INDICATOR	MET	NOT MET	COMMENTS
EMERGENCY PLAN, PROCEDURES AND PROTOCOLS			
Interview the facility leadership and ask him/her/them to describe the facility's emergency preparedness (EP) program. Review the facility's written policy and documentation on the emergency preparedness program. • **For hospitals and Critical Access Hospitals (CAHs) only:** The EP program was developed based on an all-hazards approach. • **For facilities with Transplant Centers:** A representative from the transplant center was included in the planning of the emergency preparedness program of the hospital in which the transplant center is located. • **For End Stage Renal Disease Facilities (ESRD):** There is written or electronic documentation of the EP program.			
Verify the facility has an emergency preparedness plan by asking to see a copy of the plan: • Ask facility leadership to identify the hazards (e.g. natural, man-made, facility, geographic, etc.) that were identified in the facility's risk assessment and how the risk assessment was conducted. • Review the plan to verify it contains all of the required elements • Verify that the plan is reviewed and updated annually.			
For Transplant Centers: • Verify the transplant center has emergency preparedness policies and procedures. • Verify that the transplant center's emergency preparedness policies and procedures are included in the hospital's emergency preparedness program.			
Review written documentation of the facility's risk assessments and associated strategies. • Interview the facility leadership and ask which hazards (e.g. natural, man-made, facility, geographic) were included in the facility's risk assessment, why they were included and how the risk assessment was conducted. • Verify the risk-assessment is based on an all-hazards approach specific to the geographic location of the facility and encompasses potential hazards.			
Organizational leadership can describe the following:			

INDICATOR	MET	NOT MET	COMMENTS
• The facility's patient populations that would be at risk during an emergency event. • Strategies the facility (except for an Ambulatory Surgery Center (ASC), hospice, Program of All-Inclusive Care for the Elderly (PACE) organization, Home Health Agency facility(HHA), Comprehensive Outpatient Rehabilitation Facilities (CORF), Community Mental Health Centers (CMHC), Rural Health Clinics (RHCs)/Federally-Qualified Health Centers (FQHC) and ESRD facility) has put in place to address the needs of at risk or vulnerable patient populations. • Services the facility would be able to provide during an emergency. • How the facility plans to continue operations during an emergency. • Delegations of authority and succession plans. • Verify that all of the above are included in the written emergency plan.			
Organizational leadership can describe the following: • Services the OPO would be able to provide during an emergency. • How the OPO plans to continue operations during an emergency. • Delegations of authority and succession plans. • How the OPO has included/addressed all of the hospitals with which it has agreements into its emergency plan. • Verify that all of the above are included in the written emergency plan.			
Leadership can describe their process for ensuring cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation. There is documentation of the facility's efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts.			
For ESRD facilities: There is documentation that the ESRD facility contacted the local public health and emergency management agency public official at least annually to confirm that the agency is aware of the ESRD facility's needs in the event of an emergency and know how to contact the agencies in the event of an emergency.			

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The plan lists the location(s) and use of fire alarms. Staff members can describe the facility's current procedure for containing fires.			
For CORF: The CORF and associated Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services collaborate with fire, safety and other appropriate experts to develop and maintain its emergency plan. The collaboration is documented .			
For Transplant Centers: Verify the hospital has written documentation to demonstrate that a representative of each transplant center participated in the development of the emergency program. There is documentation of emergency protocols that address transplant protocols that include the hospital, the transplant center and the associated OPOs.			
The written policies and procedures which address the facility's emergency plan indicate **(Does not apply to Transplant Centers)**: • Policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach. • policies and procedures have been reviewed and updated on an annual basis.			
For Transplant Centers: Mutually agreed upon written protocols address the duties and responsibilities of the transplant center, the hospital in which the transplant center is operated, and the designated OPO.			

The emergency plan includes:
• Policies and procedures for the provision of subsistence needs including, but not limited to, food, water and pharmaceutical supplies for patients and staff.
• Policies and procedures to ensure adequate alternate energy sources, including emergency power necessary to maintain:
  ○ Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
  ○ Emergency lighting.
  ○ Fire detection, extinguishing, and alarm systems.
• Policies and procedures to provide for sewage and waste disposal.			

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(These requirements do not apply to ASCs, Outpatient Hospice Providers, Transplant Centers, HHA, CORFs, CMHCs, RHCs/FQHCs, ESRD facilities.)			
For Hospices: The emergency plan includes policies and procedures for following up with staff and patients. Staff members/leadership can explain the procedures in place in the event they are unable to contact a staff member or patient.			
For HHA: Each patient's medical record has an individualized emergency plan documented as part of the patient's comprehensive assessment.			
For Hospitals and CAH: Staff can describe and/or demonstrate the tracking system used to document locations of sheltered patients and staff. The tracking system is documented as part of the facilities' emergency plan policies and procedures.			
For Hospice (homebound), PACE and HHAs: The emergency plan includes procedures to inform State and local emergency preparedness officials about patients in need of evacuation from their residences due to an emergency situation based on the patient's medical and psychiatric condition and home environment.			
The emergency plan includes policies and procedures for safe evacuation from the facility and that it includes: • Consideration of care and treatment needs of evacuees • Staff responsibilities • Transportation • Identification of evacuation location(s) • Primary and alternate means of communication with external sources of assistance.			
For HHA: The emergency plan includes procedures to followup with staff and patients and to inform state and local authorities when they are unable to contact any of them.			
For HHA: There are procedures in the emergency plan to follow up with on-duty staff and patients to determine the services that are needed, in the event that there is an interruption in services during or due to an emergency.			
For HHA: There is a mechanism to inform State and local officials of any on duty staff or patients that they are unable to contact.			
The emergency plan includes policies and procedures for how the organization will provide a means to shelter in place for patients, staff and volunteers who remain in a facility.			
There are policies and procedures that the facility has developed to preserve patient (or potential and actual donor for OPOs) information, protects confidentiality of patient (or			

INDICATOR	MET	NOT MET	COMMENTS
potential and actual donor for OPOs) information, and secures and maintains availability of records.			
There are policies and procedures for the use of volunteers and other staffing strategies in the emergency plan.			
There are arrangements and/or agreements with other facilities to receive patients in the event the facility is not able to care for them during an emergency. This includes arrangements for transportation in the event of an evacuation.			
There are policies and procedures in the emergency plan describing the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. **(Does not apply to Transplant Centers, HHAs, CORFs, Clinics, Rehabilitation Agencies and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services, OPOs, RHCs/FQHCs.)**			
The ESRD facility has included in its emergency plan, policies and procedures for obtaining emergency medical assistance when needed.			
The dialysis facility has a process in place where its staff can confirm that emergency equipment is on the premises and immediately available. Verify: • The process includes at least the listed emergency equipment within the emergency plan by asking to see a copy of the written processes/ policy on emergency equipment and medications. • All of the above equipment is available and in working order. • There are procedures/checklist for ensuring equipment is checked • All emergency drugs are not out of date.			
COMMUNICATIONS PLAN			
There is a written communication plan that has been reviewed (and updated as necessary) on an annual basis.			
All required contacts included in the communication plan includes contact information. All contact information has been reviewed and updated at least annually.			
The communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies. The plan includes listing the communications equipment or communication systems to be used.			
Verify the communication plan includes: • A method for sharing information and medical (or for RNHCIs (Religious Nonmedical Health Care			

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Institutions) only, care) documentation for patients under the facility's care, as necessary, with other health (or care for RNHCIs) providers to maintain the continuity of care. • **For RNCHIs**, the method for sharing patient information is based on a requirement for the written election statement made by the patient or his or her legal representative. • Policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients.			
The communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. **For hospitals, CAHs, RNHCIs, inpatient hospices, PRTFs, LTC facilities, and ICF/IIDs**: The communication plan includes a means of providing information about their occupancy.			
For LTC AND IICF ONLY: Staff can demonstrate the method the facility has developed for sharing the emergency plan with residents or clients and their families or representatives. There is evidence that residents or clients and their families or representatives have been given information regarding the facility's emergency plan. The communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan.			
TRAINING AND TESTING PROGRAM			
There is a written training and testing program. **For ESRD facilities:** There is a patient orientation program. The program is reviewed and updated on an annual basis. **For ICF/IID:** Emergency plans meet the requirements for evacuation drills and training.			
Staff have knowledge of emergency procedures as outlined in the organization's EM training program.. Staff have received initial and annual emergency preparedness training.			
For ESRD: Staff can describe the evacuation procedures and plan. All patient care staff are current in CPR certification.			
There is documentation of the annual tabletop and full scale exercises (which may include, but is not limited to, the exercise plan, the AAR, and any additional documentation used by the facility to support the exercise. There is documentation of the facility's efforts to identify a full-scale community based exercise if they did not participate in one (i.e. date and			

INDICATOR	MET	NOT MET	COMMENTS
personnel and agencies contacted and the reasons for the inability to participate in a community based exercise). There is evidence of the facility's analysis of the exercises and response and how the facility updated its emergency program based on this analysis.			
For ESRD facilities: There is evidence the organization has implemented their policies and procedures and are actively providing orientation and training of all their patients for the emergency preparedness program. Patients can describe their orientation to the facility in terms of emergency protocols and procedures.			
EMERGENCY POWER SYSTEMS			
For Hospital, CAH, and LTC: The required emergency and standby power systems to meet the requirements of the facility's emergency plan and corresponding policies and procedures is in place which includes: • The emergency plan the facility has emergency power systems or plans in place to maintain safe operations while sheltering in place and/or during evacuation. • **For hospitals, CAHs and LTC facilities which are under construction or have existing buildings being renovated:** The facility has a written plan to relocate the emergency power supply system by the time construction is completed • **For hospitals, CAHs and LTC facilities with permanently attached generators:** (New construction that takes place between November 15, 2016 and is completed by November 15, 2017) The generator is located and installed in accordance with NFPA 110 and NFPA 99. • **The hospitals, CAHs and LTC facilities with an onsite fuel source:** The organization maintains the fuel source in accordance with NFPA 110 for their generator and has a plan for how to keep the generator operational during an emergency, unless they plan to evacuate.			
HEALTHCARE SYSTEMS			
The facility has determined and documented whether or not they have opted to be part of its healthcare system's unified and integrated emergency preparedness program: • There is documentation that verifies the facility within the system was actively involved in the development of the unified emergency preparedness program.			

INDICATOR	MET	NOT MET	COMMENTS
• The facility was actively involved in the annual reviews of the program requirements and any program updates. • The entire integrated and unified emergency preparedness program contains all required components (emergency plan, policies and procedures, communication plan, training and testing program). • The facility leadership can describe how the unified and integrated emergency preparedness program is updated based on changes within the healthcare system such as when facilities enter or leave the system.			
For Transplant Centers: There is written documentation that a representative of each transplant center participated in the development of the emergency program. There is documentation of emergency protocols that address transplant protocols that include the hospital, the transplant center and the associated OPOs.			
The OPO has mutually agreed upon protocols with every certified transplant program it is associated with which includes the duties and responsibilities of the hospital, transplant program and OPO during emergencies. The OPO has a plan in place to ensure continuity of its operation from an alternate location during an emergency.			