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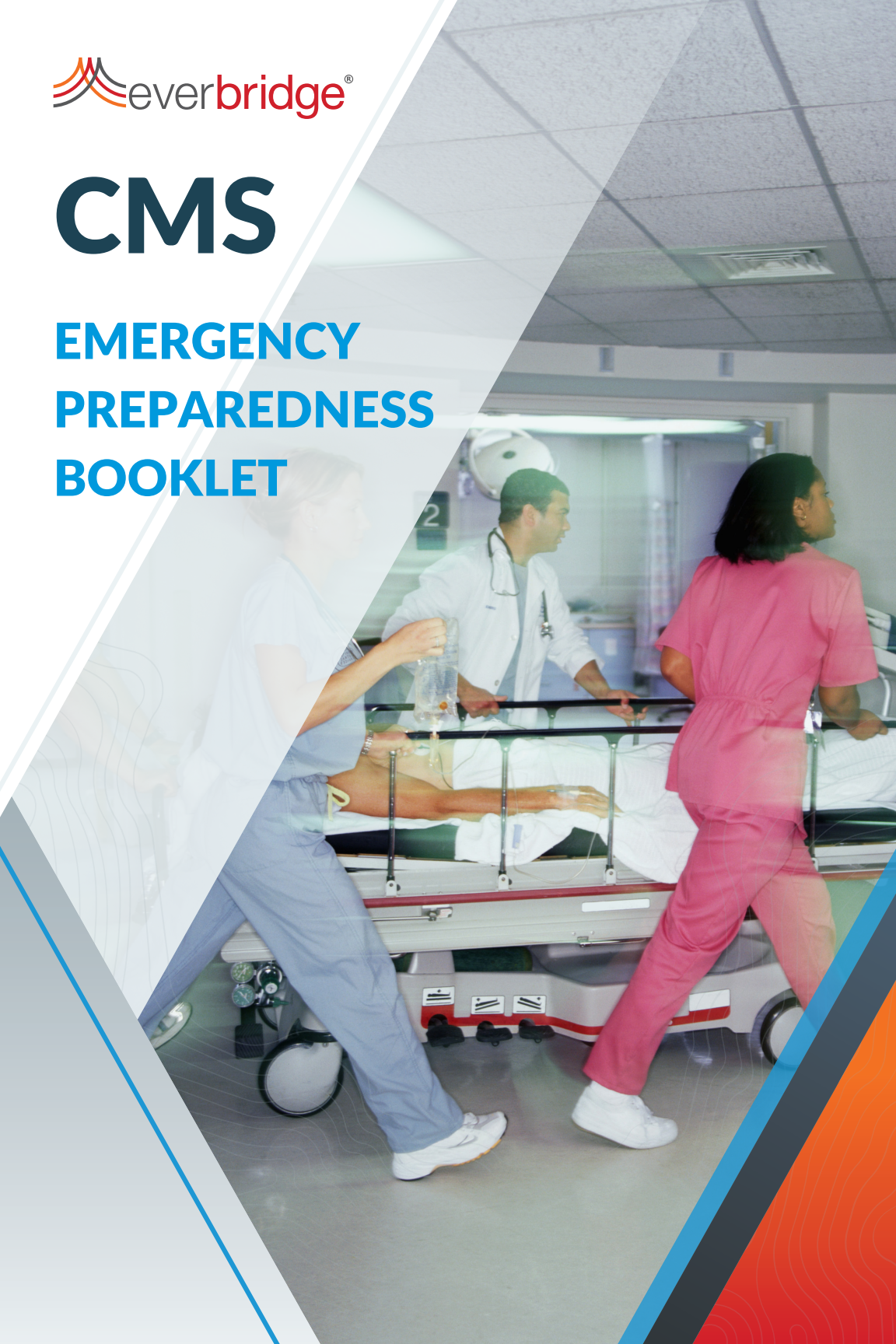
CMS

EMERGENCY PREPAREDNESS BOOKLET



CMS Readiness is Core to Building Resilience

Balancing competing events with daily clinical operations is nothing new to the healthcare industry, especially given the frequency and severity of natural disasters, cybersecurity incidents and man-made threats.

COVID-19 further emphasized the need for emergency readiness and the core role communications play in executing a successful response – components mandated by The Centers for Medicare and Medicaid (CMS), Emergency Preparedness Rule.

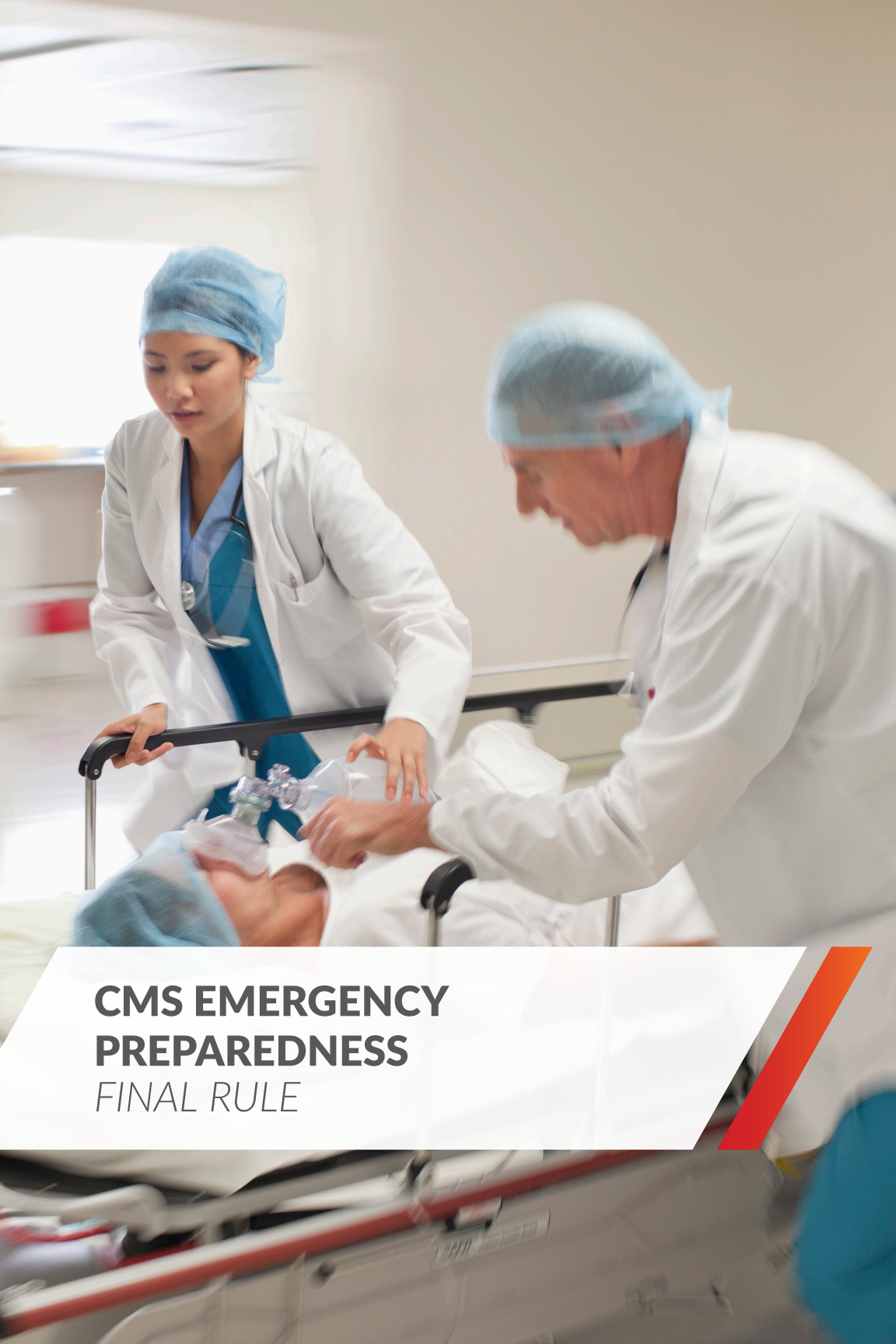
In 2017, the CMS passed the rule to ensure healthcare facilities were better equipped to adapt and respond to emergency situations, whether man made or natural disasters. The rule requires 17 types of healthcare providers to set new policies in support of better emergency coordination and plans.

There have been many changes to the Rule since 2017 including updated Interpretive Guidelines, that were issued on February 1, 2019 (see Appendix Z) and updated regulatory language as a result of a Burden Reduction Rule that went into effect on November 29, 2019.

To help you execute a well-devised plan and meet compliance, we've devised this booklet, which highlights key components of the rule, including recent CMS-issued updates.

Resources included are:

CMS Emergency Preparedness: Final Rule	***Critical Communication Points For CMS Emergency Preparedness***
CMS Emergency Preparedness Requirements by Provider Type	***Provider and Supplier Types Covered by The CMS Emergency Preparedness Rule***



CMS EMERGENCY PREPAREDNESS

FINAL RULE

What You Need to Consider to Meet the Criteria

The CMS Emergency Preparedness rule, establishes national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, regional and local emergency preparedness systems. The following provides an overview of the rule, including recent CMS-issued updates.

The core elements of the CMS Emergency Preparedness Rule, include:

1. Build an emergency plan and conduct an all-hazards risk assessment
2. Develop and maintain policies and procedures
3. Develop and maintain a communication plan
4. Develop and maintain a training and testing program

The Emergency Preparedness Plan for your hospital or healthcare system is based on an all-hazards risk assessment including the following areas:

+ Epidemic/pandemic
+ Biological
+ Chemical
+ Nuclear/radiological
+ Explosive-incendiary
+ Natural incidents
+ Cybersecurity incidents

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, including internal emergencies and a man-made emergency (or both) or natural disaster.

This approach is specific to the location of the provider or supplier and considers the particular type of hazards 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.

In February 2019 the CMS updated Appendix Z to include emerging infectious diseases (EIDs) such as Ebola and Zika viruses as part of the all-hazard risk assessment.

In light of the COVID-19 public health emergency (PHE), CMS expanded the Emergency Preparedness Interpretive Guidelines to include best practices, lessons learned, and planning considerations for emerging infectious diseases (EID)s as highlighted in Appendix Z of the Guidelines.

The CMS recommends conducting a Hazard Vulnerability Analysis (HVA) on a regular basis to quantify the level of risk and the severity of impact for pandemics and other events.

In addition, the plan must account for possible local community threats (i.e. wildfires or blizzards) and include a process for interacting with the local community groups such as police, fire, local government, and other nearby healthcare facilities, and other emergency responders.

The plan must account for possible local community threats (i.e. wildfires or blizzards) and include a process for interacting with the local community groups such as police, fire, local government, and other nearby healthcare facilities, and other emergency responders.

Emergency Preparedness Requirements

Your plan must meet the following six steps to receive approval from CMS:

+ Perform a risk analysis for your facility/facilities
+ Establish a plan to address those risks (as listed above)
+ Develop procedures and policies to protect against those risks
+ Develop a communication plan to support patient, staff and community safety
+ Train staff to readily implement the plan
+ Test the plan annually with at least one full-scale exercise and one other exercise which may be another full-scale exercise (for inpatient providers). One exercise is required annually for outpatient providers.

Devise communications that account for your local population, ensuring that all individuals within your community can access information in a language they can understand.

Meeting Communications Criteria

When assessing whether your communication platform will meet CMS guidelines, the following factors are critical to the success of your emergency preparedness plans and compliance (quotes are directly from the Federal Register Vol. 81, No. 180 guidelines on the CMS Final Rule):

Speed of Response

"It is essential that hospitals have the capacity to respond in a timely and appropriate manner in the event of a natural or man-made disaster."

Responding immediately when an incident occurs is critical. To ensure your communications network can be easily activated and all appropriate contacts are reached in a timely and appropriate manner, your communications system should have the capability to send messages via multiple options (mobile, robocalls, text, email etc.). This system should include ready-made templates to ensure messages can be quickly tailored to a specific incident.

Tailored to Your Population

"At-risk populations are individuals who may need additional response assistance, including … from diverse cultures, have limited English proficiency, or are non-English speaking."

Devise communications that account for your local population, ensuring that all individuals within your community can access information in a language they can understand. Create prepared templates that account for different languages and can easily be tailored to a specific incident with a few modifications.

Coordinate with the Local Community for CMS Emergency Response

"A hospital must have a process for ensuring cooperation and collaboration with local, tribal, regional, state, or federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency."

Hospitals are often at the center of their communities when it comes to ensuring the health of the local population. This is particularly evident during a crisis, when those in need of aid tend to turn to their local Emergency Department. The local community of police, fire, EMTs, state and local officials need to know if your hospital is available to take patients or if it needs to be evacuated. You'll likely need to work with other hospitals and healthcare

Hospitals or healthcare facilities should have a database that allows contact with all staff based on their schedules, their areas of expertise and the hospital's needs.

providers to coordinate transfers of patients during an event, ensuring your communications account for the following:

+ The ability to communicate easily with off-hospital coordinators to send and receive information
+ The ability to remain HIPAA-compliant as patients are being transferred, whether patients are incoming or being evacuated

Requirement to Track Patients and Staff

"Providers must develop policies and procedures regarding a system to track the location of staff and patients in the hospital's care both during and after an emergency."

Hospitals and healthcare facilities should have a database that allows contact with all staff based on their schedules, their areas of expertise and the hospital's needs. This will ensure you can account for all staff, where on-duty staff are located during an incident, and better assess if they are safe and are able to care for patients.

Setting up groups of contacts such as clinical staff vs. facilities staff will speed coordination of aid during an event. The guidelines specifically state that more than one mode of communication is required given that employees may be impacted in different ways and back-up forms of communication may be necessary. To help minimize disruption, your team should evaluate the best ways to interact with your team members. The CMS elaborates:

"We would expect the facility to include in its emergency plan a method for contacting off-duty staff during an emergency and procedures to address other contingencies in the event staff are not able to report to duty which may include but are not limited to staff from other facilities and state or federally-designated health professionals."

Documenting Communication

The Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction ("Omnibus Burden Reduction"), effective November 29, 2019, eliminated the requirement that the emergency plan include documentation of efforts to contact local, tribal, regional, state, and federal emergency preparedness officials and a facility's participation in collaborative and cooperative planning efforts.

Stability of Platform

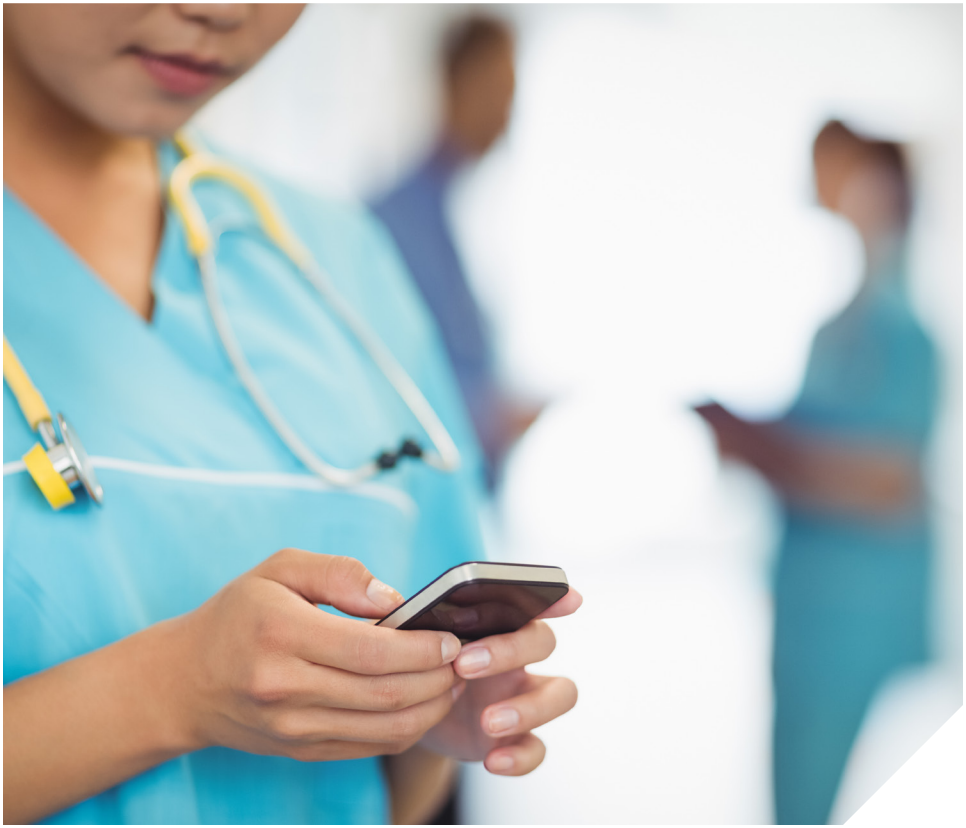
While not a specific requirement, emergency planners should consider the stability of their platform during an event. Severe weather and mass casualty events can knock out civilian-grade networks. During a terrorist attack, local officials may temporarily disconnect civilian networks to slow terrorist coordination. The Everbridge platform is on par with FEMA -- if civilian networks are down, Everbridge systems have federal clearance levels that allow our messages to get through regardless.

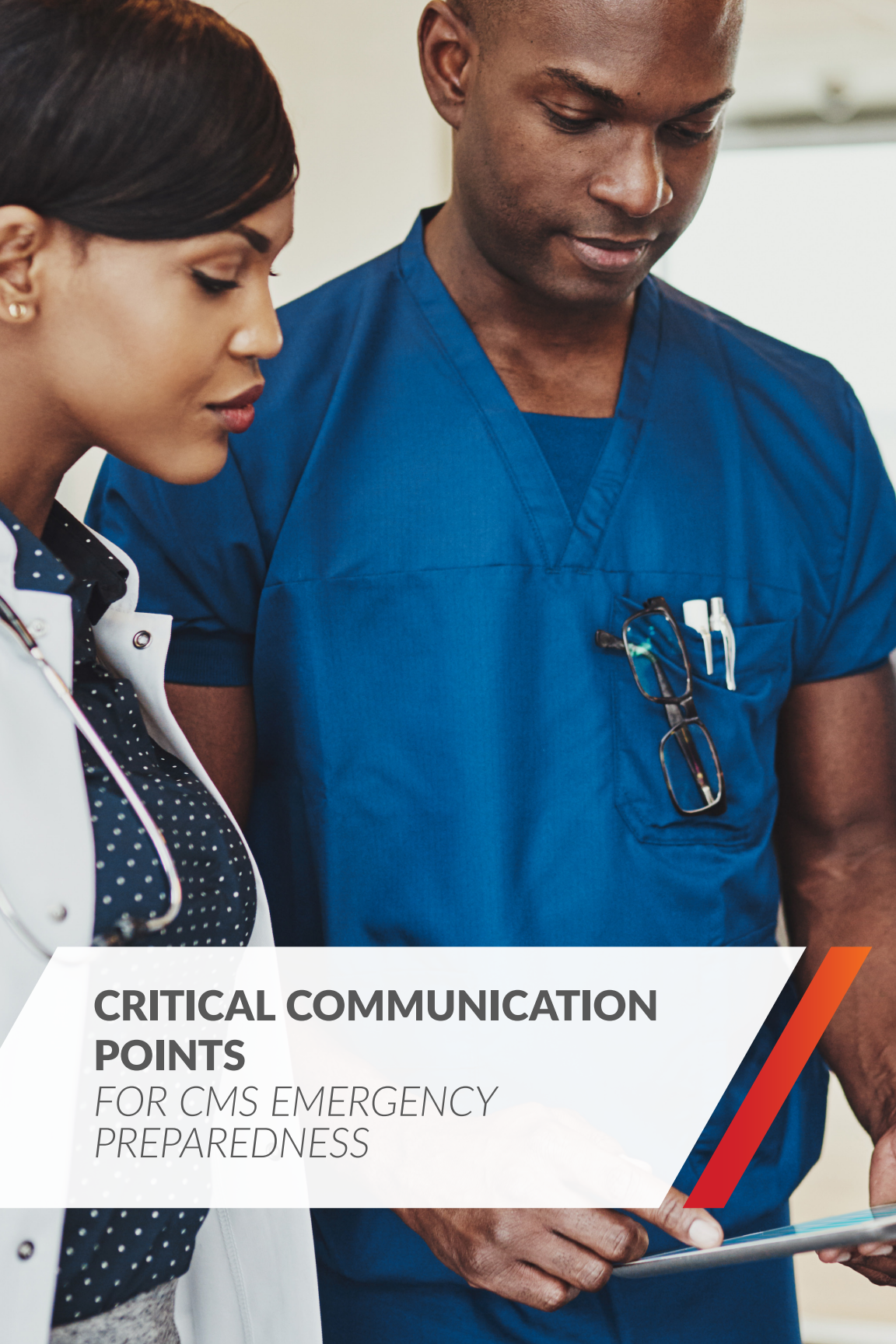
The Future of CMS Compliance

As COVID-19 first emerged in the U.S., CMS requested that hospitals perform targeted infection control surveys but many surveys were suspended when COVID-19 infection rates were high.

The CMS has discussed more oversight of accrediting organizations in recent years and the HHS Office of Inspector General has since recommended that the CMS develop regulations that allow it to require special surveys during public health emergencies and after substantive new guidance is released.

This will likely lead to changes in the quantity and types of reviews required for emergency preparedness to ensure that hospitals and healthcare providers have the right communication plans and tools in place to be better prepared should an emergency incident occur in the future.





CRITICAL COMMUNICATION POINTS

FOR CMS EMERGENCY PREPAREDNESS

Overview

The Interpretative Guidelines (IGs) for the CMS Emergency Preparedness Final Rule, clarifies communication components that are critical for hospitals and healthcare systems to meet compliance.

Below is a breakdown of the critical communication points to consider, along with excerpts from the IGs.

Our overall impression is the IGs emphasize two important aspects of preparedness:

Planners need to think of the worst-case scenarios related to a myriad of threats and plan for those. The IGs emphasize evacuations, power failures, and staff shortages. As the frequency and severity of natural and human-made disasters are on the rise, so too is the risk to healthcare organizations that must respond to these potentially devastating events. Given that large-scale emergencies can cause the greatest threat to facilities and put the most lives at risk, CMS advises including them as part of risk assessments.

Whether managing broad-impact or localized events, community cooperation is key and the IGs strongly emphasize planning and collaboration with state and local public health departments and emergency management systems. If healthcare facilities aren't able to conduct a multi-organization active drill, documentation detailing the circumstances must be provided or facilities risk not being accredited.

Now let's dive into the communication points that are emphasized in the IGs.

Communications for Essential Personnel

Whether on-duty or off-duty, planners need to take into consideration who needs to be at the facility for each planned hazard, and there needs to be a succession plan in place in case the planned responder is unavailable. Facilities should develop primary and secondary means of communication with essential personnel, contractors, and volunteers as well as federal, state, regional and local emergency management agencies. Also, facilities need a reliable way to contact essential personnel before, during and after an incident.

Excerpts from the Interpretive Guidance:

On-Duty Staff: E-0018, Facilities must have "a system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency." (pg. 27)

Off-Duty Staff: "Facilities are expected to include in its emergency plan a method for contacting off-duty staff during an emergency and procedures to address other contingencies in the event staff are not able to report to duty which may include, but are not limited to, utilizing staff from other facilities and state or federally-designated health professionals." (pg. 37)

Succession Planning: "The Emergency plan must identify which staff would assume specific roles in another's absence through succession planning and delegations of authority … Succession planning increases the availability of experienced and capable employees that are prepared to assume these roles as they become available … At a minimum, there should be a qualified person who 'is authorized in writing to act in the absence of the administrator or person legally responsible for the operations of the facility.'" (pg. 14)

Communications for Essential Functions

There are many essential functions for a healthcare facility to ensure business continuity as well as quality patient care. In addition to adequate staffing, facilities need to ensure they have plans that have accounted for power supplies and vendors that may provide food, water, medical equipment, and medicine. Do you have a way to reach staff and vendors before, during, and after an incident? Are there supplies you can stockpile? And supplies that you can bring on site as needed? Do you need to adjust staffing and supply levels given the type of threat your preparing for (i.e. chemical spill vs. a natural disaster)?

Facilities must be able to provide adequate subsistence for all patients and staff for the duration of an emergency or until all patients have been evacuated and its operations cease. There are no set requirements for the amount of provisions to be provided in facilities. However, the standard is to maintain a three-day supply of provisions to be provided in facilities. Provisions include, but are not limited to: (pg. 22)

+ Water
+ Food
+ Pharmaceuticals
+ Medical Supplies

Communications with the Local Community

The definition of local community was purposely left vague so planners could consider what is available in their region, but planners are expected to work with various agencies and responders in their area. They should also take into groups such as public health, neighboring states, any group that could aid or coordinate with a facility during an incident. Again, there must be primary and secondary means of communication. This was emphasized several times in the IGs, as summarized in the excerpt below.

Facilities must have a written emergency communication plan that contains how the facility coordinates patient care within the facility, across healthcare providers, and with state and local public health departments. The communication plan should include how the facility interacts and coordinates with emergency management agencies and systems to protect patient health and safety in the event of a disaster. The development of a communication plan will support the coordination of care. (pg. 42)

Facilities are required to have primary and alternate means of communicating with staff, Federal, State, tribal, regional, and local emergency management agencies. Facilities have the discretion to utilize alternate communication systems that best meets their needs. (pg. 47)

Communications During Evacuations

If the worst happens and a facility needs to evacuate, planners need to keep several things in mind. [Page numbers in the numbered list below are summary reference, not direct quotes]

1. What staff are needed to help with the evacuation and if staff travel with patients to maintain care (pg. 27)
2. What essential resources (food, water, medical supplies, etc.) are needed during an evacuation (pg. 9)
3. What outside agencies would assist in a patient move (pg. 37)
4. What facilities would receive the patients as well as transport options (pg.38)
5. Planning to maintain HIPAA while relaying patient information, including the sharing of medical documentation (pg. 30)
6. Planning to be the receiving facility – thinking about staffing and supply needs and other aspects of a patient surge (pg. 12)
7. Facilities also need to have the ability to include and share occupancy information including bed availability (pg. 50)
8. Facilities need to consider the clinical care needed during patient transport including life-saving equipment (pg. 29).

Facilities are encouraged to leverage the support and resources available to them through local and national healthcare systems, healthcare coalitions, and healthcare organizations for resources and tools for tracking patients. (pg. 28)

Facilities must develop a means to track patients and on-duty staff in the facility's care during an emergency event. In the event staff and patients are relocated, the facility must document the specific name and location of the receiving facility or other location for sheltered patients and on-duty staff who leave the facility during the emergency. (pg. 27)

Facilities are expected to provide patient care information to receiving facilities during an evacuation, within a timeframe that allows for effective patient treatment and continuity of care. (pg. 49)

Critical Communications and Your Emergency Preparedness Plans

We recommend taking the following steps to review your emergency preparedness communication plans to meet the CMS criteria:

1. Perform a risk assessment of your facility using an all-hazards approach.
2. Reach out to other facilities and local agencies to ensure a primary and secondary means of communication
3. Ensure you have a primary and secondary way to reach staff, contractors, and volunteers in the event of an emergency, make sure the lists are regularly updated.
4. Ensure you have a system in place to log steps during an event for review purposes.
5. Ensure you have a system in place to track patients during an emergency including hand-offs to other facilities. ways to notify family members, and maintain HIPAA compliance.

Centers for Medicare and Medicaid Services (CMS)

Emergency Preparedness Requirements by Provider Type

CMS Emergency Preparedness Rule: Provider and Supplier Types

There are 17 specific provider and supplier types affected by the newly released Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Rule. Below is a summary of outpatient and inpatient provider and supplier types, followed by requirements by type, based on information provided by CMS.

Affected Provider and Supplier Types

Inpatient	Outpatient
+ Critical Access Hospitals (CAHs) + Hospices + Hospitals + Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) + Long Term Care (LTC) + Psychiatric Residential Treatment Facilities (PRTFs) + Religious Nonmedical Health Care Facilities (RNHCIs) + Transplant Centers	+ Ambulatory Surgical Centers (ASCs) + Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services + Community Mental Health Centers (CMHCs) + Comprehensive Outpatient Rehabilitation Facilities (CORFs) + End-Stage Renal Disease (ESRD) Facilities + Home Health Agencies (HHAs) + Hospices + Organ Procurement Organizations (OPOs) + Programs of All Inclusive Care for the Elderly (PACE) + Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Inpatient Providers

Hospitals: A hospital is an institution that primarily engages in providing inpatient diagnostic and therapeutic services or rehabilitation services, by or under the supervision of licensed physicians.

Hospices: A hospice is, per CMS guidelines, a facility that's primarily focused on caring for individuals that have been certified terminally ill per the CMS guidelines. In addition to the physical needs of a terminally ill patient, a hospice meets the emotional, psychosocial, and spiritual needs of the patient and their family per a previously created plan of care.

Critical Access Hospitals (CAHs): CMS rules dictate that CAHs must be located in a state with an established State Medicare Rural Hospital Flexibility Program and be designated by the state as a CAH. Additionally, a CAH must be located in a rural part of the state that's more than 35 miles from the closest hospital or be located further than 15 miles in an area with potentially treacherous driving conditions, such as a mountainous terrain. There can't be more than 25 beds, and the average length of stay must be 96 hours or less for acute inpatient care, and the facility must be available for emergency care 24/7.

Long Term Care (LTC): This umbrella term includes nursing and skilled nursing facilities. A skilled nursing facility that operate within LTC facilities engages in offering skilled care for residents who require it as well as rehab services for disabled, injured, or ill patients. A nursing facility offers health-related care and services to patients who require additional assistance beyond room and board.

Immediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID): This particular facility operates as an optional Medicaid benefit which funds institutions with 4 or more beds for people with intellectual disabilities, offering active treatment while they reside within.

Psychiatric Residential Treatment Facilities (PRTFs): Per CMS, a PRTF is a non-hospital facility that has a provider agreement with a state Medicaid Agency to offer Medicaid-eligible people under 21 inpatient services.

Transplant Centers: A transplant center is required to operate within a hospital that has a current Medicare provider agreement. It can offer transplants of particular types of organs, including:

+ Lung
+ Heart
+ Lung/Heart
+ Liver
+ Intestine
+ Kidney
+ Pancreas

Religious Nonmedical Health Care Institutions (RNHCIs) (Inpatient): A RNHCI is a tax-exempted religious organization that offers nursing and services that are not medical to any beneficiary that opts for a religious healing method. No medical services are provided, on the basis of the religious belief that it's unnecessary.

Outpatient Providers

Ambulatory Surgical Centers (ASCs): This includes any entity that offers surgical services to patients not requiring hospitalization with an expected duration of services not to exceed more than 24 hours following admission.

Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services (Outpatient): These organizations are defined as:

+ **Rehabilitation Agency:** Any agency that offers an integrated, multidisciplinary program to improve the physical function of disabled, handicapped individuals through the coordination of specialized rehabilitation personnel.
+ **Clinic:** A facility established primarily to provide outpatient physicians' services. To qualify as a clinic the facility must provide medical services by a group of three or more physicians practicing medicine together and have a licensed physician available in the facility during hours of operation to provide medical services to patients.
+ **Public Health Agency:** An official agency created by the state or local government for the primary purpose of maintaining the health of the population served by providing environmental health services, preventative medical care, and therapeutic care.

Comprehensive Outpatient Rehabilitation Facilities (CORFs): A CORF provides coordinated outpatient services including diagnostic, restorative, and therapeutic services at a single, fixed location for the rehabilitation of disabled, injured or sick people. Occupational therapy, speech-language pathology, and physical therapy services may be provided at an offsite location.

Community Mental Health Centers (CMHC): Outpatient organizations that provide partial hospitalization services to Medicare beneficiaries for mental health services.

End-Stage Renal Disease (ESRD) Facilities: A freestanding dialysis center that provides chronic maintenance dialysis to ESRD patients on an outpatient basis including home-based dialysis services. A certified ESRD facility provides outpatient maintenance dialysis services and/or home dialysis training and support services. The facility can be hospital-based or independent.

Home Health Agencies (HHAs): An organization that provides skilled nursing and other therapeutic services. HHA policies are established by an agency-associated group of professionals that includes at least one physician and at least one registered professional nurse to govern the services provided.

Hospice (Outpatient): A public agency, private organization or a subdivision that provides care to terminally ill patients (individuals who have been certified as terminally ill per CMS requirements and Part A of Medicare) in their home or another facility certified and approved for participation as a hospice and per a valid Medicare provider agreement. Services include physical, spiritual, emotional, and psychosocial services,

as identified under the auspices of an outpatient hospice.

Organ Procurement Organizations (OPOs): OPOs provide opportunities for volunteering and raising awareness about the importance of organ donation registration. OPOs are responsible for two major roles in their service area:

+ for increasing the number of registered organ donors in the US as well as coordinating the organ donation process, and
+ evaluating and ensuring that the donated organs are recovered and matched to the proper party.

Programs of All-Inclusive Care for the Elderly (PACE): PACE offers a range of integrated, preventative acute care and long-term care services to help manage the needs of the frail, elderly population. The program provides services that address the health care needs of participants while enabling them to live safely within the community.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): RHCs are located in a rural setting and are required to meet health care requirements of 42 CFR 405 and 491, with the exception of rehabilitation or mental diseases. FQHCs provide services to an underserved area or population, offering a sliding fee scale. FQHCs provide comprehensive services and have an on-going assurance program that's overseen by a governing board of directors.

Summary of CMS Final Rule Requirements by Provider Type

	RNHCI	ASC	Hospice	PRTF	PACE	Hospitals	Transplant Centers	LTC	ICF/IID	HHA	CORF	CAH	Other Orgs.*	CMHC	OPO	RHCs & FQHC	ESRD
"All-Hazards" Approach	✓	✓	✓	✓	✓	✓	✓	✓[2]	✓[2]	✓	✓[2]	✓	✓[2]	✓	✓	✓	✓
Community & Facility-Based Risk Assessments	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Emergency Events Strategies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Assessment of Patient Population Ability to Provide Services During an Emergency	✓	✓	✓[1]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Succession Plan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Government Cooperation at All Levels***	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓[3]
Ability to Confirm Program Development Participation for All Provider Types		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Ability to Identify Unique Circumstances, Services Offered & Patient Population for Each Provider Type		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Demonstration of Facilities' Compliance with the Program		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Documented Community-Based Risk Assessment 'All Hazards' Approach		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Documented Individual Facility-Based Risk Assessment (All Hazards)		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Communication Plan & Testing/Training Plan Coordination		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Representation of All Transplant Centers							✓										
Hospital, Transplant Center & OPO Responsibility Protocol							✓										

Facilities that activated their emergency plans due to the pandemic are exempt from the next required full-scale community-based or individual, facility-based functional exercise.

Changes to the Emergency Preparedness Requirements by Provider Type

+ The CMS issued the Omnibus Burden Reduction (Conditions of Participation) Final Rule ("Final Rule") in 2019, with the goal of removing Medicare regulations that are "unnecessary, obsolete, or excessively burdensome on hospitals and healthcare providers…" Changes issued from this Final Rule were based on a review of CMS regulatory health and safety standards and feedback from healthcare providers that indicated that some requirements would divert time and resources away from high-quality patient care.

As a result, changes were made to the current emergency preparedness requirements, including the following:

+ Facilities no longer have to conduct an annual review of their emergency program. Facilities now must conduct a biennial review of the emergency program, except for long-term care facilities, which still need to submit reviews annually.
+ CMS no longer requires that the emergency plan include documentation of the facility's efforts to contact local, tribal, regional, state, and federal emergency preparedness officials.
+ The Final Rule lessens the training requirement from annually to biennially. Long-term care facilities, however, are still required to provide annual training.
+ Inpatient providers such as hospitals and long-term care facilities are still required to conduct two testing exercises annually, but have the flexibility to conduct one test through a method of their choice, such as a workshop or desktop exercise. The other testing event should still be a full-scale community exercise. For testing requirements related to outpatient providers, the Final Rule decreases the requirement for facilities to conduct two testing exercises to one testing exercise.[1]

1 CMS, Fact Sheet: Omnibus Burden Reduction (Conditions of Participation) Final Rule CMS-3346-F (Sept. 26, 2019), https://www.cms.gov/newsroom/fact-sheets/omnibus-burden-reduction-conditions-participation-final-rule-cms-3346-f. See CMS, Medicare and Medicaid Programs; Regulatory Provisions Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, 84 Fed. Reg. 51732 (Sept. 30, 2019), available at https://www.federalregister.gov/documents/2019/09/30/2019-20736/medicare-and-medicaid-programs-regulatory-provisions-to-promote-program-efficiency-transparency-and

Due to COVID-19 many providers and suppliers activated their emergency plans in order to address surge and coordinate response activities. Per CMS, facilities that activated their emergency plans are exempt from the next required full-scale community-based or individual, facility-based functional exercise. However, facilities must be able to demonstrate, through written documentation, that they activated their program due to the emergency.

Facilities may need to conduct an exercise of choice following the current public health emergency, if they were required to conduct an exercise this year and did not already do so. 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.

Facilities may choose to conduct a table-top exercise (TTX) which could assess the facility's response to COVID-19. This may include but is not limited to, discussions surrounding availability of personal protective equipment (PPE); isolation and quarantine areas for screening patients; or any other activities implemented during the activation of the emergency plan. The emergency preparedness provisions require that facilities assess and update their emergency program as needed. Therefore, lessons learned and challenges identified in the TTX may allow a facility to adjust its plans accordingly.

Centers for Medicare and Medicaid Services (CMS)

Emergency Preparedness Requirements by Provider Type

Inpatient		
Provider Type	**Emergency Plan**	**Policies and Procedures**
Hospital	Develop a plan based on a risk assessment using an "all hazards" approach, which is an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies and disasters. The plan must be updated every two years.	Develop and implement policies and procedures based on the emergency plan, risk assessment, and communication plan which must be reviewed and updated at least annually. System to track on-duty staff & sheltered patients during the emergency.
Critical Access Hospital	*	*
Long -Term Care Facility	Develop a plan based on a risk assessment using an "all hazards" approach, which is an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies and disasters. The plan must be updated annually. Must account for missing residents (existing requirement).	Tracking during and after the emergency applies to on-duty staff and sheltered residents.
PRTF	*	Tracking during and **after** the emergency applies to on-duty staff and sheltered residents.
ICF/IID	Must account for missing residents (existing requirement).	Tracking during and **after** the emergency applies to on-duty staff and sheltered clients.
RNHCI	*	*
RNHCI	*	*

*Indicates that the requirements are the same as those for hospitals. Exceptions are noted for individual provider/suppliers.

NOTE: This table is an overview of the regulation with key differences summarized. This is not meant to be an exhaustive list of the requirements nor should it serve as substitute for the regulatory text.

	Inpatient		
	Communication Plan	Training and Testing	Add'l Requirements
	Develop and maintain an emergency preparedness communication plan that complies with both federal and state laws. Patient care must be well-coordinated within the facility, across health care providers and with state and local public health departments and emergency systems. The plan must include contact information for other hospitals and CAHs; method for sharing information and medical documentation for patients. Documentation of the facility's efforts to contact local, tribal, regional, state, and federal emergency preparedness officials is no longer required.	Develop and maintain training and testing programs, including initial training in policies and procedures and demonstrate knowledge of emergency procedures and provide training at least biennially. Also, administer two emergency preparedness tests per year. Facilities may choose the type of emergency preparedness test they conduct, either a + community-based full-scale test, or + a facility-based test	Generators—Develop policies and procedures that address the provision of alternate sources of energy to maintain: + temperatures to protect patient health and safety and for the safe and sanitary storage of provisions; + emergency lighting; and + fire detection, extinguishing, and alarm systems.
	*	*	Generators
	In the event of an evacuation, method to release patient information consistent with the HIPAA Privacy Rule.	Develop and maintain training and testing programs, including initial training in policies and procedures and demonstrate knowledge of emergency procedures and provide training at least annually. Also, administer two emergency preparedness tests per year. Facilities may choose the type of emergency preparedness test they conduct, either a + community-based full-scale test, or + a facility-based test	Generators Share with resident/ family/ representative appropriate information from emergency plan.
	*	*	
		*(current requirement)	Share with client/ family/representative appropriate information from emergency plan.
	Does not include the requirement to coordinate with state or federally designated healthcare professionals.	No requirement to conduct drills.	
	*	*	Maintain agreement with transplant center & OPO.

Centers for Medicare and Medicaid Services (CMS)

Emergency Preparedness Requirements by Provider Type (continued)

Outpatient Providers
Outpatient providers are not required to provide subsistence needs for staff and patients.

Provider Type	Emergency Plan	Policies and Procedures	
Hospice	*	In home services—inform officials of patients in need of evacuation (additional requirement). Home-based hospices not required to track staff and patients.	
Ambulatory Surgical Center	*	Will not need to provide occupancy information. Not required to develop arrangements with other ASCs and other providers to receive patients in the event of limitations or cessation of operations. Not required to include the names and contact information for "other ASCs" in the communication plan.	
PACE	*	Inform officials of patients in need of evacuation (additional requirement). Tracking during and **after** the emergency applies to on-duty staff and sheltered participants.	
Home Health Agency	*	Will not require shelter in place, provision of care at alternate care sites Inform officials of patients in need of evacuation. HHAs not required to track staff and patients.	
CORF	Must develop emergency plan with assistance from fire, safety experts (existing requirement)	Will not need to provide transportation to evacuation locations, or have arrangements with other CORFs to receive patients, and not required to track staff and patients.	

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**Indicates that the requirements are the same as those for hospice. Exceptions are noted for individual provider/suppliers.

NOTE: This table is an overview of the regulation with key differences summarized. This is not meant to be an exhaustive list of the requirements nor should it serve as substitute for the regulatory text.

	Outpatient Providers Outpatient providers are not required to provide subsistence needs for staff and patients.		
	Communication Plan	**Training and Testing**	**Add'l Requirements**
	In home services—will not need to provide occupancy information.	**Training requirement:** * **Testing requirement:** One testing exercise is required annually, which may be either one community-based full-scale exercise, if available, or an individual facility-based functional exercise, every other year and in the opposite years, these providers may choose the testing exercise of their choice.	
	Community-based drill not required.	**Training requirement:** * **Testing requirement:** **	
	*	**Training requirement:** * **Testing requirement:** **	
	Will not need to provide occupancy information. Not required to include the names and contact information for other HHAs in the communication plan. Not required to develop arrangements with other HHAs.	**Training requirement:** * **Testing requirement:** **	HHAs must have policies in place for following up with patients to determine services that are still needed. In addition, they must inform State and local officials of any onduty staff or patients that they are unable to contact.
	Will not need to provide occupancy information.	**Training requirement:** * **Testing requirement:** **	

Centers for Medicare and Medicaid Services (CMS)

Emergency Preparedness Requirements by Provider Type (continued)

Outpatient Providers
Outpatient providers are not required to provide subsistence needs for staff and patients.

Provider Type	Emergency Plan	Policies and Procedures
CMHC	*	Tracking during and after the emergency applies to on-duty staff and sheltered clients.
OPO	Address type of hospitals OPO has agreement (additional requirement).	Needs to have system to track staff during & after emergency and maintain medical documentation (additional requirement).
Clinics, Rehabilitation, and Therapy	Must develop emergency plan with assistance from fire, safety experts. Address location, use of alarm systems and signals & methods of containing fire (existing requirements).	*Not required to track staff and patients.
RHC/FQHC	*	Does not have to track staff and patients, or have arrangements with other RHCs to receive patients or have alternate care sites.
ESRD	Must contact local emergency preparedness agency annually to ensure dialysis facility's needs in an emergency (existing requirement).	Policies and procedures must include emergencies regarding fire equipment, power failures, care related emergencies, water supply interruption & natural disasters (existing requirement). Tracking during and **after** the emergency applies to on-duty staff and sheltered patients.

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**Indicates that the requirements are the same as those for hospice. Exceptions are noted for individual provider/suppliers.

NOTE: This table is an overview of the regulation with key differences summarized. This is not meant to be an exhaustive list of the requirements nor should it serve as substitute for the regulatory text.

	Outpatient Providers Outpatient providers are not required to provide subsistence needs for staff and patients.		
	Communication Plan	**Training and Testing**	**Add'l Requirements**
	*	**Training requirement:** * **Testing requirement:** **	
	Does not need to provide occupancy info, method of sharing pt. info, providing info on general condition & location of patients.	Only tabletop exercise	Must maintain agreement with other OPOs & hospitals.
	Will not need to provide occupancy information.	**Training requirement:** * **Testing requirement:** **	
	Will not need to provide occupancy information.	**Training requirement:** * **Testing requirement:** **	
	Will not need to provide occupancy information.	Ensure staff demonstrate knowledge of emergency procedures, informing patients what to do, where to go, whom to contact if emergency occurs while patient is not in facility (alternate emergency phone number), how to disconnect themselves from dialysis machine. Staff maintain current CPR certification, nursing staff trained in use of emergency equipment & emergency drugs, patient orientation (existing requirements).	

ABOUT EVERBRIDGE

Everbridge CMS Capabilities

CMS Requirements	Everbridge Capabilities
All-hazards emergency and communication plans including + Natural Disasters + Epidemic/pandemic + Biological + Chemical + Nuclear/radiological + Explosive-incendiary + Cybersecurity	Pre-built communication templates for + Natural Disasters + Epidemic/pandemic + Biological + Chemical + Nuclear/radiological + Explosive-incendiary + Cybersecurity
Contact information for **ALL STAFF**, entities providing services under arrangement, patients' physicians, other hospitals, and volunteers.	+ Contact Integration with HR and other systems + Robust Self-service Contact Profiles + Key word message registration (Community Engagement)
Means of contacting **appropriate staff**, patients' treating physicians, and other necessary persons in a timely manner to ensure continuation of patient care including primary and alternate means of communication	+ One-click incident communications scenarios + Message targeting by group, role, location, availability, etc... + Communication confirmation & Quit + Multi-modal communication
Providers and suppliers to engage and collaborate with their **local healthcare coalition**	+ Healthcare Coalition Network
Collaboration with local, tribal, regional, state, or federal emergency preparedness officials during a disaster. Have **primary and alternate means** of contacting these officials.	+ Healthcare Coalition Network + Communication confirmation + Multi-modal communication + Incident Communication Reporting/Audit
Support for populations with **Limited English Proficiency**	+ Ability to message by language + Automated language translation
Meet testing requirements: + Inpatient providers (two emergency preparedness tests per year) + Outpatient providers: (one emergency preparedness test per year)	+ Unlimited emergency messaging + Sim-cell support + Incident Communication Reporting/Audit

About Everbridge

Everbridge, Inc. (NASDAQ: EVBG) is a global software company that provides enterprise software applications that automate and accelerate organizations' operational response to critical events in order to Keep People Safe and Organizations Running™. During public safety threats such as active shooter situations, terrorist attacks, a global pandemic or severe weather conditions, as well as critical business events including IT outages, cyber-attacks or other incidents such as product recalls or supply-chain interruptions, over 5,800 global customers rely on the Company's Critical Event Management (CEM) Platform to quickly and reliably aggregate and assess threat data, locate people at risk and responders able to assist, automate the execution of pre-defined communications processes through the secure delivery to over 100 different communication modalities, and track progress on executing response plans. Everbridge serves 9 of the 10 largest global consulting firms, 8 of the 10 largest global automakers, 7 of the 10 largest technology companies in the world, and 8 of the 10 largest U.S. cities. Everbridge is based in Boston, Massachusetts – USA with additional offices in 25 cities around the globe including Abu Dhabi, Auckland, Bangalore, Beijing, Budapest, Chicago, London, Munich, Oslo, Pasadena, Singapore, Tilburg, and Vancouver.

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