Introduction to Chapter 9: Emergency Management

The purpose of the HFAP Emergency Management standards is to establish emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters. Hospitals must coordinate compliance with these standards with other regulatory agency requirements that the hospital is required to follow. The Emergency Management standards in this chapter become effective November 16, 2017.

HFAP believes it is important for hospitals to consider mitigation, recovery, and business continuity while planning for emergencies, but the scope and focus of the Emergency Management standards is the continuity of operations during and immediately after the emergency.

The Emergency Management program (also known as the Emergency Preparedness Program) consists of many different plans, components, and programs. Some of these components are required to be shared with the hospital’s community emergency response agency, such as:

- The Hazard Vulnerability Analysis
- The Emergency Operations Plan (EOP)
- The Evacuation Plan

While HFAP understands that some community emergency response agencies may not approve these plans for fear of liability, it is the responsibility of the hospital to document their attempts to cooperate and collaborate with these authorities to ensure the respective plans were shared.


There are three key essential requirements for maintaining access to healthcare services during an emergency:

1. Safeguarding human resources;
2. Maintaining business operations;
3. Protecting physical resources.

There are four core elements that are central to a successful emergency preparedness program:

1. Risk Assessment and Emergency Planning:
   HFAP requires all facilities to perform a risk assessment that uses an all-hazards approach prior to establishing an Emergency Operations Plan (EOP). This risk assessment is often referred to as a Hazard Vulnerability Analysis (HVA).

2. Policies and Procedures:
   HFAP requires the facility to develop and implement policies and procedures that support the execution of the EOP. These policies and procedures may be part of the EOP, or they may be separate from the EOP. If they are separate from the EOP, they must be referenced in the EOP as to where they may be found.
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<td>3. <strong>Communication Plan:</strong></td>
<td>HFAP requires the facility to develop and maintain an emergency preparedness communication plan. The communication plan may be part of the EOP, or it may be separate from the EOP. If the communication plan is separate from the EOP, it must be referenced in the EOP as to where this may be found.</td>
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<td>4. <strong>Training and Testing:</strong></td>
<td>HFAP requires the facility to develop and maintain an emergency preparedness training and testing program. All staff must be trained as to their role in the event of an emergency, and this training must be conducted annually and documented. The facility must conduct drills or exercises to test the EOP to identify gaps and areas for improvement.</td>
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**Clarifications and Definitions:**

**Emergency (or disaster):**
An event that can affect the facility internally as well as the overall target population or the community at large. Emergencies can be internal, man-made, or natural events, and can be small or large events.

**All-hazards Approach:**
An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. An all-hazards approach to emergency planning does not exclude or limit a response to any specific type of an emergency event.

**Risk Assessment:**
The risk assessment is conducted prior to the establishment of the EOP and identifies the essential components to be integrated into the EOP. This approach is specific to the location of the provider and considers the particular type of hazard most likely to occur in their areas. These may include, but are not limited to, care-related emergencies; equipment and power failures; interruptions in communications, including cyber-attacks; loss of a portion or all of a facility; and, interruptions in the normal supply of essentials, such as water and food. This ‘all-hazards’ approach to a risk assessment is often referred to as a Hazard Vulnerability Analysis.

**Emergency Preparedness Program:**
The emergency preparedness program is the over-all program of emergency management. Whether it is called emergency preparedness or emergency management, it encompasses all activities to provide a successful program for emergency preparedness.

**Emergency Operations Plan (EOP):**
Whether it is called the Emergency Operations Plan, the Emergency Response Plan, the Emergency Management Plan, or simply the Plan, it must include key elements of emergency planning. The plan is part of the overall emergency preparedness program, and is required to be based on the top risks determined by the risk assessment.
assessment (i.e. HVA), and updated annually.

At-Risk Persons:
At-risk individuals are people with access and functional limitations that may interfere with their ability to access or receive medical care before, during, or after a disaster or emergency. The 2013 Pandemic and All-Hazards Preparedness Reauthorization Act defines at-risk individuals as children, older adults, pregnant women, and individuals who may need additional response assistance. Examples of these populations may include but are not limited to individuals with disabilities, individuals from diverse cultures, individuals who have limited English proficiency or are non-English speaking, individuals who are transportation disadvantaged, individuals who have chronic medical disorders, and individuals who have pharmacological dependency.

Staff:
The term ‘staff’ includes employees, individuals providing services under arrangement (contract), volunteers, students, chaplains, and physicians. Guests, visitors, sales representatives, and service contractors who are supervised are not considered ‘staff’.

Application:
The requirements established by this chapter apply to all facilities owned, rented, leased or used by the hospital that provides patient care and treatment services. This applies regardless of the NFPA “occupancy” designation of the facility. A hospital may have off-site facilities that are only used as physician exam offices, but all the requirements of this chapter must apply. For the purpose of clarification, the most common NFPA occupancies used in healthcare are explained:

Definition of Healthcare Occupancy:
An occupancy used to provide medical or other treatment or care simultaneously to four (4) or more patients on an inpatient basis, where such patients are mostly incapable of self-preservation due to age, physical or mental disability, or because of security measures not under the occupants’ control.

The health care facilities regulated by this occupancy chapter are those that provide sleeping accommodations for their occupants and are occupied by persons who are mostly incapable of self-preservation because of age, because of physical or mental disability, or because of security measures not under the occupants’ control.

Examples of Healthcare Occupancies:
- Hospitals
- Psychiatric hospitals
- Specialty hospitals
- Inpatient hospices
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**Definition of Ambulatory Health Care Occupancy:**

An occupancy used to provide services or treatment simultaneously to four (4) or more patients that provides, on an outpatient basis, one or more of the following:

1. Treatment for patients that renders the patient incapable of taking action for self-preservation under emergency conditions without the assistance of others;
2. Anesthesia that renders the patient incapable of taking action for self-preservation under emergency conditions without the assistance of others;
3. Emergency or urgent care for patients who, due to the nature of their injury or illness, are incapable of taking action for self-preservation under emergency conditions without the assistance of others.

Examples of Ambulatory Health Care Occupancies include:

- Physical rehab outpatient centers
- Ambulatory surgical centers
- Diagnostic centers

**Definition of Business Occupancy:**

An occupancy used for the transaction of business other than mercantile.

Examples of Business Occupancies include:

- Administrative offices
- Physician’s offices
- Support service centers (i.e. maintenance, laundry, sterile processing, boiler rooms, etc.)

For simplification purposes, this chapter will use the term ‘hospital’ and refer to all occupancies that are included within the facility that houses the healthcare occupancy, or at off-site locations.
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### Planning:

**09.00.01 Condition of Participation: Emergency Preparedness.**

The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements.

The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this chapter, utilizing an all-hazards approach.

Emergency preparedness requirements focus on continuity of operations, not recovery of operations, hazard mitigation, or business continuity. Facilities may choose to include planning for recovery of operations, hazard mitigation, and business continuity in their emergency preparedness plan, but these items are not a requirement.

§482.15

**09.00.02 Hazard Vulnerability Analysis (HVA).**

The hospital conducts a risk assessment (i.e. Hazard Vulnerability Analysis) to ascertain conceivable threats and disasters that could affect the ability to operate the facilities of the organization, or to provide services to their patients, and the probability of those events occurring.

Prior to establishing an Emergency Operations Plan, the hospital must perform a risk assessment (i.e. Hazard Vulnerability Assessment) based on using an all-hazards approach. All-hazards planning does not specifically address every possible threat but ensures hospitals will have the capacity to address a broad range of related emergencies.

The hospital may choose to create a single Hazard Vulnerability Analysis (HVA) that applies to all of the sites of the hospital, or an individual Hazard Vulnerability Analysis (HVA) for each of their locations.

The hospital may rely on a community-based assessment (i.e. HVA) developed by other entities, such as their public health agencies, emergency

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| 09.00.01           | The hospital must have an emergency preparedness program that includes: Planning, Procedures, Communication, Training & Testing | **DOCUMENT REVIEW AND INTERVIEW**
• Does the hospital have an emergency preparedness program that includes the four (4) key elements described? | □ 1 = Compliant  □ 2 = Not Compliant |

**COMMENTS:**

| 09.00.02           | Prior to establishing an Emergency Operations Plan, the hospital must perform a risk assessment (i.e. Hazard Vulnerability Assessment) based on using an all-hazards approach. All-hazards planning does not specifically address every possible threat but ensures hospitals will have the capacity to address a broad range of related emergencies. The hospital may choose to create a single Hazard Vulnerability Analysis (HVA) that applies to all of the sites of the hospital, or an individual Hazard Vulnerability Analysis (HVA) for each of their locations. The hospital may rely on a community-based assessment (i.e. HVA) developed by other entities, such as their public health agencies, emergency | **DOCUMENT REVIEW AND INTERVIEW**
• Verify that the Hazard Vulnerability Analysis (HVA) is reviewed by the organization and updated annually by the emergency management oversight committee.
• Confirm that the hospital has shared or attempted to share their HVA with one or more community partners. | □ 1 = Compliant  □ 2 = Not Compliant |

**COMMENTS:**
service area (e.g., natural disaster, bioterrorism threats, disruption of utilities such as water, sewer, electrical communications, fuel, nuclear accidents, industrial accidents, and other likely mass casualties, etc.) and develop appropriate responses that will assure that safety and wellbeing of patients.

The Hazard Vulnerability Analysis (HVA) is documented and reviewed by the oversight committee on emergency management for relevancy and accuracy on an annual basis.

All facilities where patient care and treatment is provided are required to have an assessment conducted for hazards, including facilities which the hospital may not own but where they provide treatment for their patients. Some remote locations may have different hazards and therefore a separate Hazard Vulnerability Analysis (HVA) would be appropriate.

Hospitals must prioritize the potential hazards to their organization, and these priorities are documented in the Hazard Vulnerability Analysis (HVA). The hospital shares their HVA with their community partners to help set priorities with the Hazard Vulnerability Analysis (HVA).

Community partners may include:
- The department of public health
- The department of public safety
- The department of public works
- Local municipality representatives
- Other government agencies
- Community organizations
- Vendors
- Other health care organizations

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<td>§482.15(a) §482.15(a)(1)</td>
<td>management agencies, and regional healthcare coalitions or in conjunction with conducting its own facility-based assessment. It is expected that the hospital will have a copy of this risk assessment and to work with that entity that developed it to ensure that the hospital emergency plan is in alignment.</td>
<td>§482.15(a)</td>
<td>2018</td>
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The all-hazards risk assessment (HVA) must be consistent with the concepts outlined in the National Preparedness Systems, published by the US Department of Homeland Security, as well as guidance by the Agency for Healthcare Research and Quality (AHRQ).

When meeting the requirements for the all-hazards risk assessment (HVA), hospitals must consider the following:
1. Identification of all business functions essential to the hospitals’ operations that should be considered during an emergency;
2. Identification of all risks or emergencies that the hospital may reasonably expect to confront;
3. Identification of all contingencies for which the hospital should plan;
4. Consideration of the hospital’s location, including all locations where the hospital delivers patient care or services, or has business operations;
5. Assessment of the extent to which natural or man-made emergencies may cause the hospital to cease or limit operations;
6. Determination of what arrangements with other hospitals, other healthcare providers or suppliers, or other entities might be needed to ensure that essential services could be provided during an emergency.
### Standard / Element: 09.00.03 Emergency Operations Plan

A written Emergency Operations Plan (EOP) is developed, maintained, and available to the staff for crisis preparation and response.

**The Emergency Operations Plan must be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.**

The EOP is based on the priorities established in the annual Hazard Vulnerability Analysis (HVA). The EOP is reviewed with the community’s emergency response agencies to synchronize responses to common emergency events.

The EOP is reviewed on an annual basis by the emergency management oversight committee to ensure relevancy and accuracy. Adjustments are documented and changes made based on lessons learned during actual emergency events and during planned exercises.

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<td>§482.15(a)(1); §482.15(a)(2)</td>
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Emergency preparedness is necessary to ready the hospital for possible and probable emergency events that may affect the patient care processes and normal hospital operations.

There shall be a written Emergency Operations Plan (EOP) and associated procedures for possible situations to be followed by each department and/or service within the hospital and for each building utilized for patient treatment and/or housing. The organization may choose to have one EOP that is inclusive for all their facilities where patients are treated and housed, or they may choose to have individual EOPs for each location.

The hospital uses its annual Hazard Vulnerability Analysis (HVA) as a foundation for the Emergency Operations Plan to determine the strategies and activities designed to reduce the risk associated with emergency events. The hospital shares the details of the EOP with the community’s emergency response agencies. The hospital assesses the community’s abilities to meet the needs of the hospital during an emergency event. This involvement with the community and the assessment of the community’s abilities is documented.

The Emergency Operations Plan must be integrated into the facility-wide Quality Assurance Performance Improvement (QAPI) plan.

Refer to NFPA 99 (2012 edition), *Health Care Facilities*
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| **09.00.04 Patient Population.** | When creating the EOP, emergency response considerations should be given to at-risk populations within the hospital, which include individuals with disabilities, are from diverse cultures, have limited English proficiency or are non-English speaking, lack transportation, have chronic medical disorders, or have pharmacological dependency. ‘At-risk’ individuals also mean children, pregnant women, senior-citizens, and other individuals who have special needs in the event of an emergency. | DOCUMENT REVIEW AND INTERVIEW  
- Review the Emergency Operations Plan to determine its applicability with the patient population.  
- Does the EOP identify the at-risk patients that the hospital has?  
- Does the EOP provide for the influx of patients during an emergency? | |
| §482.15(a)(3) | The EOP includes a plan for the influx or a surge of patients, and must be reviewed by the community’s emergency response agency. | | |
| **09.00.05 Services.** | When creating the EOP, the type of services that the hospital has the ability to provide during an emergency must be identified and addressed. The EOP includes a plan for the continuation of these services during the facility’s response to the emergency event. | DOCUMENT REVIEW AND INTERVIEW  
- Review the Emergency Operations Plan to determine it identifies the type of services that the hospital has the ability to provide during an emergency.  
- Does the EOP address how the hospital plans to continue to provide these services during an emergency? | |
| §482.15(a)(3) | | | |
**EMERGENCY MANAGEMENT**

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| **09.00.06  Continuity of Operations.** The Emergency Operations Plan (EOP) must address the continuity of operations, including delegations of authority and succession plans. §482.15(a)(3) | When creating the EOP, considerations should be provided on:  
- how the hospital will continue to operate the facility during the emergency event, and  
- who is delegated as the authority during the emergency event and  
- how the succession of that authority is provided. |  
- Review the Emergency Operations Plan to determine it provides for the continuity of operations.  
- Does the EOP address the delegation of authority during the emergency event, and the succession of that authority? |   |
| **09.00.07  Collaboration.** The Emergency Operations Plan (EOP) must include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the hospital’s efforts to contact such officials. | When creating the EOP, considerations should be provided on how the hospital will cooperate with the authorities during the planning process regarding emergency management, in order to maintain an integrated response during the emergency. The EOP must provide a process on how the hospital will document all efforts to communicate with the authorities they are required to collaborate with during the planning process. |  
- Review the Emergency Operations Plan to determine it provides for the collaboration with the authorities they are required to cooperate with during the planning process for emergency management.  
- Does the EOP address how the hospital will document their efforts to communicate with the authorities? |   |
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<td>officials and, when applicable, its participation in collaborative and cooperative planning efforts.</td>
<td>Planning with officials in advance of an emergency to determine how such collaborative and cooperative efforts would achieve and foster a smoother, more effective, and more efficient response in the event of a disaster.</td>
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<td>§482.15(a)(4)</td>
<td>Hospitals must document efforts made by the facility to cooperate and collaborate with emergency preparedness officials.</td>
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Procedures:

09.01.01 Policies & Procedures.
The hospital must develop and implement emergency preparedness policies and procedures. These policies and procedures must be based on the Emergency Operations Plan (EOP), the Hazard Vulnerability Analysis, and the Communication plan.

These Policies & Procedures must be reviewed and updated annually by the Emergency Management oversight committee.

§482.15(b)

The format of the EOP and the Policies & Procedures that a facility uses are at their discretion. HFAP does not prescribe or specify how these documents appear or whether the EOP includes the content of the Policies & Procedures, or they are separate documents. However, the facility must include all of the requirements for the EOP and all of the requirements for the Policies & Procedures.

If the Policies & Procedures are not included in the EOP, then they must be referenced in the EOP as to where they may be located.

09.01.02 Nutritional Services.
The Policy & Procedure for food, water and nutritional services must address the provision of subsistence needs for staff and patients whether they evacuate or shelter in place.

These Policies & Procedures must be reviewed and updated annually by the Emergency Management oversight committee.

§482.15(b)(1)(i)

The Policy & Procedure for Nutritional Services describes the strategies for ensuring nutritional needs are met during situations in which hospital services or utilities are disrupted.

The Policy & Procedure outlines methods for meeting the nutritional needs of patients, visitors, and staff while sheltered in place, or evacuated to other locations. During an emergency event, the facility may experience a disruption in one or multiple services, such as:

1. Loss of water, gas, fuel, or electricity;
2. Equipment failure, e.g., dishwashing machines, pumps, refrigeration, cooking
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<td>appliances;</td>
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<td>3. Disruption with the delivery and grocery and food preparation items.</td>
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The Policy & Procedure for Nutritional Services anticipates the possible disruptions and prepares strategies, in advance, for ensuring continuity of services, including:
1. Alternative methods for heating foods and water used for cooking.
2. A disruption with delivery of food products.

The hospital has written agreements with food suppliers for priority grocery delivery. The written agreements are updated on an annual basis.

The hospital calculates the volume of food, drinking water, paper products, and utensils needed to feed the patients, staff, and visitors for at least three (3) days. The hospital stores a 3-day inventory of:
1. Fresh and frozen foods
2. Dairy products
3. Drinking water
4. Paper products
5. Special dietary requirements, e.g., diabetic, Kosher, and vegetarian diets

- Review Policies & Procedures to ensure they have been reviewed and updated annually.
During an emergency event, the availability of medical supplies, pharmaceutical supplies, and general equipment needed at the beginning of the event is critical for an effective response.

The hospital’s Policy & Procedure for medical supplies, pharmaceutical supplies, and general equipment must meet the needs of staff and patients while sheltered in place.

The Office of the Assistant Secretary for Preparedness and Response (ASPR) states that organizations should be prepared to “stand on their own” for at least 72 hours before an organized Federal response can effectively relieve the situation. That benchmark must be considered when identifying the medical supplies, pharmaceutical supplies, or general equipment that are required whether sheltered in place or evacuated to other locations.

The amount and type of emergency supplies and equipment is left to the individual facility to determine but must be based on the reality of their EOP.

Emergency supplies and equipment must be maintained to ensure an acceptable response at the beginning of an event. This would require the supplies and equipment are stored in such a manner to ensure their safety (protection against theft or damage, contamination, or deterioration) and availability when needed.

The hospital identifies in writing the medical supplies, pharmaceutical supplies, and general equipment in inventory and stored for the first response phase of an emergency. The organization has reviewed and updated the inventory of emergency response supplies on a semi-annual basis. Review the Policy & Procedures to ensure it provides for the supplies and equipment needed in the initial phase of an emergency event. Has the hospital made adequate provisions to ensure the availability of those supplies and equipment when needed? Review Policies & Procedures to ensure they have been reviewed and updated annually.

DOCUMENT REVIEW AND INTERVIEW
- Interview the person in charge of Emergency Management and determine if there are medical supplies, pharmaceutical supplies and general equipment inventoried and stored for the first response phase of an emergency.
- Determine if the organization has reviewed and updated the inventory of emergency response supplies on a semi-annual basis.
- Review the Policy & Procedures to ensure it provides for the supplies and equipment needed in the initial phase of an emergency event.
- Has the hospital made adequate provisions to ensure the availability of those supplies and equipment when needed?
- Review Policies & Procedures to ensure they have been reviewed and updated annually.

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| pharmaceutical supplies, and general equipment it will need to potentially meet the needs of patients in an emergency situation. The hospital makes provisions to ensure the availability of those supplies when needed. The hospital must have a plan to protect these limited emergency supplies and must have a plan for prioritizing their use until replacement supplies are available. The plan must also address the events of a disruption in the supply chain for these emergency utilities, such as a disaster involving the entire surrounding community. Once patients have been evacuated to other facilities, it would be the responsibility of the receiving facility to provide for the patient’s subsistence needs. This standard does not require the facility to be responsible for subsistence needs of individuals in the community. The provision of subsistence needs only applies to staff and patients.

09.01.04 Utilities. The Policy & Procedure for alternate sources of energy must address the provision of subsistence needs for staff and patients whether they evacuate or shelter in place. The alternate sources of energy must maintain:

- emergency power;
- fuel for generators and boilers;
- medical air, gas and vacuum;
- sewage and waste disposal.

The hospital must ensure the continuation of operation of strategic utilities during an emergency event, including:

- emergency power;
- fuel for generators and boilers;
- medical air, gas and vacuum;
- sewage and waste disposal.

The hospital needs to document what areas of the hospital must ensure the continuation of operation of strategic utilities during an emergency event, including:

- emergency power;
- fuel for generators and boilers;
- medical air, gas and vacuum;
- sewage and waste disposal.

- Verify written policies and procedures are in place regarding the provision for alternate sources of emergency to maintain temperature; emergency lighting; fire detection; fire extinguishing; fire alarm systems; and sewage and waste disposal.

- Verify that the utility supplies for emergency

1 = Compliant
2 = Not Compliant

COMMENTS:
• 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 dis­pos­i­tion.

The Pol­i­cy & Pro­ce­dure for al­ter­na­tive sources of ener­gy pro­vides for the con­tin­u­a­tion of util­i­ties such as emer­gency power, fuel, med­i­cal air, gas, and vac­uum, dur­ing an emer­gency event.

These Pol­i­cies & Pro­ce­dures must be re­viewed and up­date­d an­nu­al­ly by the Emer­gency Man­age­ment over­sight com­mit­tee.

§482.15(b)(1)(ii)(A)
§482.15(b)(1)(ii)(B)
§482.15(b)(1)(ii)(C)
§482.15(b)(1)(ii)(D)

The hospital shall de­term­ine the quan­ti­ty of fuel sup­ply to have on hand for the emer­gency gen­er­a­tors and boilers. This quan­ti­ty is based on the cir­cum­stances of the hos­pi­tal and the avail­a­bil­ity of re­place­ment fuel.

At a mini­mu­m, the quan­ti­ty of fuel main­tained for the emer­gency gen­er­a­tors must be at least a 26-hour sup­ply, as re­quired by NFPA 72 (2010), for the fire alarm sys­tem. For in­stalla­tions in sei­smic areas,
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<tbody>
<tr>
<td>2018 Healthcare Facilities Accreditation Program (HFAP) Accreditation Requirements for Acute Care Hospitals</td>
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Whatever quantity of fuel is maintained, consideration must be given to its capability to replenish the fuel supply before it is exhausted. The hospital shall maintain documentation of its fuel supply needs and its procedures for fuel replenishment in times of emergency. If the hospital uses the same fuel supply for multiple uses (heating, hot water, generator, etc.) the hospital must maintain fuel supplies to address its total needs and to address periods where re-supply may be limited (i.e., snow, flooding, transportation disruption, etc.).

Hospitals must develop policies and procedures to address the provisions of sewage and waste disposal including solid waste, recyclables, chemical, biomedical waste, and waste water. Facilities must identify and assess their sewage and wastewater disposal systems as part of their facility-based risk assessment and make necessary plans to maintain these services. This standard does not require the onsite treatment of sewage but the facility must make provisions for maintaining necessary services.
### 09.01.05 Patient & Staff Tracking

**The Policies & Procedures must address a system to track the location of on-duty staff and sheltered patients in the hospital’s care during an emergency.** If on-duty staff and sheltered patients are relocated during an emergency, the hospital must document the specific name and location of the receiving facility or other location.

These Policies & Procedures must be reviewed and updated annually by the Emergency Management oversight committee.

§482.15(b)(2)

**The Policies & Procedures must address** the safe evacuation from the hospital, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

The Policies & Procedures provide for a written Emergency Evacuation Plan which identifies when and how the patients will be evacuated from the hospital.

**The evacuation plan may be part of the Emergency Operations Plan (EOP) or it may be separate. If separate, the EOP must reference where to find the evacuation plan.**

Hospitals must consider multiple transportation options for patient evacuation, and collaborate with healthcare coalitions to better inform and assist in planning activities for the efficient and effective use of limited resources.

A written Emergency Evacuation Plan must be created which identifies when and how the hospital will evacuate patients from the hospital when it is no longer safe to provide patient care and treatment.

**Document Review and Interview**
- Verify written policies and procedures are in place regarding the tracking of on-duty staff and sheltered patients in the hospital’s care during an emergency.
- Review Policies & Procedures to ensure they have been reviewed and updated annually.

**COMMENTS:**

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<tr>
<td>09.01.05</td>
<td>Hospitals must have policies and procedures in place regarding a system to track the location of staff and patients in the hospital’s care during an emergency. Tracking patients after an emergency is not a requirement of this standard.</td>
<td>- Verify written policies and procedures are in place regarding the tracking of on-duty staff and sheltered patients in the hospital’s care during an emergency. - Review Policies &amp; Procedures to ensure they have been reviewed and updated annually.</td>
<td>1 = Compliant 2 = Not Compliant</td>
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<tr>
<td>09.01.06</td>
<td>Hospitals must consider multiple transportation options for patient evacuation, and collaborate with healthcare coalitions to better inform and assist in planning activities for the efficient and effective use of limited resources. A written Emergency Evacuation Plan must be created which identifies when and how the hospital will evacuate patients from the hospital when it is no longer safe to provide patient care and treatment.</td>
<td>- Review the Policies &amp; Procedures to determine if it provides for the Emergency Evacuation Plan. - Review documentation from the local authorities to determine if the Emergency Evacuation Plan was reviewed by the local community emergency response agency. - Verify that the Policies &amp; Procedures considered multiple transportation options for patient evacuation needs. - Review Policies &amp; Procedures to ensure they</td>
<td>1 = Compliant 2 = Not Compliant</td>
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facility. The Emergency Evacuation Plan is reviewed by the community emergency response agency. These Policies & Procedures must be reviewed and updated annually by the Emergency Management oversight committee.

§482.15(b)(3)

09.01.07 Shelter in Place. The Policies & Procedures must address the means to shelter in place for patients, staff, and volunteers who remain in the facility during an emergency event. These Policies & Procedures must be reviewed and updated annually by the Emergency Management oversight committee.

§482.15(b)(4)

The hospital must have Policies & Procedures in place that addresses a means to shelter in place for patients, staff and volunteers who remain in the facility during an emergency event. The policy must include criteria for selecting patients and staff that would be sheltered in place and a description of how they would ensure their safety. Hospitals must make plans to shelter all patients in the event that an evacuation cannot be executed.

- **DOCUMENT REVIEW AND INTERVIEW**
  - Review the Policies & Procedures to verify that they address a means to provide shelter for patients, staff and volunteers who remain in the facility during an emergency.
  - Review Policies & Procedures to ensure they have been reviewed and updated annually.

1 = Compliant
2 = Not Compliant

COMMENTS:
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<tr>
<td><strong>09.01.08 Medical Documentation.</strong></td>
<td>The Policies &amp; Procedures must address a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.</td>
<td><strong>DOCUMENT REVIEW AND INTERVIEW</strong></td>
<td>1 = Compliant 2 = Not Compliant</td>
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<td></td>
<td>§482.15(b)(5)</td>
<td>- Review the Policies &amp; Procedures to verify that they address a system of medical documentation to be used in the event of an emergency.</td>
<td>COMMENTS:</td>
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<tr>
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<td></td>
<td>- Verify that the medical documentation system preserves patient information and protects the confidentiality of patient information.</td>
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<td></td>
<td>- Are the patient medical records available during the emergency event?</td>
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<td>- Review Policies &amp; Procedures to ensure they have been reviewed and updated annually.</td>
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<tr>
<td><strong>09.01.09 Volunteers.</strong></td>
<td>The Policies &amp; Procedures must address the use of volunteers in an emergency, and must address other emergency staffing strategies, including the process and role for integration of State and Federally designated healthcare professionals to address surge needs during an emergency.</td>
<td><strong>DOCUMENT REVIEW AND INTERVIEW</strong></td>
<td>1 = Compliant 2 = Not Compliant</td>
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<td>- Review the Policies &amp; Procedures to determine if it includes a volunteer management program.</td>
<td>COMMENTS:</td>
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<td>- Review Policies &amp; Procedures to ensure they have been reviewed and updated annually.</td>
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</table>
**Standard / Element** | **Explanation** | **Scoring Procedure**
--- | --- | ---
These Policies & Procedures must be reviewed and updated annually by the Emergency Management oversight committee. | Federal, local or state-based systems shall be utilized to verify the identity and credentials of health professionals, when possible. | DOCUMENT REVIEW AND INTERVIEW
- Review the Policies & Procedures to determine if it identifies the local hospitals with whom they have transfer agreements.
- Verify that the transfer agreements are completed and signed by representatives from each organization.
- Review Policies & Procedures to ensure they have been reviewed and updated annually.

§482.15(b)(6)

$09.01.10$ **Continuity of Services.**
The Policies & Procedures must address the development of arrangements with other hospitals and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to patients.

These Policies & Procedures must be reviewed and updated annually by the Emergency Management oversight committee.

A transfer agreement must be signed with other hospitals in the region whereby patients may be expected to evacuate to or from.

The purpose of these transfer agreements is:
- to assist physicians and facilities in the treatment of trauma patients;
- to facilitate the timely transfer of patients and information necessary in the care and treatment of patients;
- the continuity of the care and treatment appropriate to the needs of the trauma patients; and
- the utilization of knowledge and other resources of both facilities in a coordinated manner to improve the professional health care of trauma patients.

§482.15(b)(7)
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<tr>
<td>09.01.11 Invoking the 1135 Waiver.</td>
<td>When the President of the United States declares a disaster and the HHS Secretary declares a public health emergency, the Secretary is authorized under section 1135 to take certain actions to waive or modify certain Medicare, Medicaid, or Children’s Health Insurance Program requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the Social Security Act programs in the emergency areas. These Policies &amp; Procedures must be reviewed and updated annually by the Emergency Management oversight committee. §482.15(b)(8)</td>
</tr>
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</table>

**DOCUMENT REVIEW AND INTERVIEW**
- Review the Policies & Procedures to determine if it includes the role the hospital has under an 1135 Waiver.
- Verify that the Policies & Procedures identify the alternate care site identified by the state or local emergency management officials.
- Review Policies & Procedures to ensure they have been reviewed and updated annually.

**SCORE**

1 = Compliant
2 = Not Compliant

**COMMENTS:**

This will allow hospitals who provide such services in good faith to be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).

Once an 1135 Waiver is authorized, health care providers can submit requests to operate under that authority or for other relief that may be possible outside the authority, to the CMS Regional Office with a copy to HFAP.

CMS has stated that they expect the state or local emergency management officials would designate alternate care sites, and would plan jointly with local facilities on issues related to staffing, equipment and supplies at such alternate sites.

This requirement encourages providers to collaborate with their local emergency officials in proactive planning to allow an organized and systematic response to assure continuity of care even when services at their facilities have been severely disrupted.
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| **09.01.12 Security.** | The Policies & Procedures must address a comprehensive process to provide for the security of the patients, staff and visitors during an emergency event. These Policies & Procedures must be reviewed and updated annually by the Emergency Management oversight committee. During an emergency event, patients, visitors and staff must be protected from threats concerning security. Policies, procedures and systems must be developed to monitor and reduce adverse outcomes. The organization identifies and implements a process on how supplemental security resources are obtained in the event of a disaster. The Policies & Procedures must address the following: 1. The differing needs of each location where the hospital operates; 2. The special needs of patient populations treated at the hospital (e.g., patients with psychiatric diagnoses, patients on special diets, newborns, etc.); 3. Security of patients and walk-in patients; 4. Security of supplies from misappropriation; 5. Identification of personnel that are needed to implement and carry out the hospital’s emergency plans. | DOCUMENT REVIEW AND INTERVIEW  
- Review the Policies & Procedures to verify that the hospital has developed and implemented a comprehensive plan to ensure that the security and wellbeing of patients are assured during emergency situations.  
- Review policies to determine how supplemental security forces are obtained in the event of a disaster.  
- Determine if policies, procedures and systems are in place to provide emergency security services.  
- Review Policies & Procedures to ensure they have been reviewed and updated annually. | □ 1 = Compliant  
□ 2 = Not Compliant | COMMENTS: |

| **09.01.13 Decontamination.** | The Policies & Procedures must address how the hospital arranges for the chemical, biological and radioactive decontamination. These Policies & Procedures must be reviewed and updated annually by the hospital. Decontamination procedures must be in place for internal and external accidents. The hospital designates teams to respond to emergency events and initiate the decontamination procedures. A plan describing the decontamination procedures can be integrated into a single plan or multiple plans. During an emergency, aspects of the physical | DOCUMENT REVIEW AND INTERVIEW  
- Review the Policies & Procedures to ensure decontamination activities are addressed.  
- Review Policies & Procedures to ensure they have been reviewed and updated annually. | □ 1 = Compliant  
□ 2 = Not Compliant | COMMENTS: |
### EMERGENCY MANAGEMENT

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<tr>
<td>Emergency Management oversight committee.</td>
<td>environment must contain, neutralize, or destroy potentially harmful materials and wastes.</td>
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<tr>
<td><strong>09.01.14 Incident Command Center.</strong></td>
<td>The procedures for the cleanup of spills and accidents must include the notification of the appropriate authorities based on the size and severity of the spill and hospital resources available.</td>
<td><strong>DOCUMENT REVIEW AND INTERVIEW</strong></td>
<td></td>
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<tr>
<td>The Policies &amp; Procedures must address the identification where the hospital's incident command center will be located.</td>
<td>There is a reference in the Policies &amp; Procedures to the location of the command center for directing and controlling hospital emergency response functions.</td>
<td>- Review the Policies &amp; Procedures to determine that the command center is identified.</td>
<td>1 = Compliant 2 = Not Compliant</td>
</tr>
<tr>
<td>The policies ensure essential equipment and support is intact and maintained for use in directing and controlling response and recovery operations.</td>
<td>The Policies &amp; Procedures also include or reference:</td>
<td>- Review the Policies &amp; Procedures to determine that the organization's command center setup process includes instructions for the Incident Command Center set-up and drawings.</td>
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<tr>
<td>The policy provides for a process for activation of the incident command center, and how it is operated.</td>
<td>- a layout diagram;</td>
<td>- Determine if a list of facility equipment and supplies meets the anticipated needs during an emergency.</td>
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<tr>
<td>These Policies &amp; Procedures must be reviewed and updated annually by the Emergency Management oversight committee.</td>
<td>- a list of facility equipment (e.g., telephones, displays, fax machines, computers), and</td>
<td>- Review Policies &amp; Procedures to ensure they have been reviewed and updated annually.</td>
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<td>- the source(s) of backup power (if available).</td>
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Communication:

09.02.01 Communication Plan.

The hospital must develop and maintain an emergency communication plan that complies with Federal, State, and local laws, and must be reviewed and updated annually.

The communication plan must include a tiered rapid process for alert and notification of staff in an emergency. This includes staff mobilization and communications call-back processes used at the beginning of an emergency event.

The communication plan provides for the dispensing of information by hospital designated spokespersons to the media.

§482.15(c)

The communication plan may be part of the EOP or it may be separate. If separate, the EOP must reference where to find the communication plan.

All hospital units and departments must have a process in place to initiate the call back of staff on each unit. Staff must be able to make external notifications and demonstrate the capability to share information with the incident commander and necessary external partners.

The communication plan must include a process for the notification of key personnel who are either at the hospital or away from the hospital whenever the Incident Command System is activated.

The staff call-back roster is dated and is updated at least semi-annually. NOTE: Real-time electronic tracking systems of current and former staff members are deemed to meet the requirement for semi-annual updates.

The communication plan identifies the location where the media will be briefed.

DOCUMENT REVIEW AND INTERVIEW

- Determine if the staff call-back roster has been updated semi-annually.
- Verify that the communication plan has been reviewed and updated on an annual basis.

COMMENTS:
### Contact Information

The communication plan must include the names and contact information for:

- **Staff**
- **Entities providing services under arrangement**
- **Patient’s physicians**
- **Other hospitals and CAHs**
- **Volunteers**
- **Federal, State, tribal, regional, and local emergency preparedness staff**
- **Other sources of assistance.**

§482.15(c)(1)(i)  
§482.15(c)(1)(ii)  
§482.15(c)(1)(iii)  
§482.15(c)(1)(iv)  
§482.15(c)(1)(v)  
§482.15(c)(2)(i)  
§482.15(c)(2)(ii)

#### Document Review and Interview

- Review the emergency communications plan to verify it contains the names and contact information of the individuals noted.

1 = Compliant  
2 = Not Compliant

**COMMENTS:**
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<tr>
<td><strong>09.02.03 Primary &amp; Alternate Means of Communication.</strong></td>
<td>Reliable communication must be maintained by the hospital during an emergency event. Backup technology must be considered and utilized with the consideration that traditional methods of communication may not be available. Alternative methods must be explored and planned for in the written procedure. Primary and alternate means of communication include:</td>
<td>• Review the emergency communications plan and determine that it meets the requirement for primary and alternate communication means with staff and outside agencies. [ ] 1 = Compliant [ ] 2 = Not Compliant</td>
<td>COMMENTS:</td>
</tr>
<tr>
<td>The communication plan must include primary and alternate means for communication with the following:</td>
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<tr>
<td>• The hospital’s staff</td>
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<td>• Federal, State, tribal, regional, and local emergency management agencies.</td>
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<td>§482.15(c)(3)</td>
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<tr>
<td>The communication plan provides for written procedures and methods on how the hospital communicates with staff and outside agencies that have a functional role with the hospital’s response and recovery phases during an emergency event.</td>
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<tr>
<td>09.02.04 Information Sharing.</td>
<td>The communication plan must include a method for sharing information and medical documentation for patients under the hospital’s care, as necessary, with other health care providers to maintain the continuity of care. Sharing patient information with other healthcare providers is critical during an emergency, especially when patient transfer and evacuation is conducted. The hospital must have a method that allows this sharing of information in a timely and efficient manner.</td>
<td><strong>DOCUMENT REVIEW AND INTERVIEW</strong>&lt;br&gt;- Review the emergency communications plan to determine it addresses the hospital’s plan on sharing patient information with other healthcare providers.</td>
<td>1 = Compliant 2 = Not Compliant</td>
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§482.15(c)(4)

| 09.02.05 Release of Information. | The communication plan must include a means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). The communication plan must include 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). | **DOCUMENT REVIEW AND INTERVIEW**<br>- Review the emergency communications plan to verify it includes the necessary means to provide patient information to family members, personal representative, or other individuals responsible for the care of the patient. | 1 = Compliant 2 = Not Compliant |

§482.15(c)(5)  §482.15(c)(6)

A covered entity may use or disclose protected health information to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location, general condition, or death. Any such use or disclosure of protected health information for such notification purposes must be in accordance with paragraphs (b)(2), (b)(3), (b)(4), or (b)(5) of section 45 CFR 164.510, as applicable.

A covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures permitted by paragraph (b)(1)(ii) of section 45 CFR 164.510. The requirements in paragraphs (b)(2), (b)(3), or (b)(5) of section 45 CFR 164.510 apply to such uses and disclosures to the extent that the covered entity, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.
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<tr>
<td>09.02.06 Hospital Information.</td>
<td>The communication plan must include a means of providing information about the hospital’s occupancy, needs, and its ability to provide assistance, to the authorities having jurisdiction, the Incident Command Center, or designee.</td>
<td><strong>DOCUMENT REVIEW AND INTERVIEW</strong> - Review the emergency communications plan to determine it addresses how it will communicate its abilities during an emergency to the appropriate authorities.</td>
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§482.15(c)(7) | Communicating critical information to the authorities having jurisdiction regarding the hospital during an emergency is vital to a well-organized response to an emergency. The hospital may have multiple authorities having jurisdiction they need to communicate their capabilities with during an emergency: Local, regional, tribal, and or State authorities. | | 1 = Compliant 2 = Not Compliant |
### Training and Testing:

### 09.03.01 Emergency Training

The hospital must develop and maintain a training program that is based on the Emergency Operations Plan (EOP), the Hazard Vulnerability Assessment (HVA), the Policies & Procedures, and the communication plan.

The training program must be reviewed and updated annually.

- A well organized, effective training program must include initial training for new and existing staff in emergency preparedness policies and procedures as well as annual refresher trainings.

- The facility must offer annual emergency preparedness training in which staff can demonstrate knowledge of emergency procedures. Facilities are expected to delineate responsibilities for all of their facility’s workers in their EOP and to determine the appropriate level of training for each professional role.

- The training program may be part of the EOP or it may be separate. If separate, the EOP must reference where to find the training program.

- The hospital must provide initial training in emergency preparedness policies and procedures to all new and existing staff, including individuals providing services under arrangement, volunteers, and physicians, consistent with their expected role.

- The hospital must provide emergency preparedness training to all staff at least annually. The hospital must maintain documentation of the training. The hospital must be able to demonstrate staff knowledge of emergency procedures.

### DOCUMENT REVIEW AND INTERVIEW

- Review the training program to ensure all staff are educated on the emergency preparedness program.

- Are staff being trained on an annual basis?

- Can the hospital demonstrate that all staff (including contract workers and physicians) have received training on emergency preparedness on an annual basis?

1 = Compliant  
2 = Not Compliant

### COMMENTS:
09.03.02 Emergency Exercises.
The hospital must develop and maintain a testing program (exercises) that is based on the Emergency Operations Plan (EOP), the Hazard Vulnerability Assessment (HVA), the Policies & Procedures, and the communication plan.

The testing program must be reviewed and updated annually.

Hospitals and free-standing ambulatory health care occupancy facilities that are part of the hospital system must participate in two (2) emergency exercises to test the EOP per calendar year.

Each exercise (disaster drill) is to be planned by the oversight committee on emergency management and implemented to build competencies in staff.

The hospital must analyze the hospital's response to and maintain documentation of all drills, and emergency events, and revise the hospital's emergency plan, as needed.

§482.15(d) §482.15(d)(2)(i)

The purpose of the emergency exercises is to demonstrate the effectiveness of the hospital’s emergency plan and to use the results of the exercises to improve the hospital’s EOP.

The testing program may be part of the EOP or it may be separate. If separate, the EOP must reference where to find the testing program.

Hospitals and free-standing ambulatory health care occupancy facilities that are part of the hospital system must participate in two (2) emergency exercises to test the EOP per calendar year:

1. The first must be a full-scale exercise that is community-based or when a community-based exercise is not available, an individual facility-based full-scale exercise. If the hospital experiences an actual natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in a community-based or individual facility-based full-scale exercise for 1 year following the onset of the actual event.

2. The second must be a full-scale exercise that is a facility-based full-scale exercise.

Table-top drills, while useful in the planning phase, are not an acceptable substitute for these exercises.

Each implementation (either an actual emergency or an exercise) shall be analyzed and evaluated and all documentation of the analysis and evaluations (after-

**DOCUMENT REVIEW AND INTERVIEW**

- Review the evaluation records of the emergency exercises.
- Assure that all after-action plan items have been documented in the oversight committee on emergency management meeting minutes and the Quality Assurance Performance Improvements (QAPI) minutes.
- Ensure that each exercise is based on one of the identified Hazard Vulnerability Analysis (HVA) hazards.
- Ensure that buildings classified as healthcare occupancy or ambulatory healthcare occupancy each receives at least two (2) emergency exercises within the past calendar year.
- Ensure that buildings classified as business occupancies and provide patient care activities each receives at least one emergency exercise within the past calendar year.

**COMMENTS:**

1 = Compliant
2 = Not Compliant
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<td>§482.15(d)(2)(ii)</td>
<td>action report / critique) must be maintained. The emergency management committee uses this information to improve the hospital’s capability to respond to emergencies, and to make improvements to the Emergency Operations Plan. The emergency committee submits reports to hospital leadership, and as appropriate, state and Federal entities. Buildings classified as “business occupancies” and provide patient care activities are required to perform one (1) emergency exercise per calendar year.</td>
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<td>§482.15(d)(2)(iii)</td>
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EMERGENCY MANAGEMENT
## Operational Requirements:

### 09.04.01 Emergency Power

The hospital must implement emergency power systems based on the Emergency Operations Plan (EOP) in the ‘Planning’ section (see standard 09.00.01), and the Policies & Procedures in the ‘Procedures’ section (see standard 09.01.01).

- §482.15(e)(1)
- §482.15(e)(2)
- §482.15(e)(3)

The hospital must implement the emergency power inspection, testing, and maintenance requirements found in NFPA 99-2012, NFPA 101-2012, and NFPA 110-1010. The hospital must maintain an onsite fuel source to power emergency generators and must have a plan on how it will keep emergency power systems operational during the emergency, unless the hospital decides to evacuate.

Additional load testing of the generator, other than what is required by NFPA 110-2010 is not required by this standard.

### 09.04.02 Integrated Healthcare Systems

If a hospital is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and

Large health systems may develop an integrated emergency preparedness program for all of their facilities, which would include an integrated training program. Therefore, to offset some of the financial burden, facilities that are part of a large health system may opt to participate in their health system’s

### DOCUMENT REVIEW AND INTERVIEW

- **NOTE:** Generator inspection and testing requirements are scored in the Life Safety chapter.
- Review the hospital’s plan on how it will keep the generator operational during the emergency.
- Verify that newly installed generators (since July 5, 2016) have been located in an area to minimize the damage from flooding.

### COMMENTS:

- If elected, review the hospital’s plan on how it will provide a unified and integrated approach to emergency preparedness to all separately certified healthcare facilities.

### SCORE

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
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integrated emergency preparedness program, the hospital may choose to participate in the healthcare system's coordinated emergency preparedness program.

§482.15(f)(1)
§482.15(f)(2)
§482.15(f)(3)
§482.15(f)(4)
§482.15(f)(4)(i)
§482.15(f)(4)(ii)
§482.15(f)(5)

universal training program.

If elected, the unified and integrated emergency preparedness program must:

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

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

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

4. Include a unified and integrated Emergency Operations Plan that meets the requirements of the Planning section of this chapter. The unified and integrated EOP must also be based on and include the following:
   a. A documented community-based risk assessment, utilizing an all-hazards approach;
   b. 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
09.04.03 Transplant Hospitals.

If a hospital has one or more transplant centers (as defined in §482.70), then a representative from each transplant center must be included in the development and maintenance of the hospital’s emergency preparedness program, and the hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant center, and the Organ Procurement Organization (OPO) for the Donation Service Area (DSA) where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency.

§482.15(g)
§482.15(g)(1); §482.15(g)(2)

meet the requirements set forth in the Procedures section of this chapter; a coordinated communication plan that meets the requirements set forth in the Communication section of this chapter; and a training and testing program that meets the requirements set forth on the Testing & Training section of this chapter.

DOCUMENT REVIEW AND INTERVIEW

- Did a representative from each transplant center participate in the development of the hospital’s emergency preparedness program?
- Have mutually agreed upon protocols that address the duties and responsibilities of the hospital and each transplant center been developed?

COMMENTS:
CMS Resources:  
[§482.15(h)]

The standards incorporated by reference in this chapter are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA).

For information on the availability of this material at NARA, call 202-741-6030, or go to:  

If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.

(1) National Fire Protection Association
1 Batterymarch Park
Quincy, MA 02169 617-770-3000
www.nfpa.org


(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.
(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.
(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.
(v) TIA 12-5 to NFPA 99, issued August 1, 2013.
(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.
(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.
(x) TIA 12-3 to NFPA 101, issued October 22, 2013.
(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.

(2) [Reserved]