communication Plan

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:

Names and contact information for the following:

➢ Hospice Employees
➢ Entities providing services under arrangement
➢ Patients’ physicians
➢ Other Hospices

Contact information for the following:

− Federal, State, tribal, regional, and local emergency preparedness staff.
− 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.

Primary and alternate means for communicating with the following:

− Agency Staff
− Federal, State, tribal, regional, and local emergency management agencies.
Hospice Emergency Preparedness
Standard - (c) Communication Plan

- 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.

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

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, agencies 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.
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.

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.
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

Hospice Emergency Preparedness

Training and Testing

Emergency Preparedness Standard -(d) Training and Testing
Training and Testing - The Agency must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan, risk assessment, policies and procedures, and the communication plan. The training and testing program must be reviewed and updated at least every 2 years.

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.
Hospice Emergency Preparedness

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.

Hospice Emergency Preparedness

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

**Training Program** - The Hospice Agency Must do ALL of the following:

- 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.
- Demonstrate staff knowledge of emergency procedures.
- Provide emergency preparedness training at least every 2 years.
- 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.
- Maintain documentation of the training.

*If the emergency preparedness policies and procedures are significantly updated, the Hospice must conduct training on the updated policies and procedures.*
Hospice Emergency Preparedness

Standard - (d)(1) Training and Testing

- Training should include:
  - Individual-based response activities in the event of a natural disaster, 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.
  - 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.

Hospice Emergency Preparedness

Standard - (d)(2) Training and Testing

Testing: The Agency must conduct exercises to test the emergency plan at least annually. The Agency must do one of the following:

Participate in a full-scale exercise that is community-based; or
  - When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years.
  - 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.
Hospice Emergency Preparedness Standard - (d) Training and Testing

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 one of the following:

- A second full-scale exercise that is community-based or facility-based functional exercise;
- A mock disaster drill
- 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.

Assessments and Documentation

All providers and suppliers must continue to analyze their facility's response to and maintain documentation of all drills, table-top exercises, and activation of their emergency plan. This would include documentation showing any revisions to the facility's emergency plan as a result of the after-action review process.
Exemption Guidance

The updated guidance only applies if a facility is still currently operating under its activated emergency plan or reactivated its emergency plan for COVID-19 in 2021 or 2022. Facilities which have resumed normal operating status (not under their activated emergency plans) are required to conduct their testing exercises based on the regulatory requirements for their specific provider or supplier type. This guidance provides clarifications on testing exemptions for those providers/suppliers who continue to operate under their activated emergency plan and those which may have reactivated their emergency plans for COVID-19.

This guidance will also apply for any subsequent 12-month cycles in the future, in the event facilities continue to operate under their activated emergency plans for COVID-19 response activities.

Hospice Emergency Preparedness

Exemption Guidance

Freestanding - Home-Based Hospices

If the facility claimed the full-scale exercise exemption in 2020 based on its activated emergency plan for COVID-19 response and has since resumed normal operating status, the outpatient provider/supplier is expected to complete its required full-scale exercise in 2022, unless it has reactivated its emergency plan for an actual emergency during its 12-month cycle for 2022. If the facility claimed the full-scale exercise exemption in 2021 based on its activated emergency plan for COVID-19 response and has since resumed normal operating status, the outpatient provider/supplier is expected to complete its required full-scale exercise in 2024.
EP Testing Exemption and Guidance

**Requirement & Guidance:** All 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 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 based on the facility’s 12-month exercise cycle. The cycle is determined by the facility (e.g. calendar, fiscal or another 12-month timeframe).

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 12-month cycle.

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**Hospice Emergency Preparedness**

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.

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**Hospice Emergency Preparedness**
Testing Exercise Options

2 categories of Testing Exercises:

1) REQUIRED EXERCISES: Full-scale functional and individual facility-based exercises

2) EXERCISES OF CHOICE: Mock disaster drills, table-top exercises, or workshops (may also include the full-scale functional and individual facility-based exercises.

Hospice Emergency Preparedness

Testing Scenarios Freestanding/Home-Based Hospices
(Outpatient)
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.

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.

Testing Scenario # 4
(Updated Guidance 05/26/22)

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. However, since the facility is continuing to operate under its activated emergency plan in early 2022, the facility is exempt from the full-scale exercise in June 2022.
(E) Integrated health care systems - If 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 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.
Standard-(e) Integrated Healthcare Systems

(4) Include a unified and integrated emergency plan that meets the requirements. 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.

Hospice Emergency Preparedness

Surveyor Steps for Determining Use of Exemption Clause:

▪ Determine the facility's annual cycle.

▪ Ensure that the hospice has conducted one full-scale/functional exercise within the 12-month period followed by an exercise of choice on opposite years, dependent on the scenarios above.

▪ Ask the facility to describe the exemption to ensure understanding that exemption is based on the scheduled next-required full-scale exercise, not the exercise of choice.
Surveyor Steps for Determining Use of Exemption Clause: (cont.)

- Verify documentation evidence that the facility activated its emergency plan (in order to determine whether the testing exemption is acceptable for use). Documentation may include, but is not limited to, the following:
  - Notice of activation to staff via electronic systems (alerts);
  - Proof of patient transfers and changes in daily operations based on the emergency;
  - Initiation of additional safety protocols, for example, mandate for use of personal protective equipment (PPE) for staff, visitors and patients as applicable;
  - Coordination with state and local emergency officials;

- Minutes of board/facility meetings;
- 1135 Waiver (individual or use of blanket flexibilities); or,
- Incident command system related reports, such as situation reports or incident action plans.

Determine, based on the above examples, whether the facility is compliant with the exemption clause and has conducted the appropriate required exercises.
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).

Hospice Emergency Preparedness

Elements of the EP Program 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
Thank You For Participating!

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§418.113 Hospice Emergency Preparedness - Take Away

**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 of the EP Rule are focused on three key essentials necessary for maintaining access to healthcare during disasters or emergencies:

- Safeguarding Human Resources
- Maintaining Business Continuity
- Protecting Physical Resources

EP requirements were developed to enable all providers and suppliers to:

- Better anticipate and plan for needs
- Rapidly respond as a facility
- Integrate with local public health and emergency management agencies and healthcare coalitions’ response activities
- Rapidly recover following the disaster

Burden Reduction Final Rule (September 30, 2019) CMS revised the requirements for all providers and suppliers for Emergency Preparedness:

- 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.

**NOTE:** Training is required at time of hire and if the emergency plan is significantly updated.

- Revised Testing Exercise requirements were 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.*

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 hospice.

(There are no corresponding L tags for Emergency Preparedness)
UPDATED EP GUIDANCE

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

NOTE: The CoP for the Emergency Preparedness requirements did not change due to the pandemic. CMS expanded the EP Guidelines based on:
- Best practices
- Lessons learned
- Planning considerations for EIDs due to the COVID-19 Public Health Emergency.

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 EIDs 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.
- 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.

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

ELEMENTS OF THE EP PROGRAM REQUIRED BY CMS

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Standard (a) Emergency Plan

The hospice must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years. The plan must:

- Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
- Include strategies for addressing emergency events identified by the risk assessment that would affect the agency’s ability to provide care.
- 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.
- 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.

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.

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.

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

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.
• Hospices 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 a hospice 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.

Cooperation and Collaboration:
• The hospice 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.
• Hospices 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.

Standard (b) Policies and Procedures
The hospice 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, if 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.*

• 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.

Hospices must develop policies and procedures:
• That address the use of hospice employees in an emergency and the hospices’ potential surge needs; hospices should consider their roles during a natural disaster and EID 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 in an 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, if there is an interruption in services during or due to an emergency.

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.

Patient and Staff Communication in EP
(b)(2) Procedures to inform State and local officials about homebound 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.
• These policies and procedures must address when and how this information is communicated to emergency officials and 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 comply 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.
• The hospice 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?
• Hospices should also account for contingency planning in the event that staff are unaccounted for and how this relates to providing patient care.
• A hospice’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.
• The hospice must have a system of medical documentation that preserves patient information, protects confidentiality and secures and maintains availability of records.
• The use of volunteers or other emergency staffing strategies including th process and role for integration of State or Federally designated healthcare professionals.
• Arrangements with other facilities to receive patients in the event the agency is unable to maintain continuity of services.

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. Hospices 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.

Standard (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:
Names and contact information for the following:
  (i) Hospice Employees
  (ii) Entities providing services under arrangement
  (iii) Patients’ physicians
  (iv) Other Hospices

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.
Primary and alternate means for communicating with the following:
(i) Agency Staff
(ii) Federal, State, tribal, regional, and local emergency management agencies.

- 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.

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

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.

Hospices 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.

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.

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.

**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

**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.

**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.
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.

- 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.

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.
- 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.

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.

(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:
(A) A second full-scale exercise that is community-based or facility-based functional exercise; or
(B) A mock disaster drill; or
(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.

(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.

ASSESSMENTS AND DOCUMENTATION
All providers and suppliers must continue to analyze their facility's response to and maintain documentation of all drills, table-top exercises, and activation of their emergency plan. This would include documentation showing any revisions to the facility's emergency plan as a result of the after-action review process.

EXEMPTION GUIDANCE
The updated guidance only applies if a facility is still currently operating under its activated emergency plan or reactivated its emergency plan for COVID-19 in 2021 or 2022. Facilities which have resumed normal operating status (not under their activated emergency plans) are required to conduct their testing exercises based on the regulatory requirements for their specific provider or supplier type. This guidance provides clarifications on testing exemptions for those providers/suppliers who continue to operate under their activated emergency plan and those which may have reactivated their emergency plans for COVID-19.

This guidance will also apply for any subsequent 12-month cycles in the future, in the event facilities continue to operate under their activated emergency plans for COVID-19 response activities.

EXEMPTION GUIDANCE – HOME-BASED HOSPICES
If the facility claimed the full-scale exercise exemption in 2020 based on its activated emergency plan for COVID-19 response and has since resumed normal operating status, the outpatient provider/supplier is expected to complete its required full-scale exercise in 2022, unless it has reactivated its emergency plan for an actual emergency during its 12-month cycle for 2022. If the facility claimed the full-scale exercise exemption in 2021 based on its activated emergency plan for COVID-19 response and has since resumed normal operating status, the outpatient provider/supplier is expected to complete its required full-scale exercise in 2024.

EP TESTING AND EXEMPTION GUIDANCE
Requirement & Guidance: All 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 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 based on the facility’s 12-month exercise cycle. The cycle is determined by the facility (e.g. calendar, fiscal or another 12-month timeframe). 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 12-month cycle.

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.

2 categories of Testing Exercises:

1) REQUIRED EXERCISES: Full-scale functional and individual facility-based exercises
2) EXERCISES OF CHOICE: Mock disaster drills, table-top exercises, or workshops (may also include the full-scale functional and individual facility-based exercises.

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

Functional Exercises (FES) are designed to validate and evaluate capabilities, multiple functions and/or sub-functions, or interdependent groups of functions. FEs are typically focused on exercising plans, policies, procedures, and staff members involved in management, direction, command, and control functions" as defined by DHS’s Homeland Security Exercise and Evaluation Program (HSEEP).

Mock Disaster Drill (Exercise of Choice Only) A drill is a coordinated, supervised activity usually employed to validate a specific function or capability in a single agency or organization. Drills are commonly used to provide training on new equipment, validate procedures, or practice and maintain current skills. For example, drills may be appropriate for establishing a community-designated disaster-receiving center or shelter. Drills can also be used to determine if plans can be executed as designed, to assess whether more training is required, or to reinforce best practices. A drill is useful as a stand-alone tool, but a series of drills can be used to prepare several organizations to collaborate in an FSE.
Table-Top Exercise (TTX) (Exercise of Choice Only)
A table-top exercise involves key personnel discussing simulated scenarios in an informal setting. TTXs can be used to assess plans, policies, and procedures. A table-top exercise is a discussion-based exercise that involves senior staff, elected or appointed officials, and other key decision-making personnel in a group discussion centered on a hypothetical scenario. TTXs can be used to assess plans, policies, and procedures without deploying resources.

Workshop (Exercise of Choice Only)
A workshop, for the purposes of this guidance, is a planning meeting/workshop, which establishes the strategy and structure for an exercise program as defined in HSEEP guidelines.

Changes Specific to Exercise Requirements for Outpatient/Home-Based Hospices (Freestanding)
These providers must continue to test their program annually, by participating in a community-based full-scale exercise (if available) or conduct an individual facility-based functional exercise every other year. In the opposite years off the full-scale exercise, the providers are required to conduct a testing exercise of their choice, which may include either a community-based full-scale exercise (if available), an individual, facility-based functional exercise, a drill, or a table-top exercise or workshop that includes a group discussion led by a facilitator.

Testing Scenarios Freestanding/Home-based Hospices (Outpatient)

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.
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.
Testing Scenario # 4  
(Updated Guidance 05/26/22)

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. However, since the facility is continuing to operate under its activated emergency plan in early 2022, the facility is exempt from the full-scale exercise in June 2022.

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**Standard (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 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.

4. Include a unified and integrated emergency plan that meets the requirements. 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.
Survey Steps for Determining Use of Exemption Clause:

- Determine the facility's annual cycle.
- For outpatient providers, ensure the facility has conducted one full-scale/full-functional exercise within the 12-month period followed by an exercise of choice on opposite years, dependent on the scenarios above.
- Ask the facility to describe the exemption to ensure understanding that exemption is based on the scheduled next-required full-scale exercise, not the exercise of choice.
- Verify documentation evidence that the facility activated its emergency plan (in order to determine whether the testing exemption is acceptable for use). Documentation may include, but is not limited to, the following:
  - Notice of activation to staff via electronic systems (alerts);
  - Proof of patient transfers and changes in daily operations based on the emergency
  - Initiation of additional safety protocols, for example, mandate for use of personal protective equipment (PPE) for staff, visitors and patients as applicable
  - Coordination with state and local emergency officials
  - Minutes of board/facility meetings
  - 1135 Waiver (individual or use of blanket flexibilities); or,
  - Incident command system related reports, such as situation reports or incident action plans.
- Determine, based on the above examples, whether the facility is compliant with the exemption clause and has conducted the appropriate required exercises.
- Determine the facility's annual cycle.
- For inpatient providers, ensure the facility has conducted two required exercises within the 12-month period, dependent on the scenarios above. Since the COVID-19 PHE is ongoing (over a 12-month period), CMS is clarifying that the inpatient provider/supplier is exempt from the 2021 and 2022 full-scale exercises so long as it is still currently operating under an activated emergency plan or has reactivated its plan at the onset of its 12-month cycle period (exercise cycle).
- Ask the facility to describe the exemption to ensure understanding that exemption is based on the scheduled next-required full-scale exercise, not the exercise of choice.
- Verify documentation evidence that the facility activated its emergency plan in order to determine whether the testing exemption is acceptable for use. Documentation may include, but is not limited to, the following:
  - Notice of activation to staff via electronic systems (alerts)
  - Proof of patient transfers and changes in daily operations based on the emergency
  - Initiation of additional safety protocols, for example, mandate for use of personal protective equipment (PPE) for staff, visitors and patients as applicable
  - Coordination with state and local emergency officials
  - Minutes of board/facility meetings
  - 1135 Waiver (individual or use of blanket flexibilities); or,
  - Incident command system related reports, such as situation reports or incident action plans.
- Determine based on the above examples, whether the facility is compliant with the exemption clause and has conducted the appropriate required exercises.
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.

References:

SOM Appendix M Guidance to Surveyors: Hospice

SOM - Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance