PROPOSED RULE	NATIONAL STANDARD	ASHE COMMENT
We are proposing a new requirement under 42 CFR 482.15 that would require that hospitals have both an emergency preparedness program and an emergency preparedness plan. (EPR-001)	NFPA 99 2012 - 12.4 General – 12.2.3.2 The emergency management committee shall have the responsibility for the emergency management program within the facility. 12.2.3.3* The emergency management committee shall model the emergency operations plan on an incident command system (ICS) in coordination with federal, state, and local emergency response agencies, as applicable. 12.4.1 Health care facilities shall develop an emergency management program with a documented emergency operations plan based on the category of the health care facility as defined in Table 12.3. 12.4.1.1 The emergency management program shall include elements as required to manage an emergency during all four phases: mitigation, preparedness, response, and recovery. 12.4.1.2 The emergency management program shall comply with applicable regulations, directives, policies, and industry standards of practice.	This proposal mimics the current industry standard, although the terminology is different. NFPA 99-2012: *Health Care Facilities Code* uses the terminology "emergency management program" and "emergency operations plan (EOP)," whereas the CMS Proposed Rule uses "emergency preparedness program" and "emergency preparedness plan." A proposal that reflects the current industry standard using different language instead of referring to it as the source for this requirement can cause misinterpretation and lead to conflict between requirements as the various regulations are interpreted and change over time.
We are also proposing that a hospital, and all other providers and suppliers, utilize an "all-hazards" approach in the preparation and delivery of emergency preparedness services (EPR-002)	NFPA 99 2012 - 12.5.2 The elements and complexity of the subsequent code sections in this chapter shall apply, as appropriate to the hazard vulnerability analysis (HVA), the community's expectations, and the leadership's defined mission of the health care facility. 12.5.3.1.2 The hazards to be considered shall include, but not be limited to, the following: (1) Natural hazards (geological, meteorological, and biological (2) Human-caused events (accidental or intentional) (3) Technological events 12.5.3.1.3 The analysis shall include the potential impact of the hazards on conditions including, but not limited to, the following: (1)Continuity of operations (2) Care for new and existing patients/residents/ clients (3) Health, safety, and security of persons in the affected area (4) Support of staff (5) Property, facilities, and infrastructure (6) Environmental impact	This proposal does not define the "all-hazards" approach, opening it up to misinterpretation. To avoid this, the proposed rule must clearly define what is meant by an "all hazards" approach to emergency planning. It must also make clear that this approach applies to generalized portions of the emergency operations plan (e.g., incident command, communications, resource management) that can be applied to any type of emergency and does not imply that a hospital must plan for every conceivable type of emergency. Aligning the CMS requirement with the 2012 edition of NFPA 99 would provide more specific direction for addressing high-risk, individual hazards and a more focused approach to emergency planning and overall emergency management programming. In the current NFPA 99-2012, each hospital conducts a hazard vulnerability analysis (HVA) to determine the hazards to which it is most susceptible and develops specific procedures to respond to those hazards that are determined as the highest priority in the HVA. This approach is intended to focus the hospital's efforts on the types of

	(7) Economic and financial conditions (8) Regulatory and contractual obligations (9) Reputation of, or confidence in, the facility 12.5.3.1.4 The facility shall prioritize the hazards and threats identified in the HVA with input from the community.	emergency events that will most likely affect the organization and prevent unnecessary activities such as developing a hurricane plan for a Midwest hospital.
The emergency preparedness plan would have to be reviewed and updated at least annually. (EPR-003)	NFPA 99 2012 - 12.5.3.6 Administration. 12.5.3.6.1 The facility shall update its emergency management program annually, which shall include the following: (1) Updates to the facility HVA (2) Updates to the facility EOP 12.5.3.6.2 The facility shall maintain written records of drills, exercises, and training as required by this chapter for a period of 3 years. Note in 2015 an annual update of the resource inventory will also be required. 12.5.3.3.9.7 – Opportunities for improvement identified in critiques shall be incorporated in the facility's improvement plan.	NFPA 99 currently requires an annual review of the overall emergency operations plan and the hazard vulnerability analysis and, in 2015, the resource inventory. In addition, the standard requires a limited review of the emergency management program two times each year and encourages making improvements identified during these reviews. By creating this new requirement for an annual review and update, CMS will allow facilities to reduce the number of times a plan is reviewed and the depth to which the reviews are performed.
We propose that prior to establishing an emergency preparedness plan, the hospital and all other providers would first perform a risk assessment based on utilizing an "all-hazards" approach. (EPR-004)	NFPA 99 2012 - 12.5.3 Program Elements. 12.5.3.1 Hazard Vulnerability Analysis (HVA). 12.5.3.1.1 A hazard vulnerability analysis (HVA) shall be conducted to identify and prioritize hazards that pose a threat to the facility and can affect the demand for its services. 12.5.3.1.2 The hazards to be considered shall include, but not be limited to, the following: (1) Natural hazards (geological, meteorological, and biological (2) Human-caused events (accidental or intentional) (3) Technological events 12.5.3.1.3 The analysis shall include the potential impact of the hazards on conditions including, but not limited to, the following: (1) Continuity of operations (2) Care for new and existing patients/residents/ clients (3) Health, safety, and security of persons in the affected area (4) Support of staff (5) Property, facilities, and infrastructure	By requiring an "all-hazards" approach to risk assessment, this CMS requirement could potentially cause facilities to inappropriately limit planning and policy preparation for their emergency management programs. The proposed rule quotes a 2007 paper saying, "Rather than managing planning initiatives for a multitude of threat scenarios, all-hazards planning focuses on developing capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters." The rule continues, "Thus, all-hazards planning does not specifically address every possible threat but ensures that hospitals and all other providers will have the capacity to address a broad range of related emergencies." Aligning the CMS requirement with the 2012 edition of NFPA 99 would provide more specific direction for preparing for high-risk, individual hazards and support a more focused approach to emergency preparedness planning and overall emergency management programming. This focused programming would allow for training, direction, and involvement of staff, better preparing them for response

	(6) Environmental impact (7) Economic and financial conditions (8) Regulatory and contractual obligations (9) Reputation of, or confidence in, the facility 12.5.3.1.4 The facility shall prioritize the hazards and threats identified in the HVA with input from the community.	efforts and thus protecting the lives of more patients, visitors, and staff. Following NFPA 99 requirements, each hospital performs a hazard vulnerability analysis (HVA), which identifies the hazards most likely to affect the facility. The HVA does not lead to preparation for every imaginable hazard; rather, it starts with a list of hazards developed by the facility based on the general criteria established in NFPA 99 and ranks them based on probability, severity, and preparedness level. The hospital then prepares etailed response procedures for the hazards that rank high on the list.
We propose at § 482.15(a)(2) that the emergency plan include strategies for addressing emergency events identified by the risk assessment. (EPR-005)	12.5.3.2 Mitigation. 12.5.3.2.1 The facility shall develop and implement a strategy to eliminate hazards or mitigate the effects of hazards that cannot be eliminated. 12.5.3.2.2 A mitigation strategy shall be developed for priority hazards defined by the HVA. 12.5.3.2.3 The mitigation strategy shall consider, but not be limited to, the following: (1) Use of applicable building construction standards (2) Hazard avoidance through appropriate land-use practices (3) Relocation, retrofitting, or removal of structures at risk (4) Removal or elimination of the hazard (5) Reduction or limitation of the amount or size of the hazard (6) Segregation of the hazard from that which is to be protected (7) Modification of the basic characteristics of the hazard (8) Control of the rate of release of the hazard (9) Provision of protective systems or equipment for both cyber or physical risks (10) Establishment of hazard warning and communications procedures (11) Redundancy or duplication of essential personnel, critical systems, equipment, information, operations, or materials.	NFPA 99 currently requires the facility to develop and implement a strategy to eliminate hazards or mitigate the effects of hazards that cannot be eliminated based on the hazard prioritization determined by the HVA. This mitigation strategy is to consider, at minimum, these actions: (1) Use of applicable building construction standards; (2) Hazard avoidance through appropriate land use practices; (3) Relocation, retrofitting, or removal of structures at risk; (4) Removal or elimination of the hazard; (5) Reduction or limitation of the amount or size of the hazard; (6) Segregation of the hazard from that which is to be protected; (7) Modification of the basic characteristics of the hazard; (8) Control of the rate of release of the hazard; (9) Provision of protective systems or equipment for both cyber or physical risks; (10) Establishment of hazard warning and communications procedures; and (11) Redundancy or duplication of essential personnel, critical systems, equipment, information, operations, or materials. The CMS proposal would require the emergency plan to include strategies for addressing emergency events identified by a risk assessment rather than a hazard analysis, which would greatly reduce the guidance and direction for emergency planning and would allow facilities to establish broad general emergency plans. NFPA 99-2012 clearly addresses the areas for which facilities need to properly evaluate and prepare emergency

	12.5.3.3 Preparedness. 12.5.3.3. The facility shall prepare for any emergency as determined by the HVA by organizing and mobilizing essential resources. 12.5.3.3.5 The facility shall write an emergency operations plan (EOP) that describes a command structure and the following critical functions within the facility during an emergency: (1) Communications (2) Resources and assets (3) Safety and security (4) Clinical support activities (5) Essential utilities (6) Exterior connections (7) Staff roles 12.5.3.3.6 Critical Function Strategies. During the development of the EOP, the facility shall consider the strategies required in 12.5.3.3.6.l through 12.5.3.3.6.8 in order to manage critical functions during an emergency within the facility.	management plans. Providing a proposal that generalizes the effort will allow for reduced effort and make for less effective verification of adherence to the generalized requirement.
At § 482.15(a)(3), we propose that a hospital's emergency plan address its patient population, including, but not limited to, persons at-risk. (EPR-006)	12.5.3.3.6.4 Clinical Support Activities. The facility shall plan for the following during an emergency: (1) Clinical activities that could need modification or discontinuation during an emergency, such as patient scheduling, triage, assessment, treatment, admission, transfer, discharge, and evacuation (2) Clinical services for special needs populations in the community, such as pediatric, geriatric, disabled, chronically ill patients and those with addictions (Category 1 only) (3) Patient cleanliness and sanitation (4) Behavioral needs of patients (5) Mortuary services (6) Evacuation both horizontally and, when required by circumstances, vertically, when the environment cannot support care, treatment, and services (7) Transportation of patients, and their medications and	NFPA 99 currently requires that facilities plan for the following clinical support activities during an emergency: (1) Clinical activities that could need modification or discontinuation during an emergency, such as patient scheduling, triage, assessment, treatment, admission, transfer, discharge, and evacuation; (2) Clinical services for special needs populations in the community, such as pediatric, geriatric, disabled, chronically ill patients and those with addictions (Category 1 only); (3) Patient cleanliness and sanitation; (4) Behavioral needs of patients; (5) Mortuary services; (6) Evacuation both horizontally and, when required by circumstances, vertically, when the environment cannot support care, treatment, and services; (7) Transportation of patients, and their medications and equipment, and staff to an alternative care site(s) when the environment cannot

	equipment, and staff to an alternative care site(s) when the environment cannot support care, treatment, and services (8) Transportation of pertinent patient information, including essential clinical and medication-related information, to an alternative care site(s) when the environment cannot support care, treatment, and services (9) Documentation and tracking of patient location and patient clinical information	support care, treatment, and services; (8) Transportation of pertinent patient information, including essential clinical and medication-related information, to an alternative care site(s) when the environment cannot support care, treatment, and services; and (9) Documentation and tracking of patient location and patient clinical information. This CMS proposal would greatly reduce the details required for planning to address the needs of patient populations during an emergency. NFPA 99-2012 requires that, in addition to the patient population and persons at-risk outlined in the CMS proposed rule, the plan address the potential impact of care, health, safety, and security for new and existing patients, residents, and clients. The language as proposed would reduce the current requirements, significantly increasing the potential for causing confusion and misunderstanding in the planning process and harming those the plan is supposed to help protect.
We also propose at § 482.15(a)(3) that a hospital's emergency plan address the types of services that the hospital would be able to provide in an emergency. (EPR-007)	NFPA 99 2012 - 12.5.3.3.6.4 – Clinical Support Activities. The facility shall plan for the following during an emergency: (1) Clinical activities that could need modification or discontinuation during an emergency, such as patient scheduling, triage, assessment, treatment, admission, transfer, discharge, and evacuation (2) Clinical services for special needs populations in the community, such as pediatric, geriatric, disabled, chronically ill patients and those with addictions (Category 1 only) 12.5.3.3.6.8 The facility shall include the following in its EOP: (4) Facility capabilities and appropriate response efforts when the facility cannot be supported from the outside for extended periods in the six critical areas with an acceptable response, including examples such as the following: (a) Resource conservation (b) Service curtailment (c) Partial or total evacuation consistent with the staff's designated role in community response plan (5) Alternative treatment sites to meet the needs of the patients	NFPA 99-2012 clearly addresses the areas for which facilities need to prepare and evaluate emergency management plans for clinical support, including planning for the types of services the facility would be able to provide in an emergency, clinical activities that may need modification, clinical services for special needs populations, facility capabilities and appropriate response efforts when the facility cannot receive outside support for extended periods, and alternative treatment sites to meet the needs of patients. The CMS proposal as written generalizes the efforts a hospital would need to take to determine the types of services it could provide in an emergency. This would allow a facility to reduce its planning for services during an emergency and make for less-effective verification of adherence to the generalized requirement.
In regard to emergency	NFPA 99 2012 - 12.5.3.3.6.8 – The facility shall include the	NFPA 99-2012 clearly addresses the need to coordinate a

preparedness planning, we are also proposing at § 482.15(a)(3) that all hospitals include delegations and succession planning in their emergency plan to ensure that the lines of authority during an emergency are clear and that the plan is implemented promptly and appropriately. (EPR-008)	following in its EOP: (1) Standard command structure that is consistent with its community (2) Reporting structure consistent with the command structure (3) Activation and deactivation of the response and recovery phases, including the authority and process (4) Facility capabilities and appropriate response efforts when the facility cannot be supported from the outside for extended periods in the six critical areas with an acceptable response, including examples such as the following: (a) Resource conservation (b) Service curtailment (c) Partial or total evacuation consistent with the staff's designated role in community response plan (5) Alternative treatment sites to meet the needs of the patients	facility's command structure with the community, which is vital for effective communication during an emergency. It also requires the reporting structure that details the line of authority to be included in the emergency plan, including succession planning and activation and deactivation of the response. This CMS proposal actually reduces what is required by the current standard due to the general nature of its language and the lack of a requirement to include coordination with the community. Providing a proposal that generalizes the effort will allow for reduced effort and make for less-effective verification of adherence to the generalized requirement.
Finally, at § 482.15(a)(4), we propose that a hospital 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 situation, including documentation of the hospital's efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts. (EPR-009)	NFPA 99 2012 - 12.2.3.3 – The emergency management committee shall model the emergency operations plan on an incident command system (ICS) in coordination with federal, state, and local emergency response agencies, as applicable. 12.4.2 When developing its emergency management program, the facility shall communicate its needs and vulnerabilities to community emergency response agencies and identify the capabilities of its community in supporting their mission. 12.5.3.4.10 The decision to reduce medical care shall be conducted witl1 the full knowledge and concurrence of community leadership. 12.5.3.5.3 Facility leadership shall accept and accommodate federal, state, and local assistance that will be beneficial for recovery of operations.	NFPA 99-2012 requires a facility to cooperate and collaborate with federal, state and local emergency response agencies throughout the standard. This CMS proposal mimics that language but fails to include the recovery of operations phase of emergency response and does not provide the same level of detail for the cooperation during the response phase of an emergency. Using language that generalizes the effort required will allow for reduced effort and make for less-effective verification of adherence to the generalized requirement.
We are proposing at § 482.15(b) that a hospital be required to develop and implement emergency preparedness policies and procedures based on the	NFPA 99 2012 – 12.4.1 General – Health care facilities shall develop an emergency management program with a documented emergency operations plan based on the category of the health care facility as defined in Table 12.3. 12.4.1.1 The emergency management program shall include	NFPA 99-2012 requires a detailed emergency management program that includes four phases—mitigation, preparedness, response. and recovery—and also requires an annual review of the overall emergency management program and plan as well as the EOP, HVA and, in 2015, the

emergency plan proposed at § 482.15(a), the risk assessment proposed at § 482.15(a)(1), and the communication plan proposed at § 482.15(c). These policies and procedures would be reviewed and updated at least annually. We are soliciting public comment on the timing of the updates. (EPR-010)	elements as required to manage an emergency during all four phases: mitigation, preparedness, response, and recovery. 12.4.1.2 The emergency management program shall comply with applicable regulations, directives, policies, and industry standards of practice. 12.3.2.2 – A mitigation strategy shall be developed for priority hazards defined by the HVA. 12.5.3.3.4 – The facility shall establish a protocol for monitoring the quantity of assets and resources as they are utilized. 12.5.3.3.6 – Critical Function Strategies. During the development of the EOP, the facility shall consider the strategies required in 12.5.3.3.6.1 through 12.5.3.3.6.8 in order to manage critical functions during an emergency within the facility. 12.5.3.3.6.1 Communications, 12.5.3.3.6.2 Resources and Assets, 12.5.3.3.6.3 Safety and Security, 12.5.3.3.6.4 Clinical Support Activities, 12.5.3.3.6.5 Essential Utilities, 12.5.3.3.6.6 Exterior Connections, 12.5.3.3.6.7 Staff Roles 12.5.3.3.6.8 The facility shall include the following in its EOP. (1) Standard command structure that is consistent with its community (2) Reporting structure consistent with the command structure (3) Activation and deactivation of the response and recover phases, including the authority and process (4) Facility capabilities and appropriate response efforts when the facility cannot be supported from the outside for extended periods in the six critical areas with an acceptable response, including examples such as the following: (a) Resource conservation (b) Service curtailment (c) Partial or total evacuation consistent with the staff's designated role in community response plan (5) Alternative treatment sites to meet the needs of the patients. For Category 1 Facilities – 12.5.3.4.12.1 The facility shall plan for surge capacity.	resource inventory. In addition, the requirement to incorporate opportunities for improvements identified in test critiques requires a limited review of the program two additional times each year. This CMS proposal requires policies and procedures based on the emergency management program, the risk assessment and the communication plan, which mimics the NFPA 99 criteria. Language that mimics the current standard can cause misinterpretation and lead to conflict between regulations as the various regulations are interpreted and change over time. By requiring only an annual review and update, CMS will create the opportunity for facilities to reduce the number of times a plan is reviewed and the depth to which these reviews will be performed.

	12.5.3.5.1 Plans shall reflect measures needed to restore operational capability to pre-disaster levels. 12.5.3.6 Administration – The facility shall update its emergency management program annually, which shall include the following: (1) Updates to the facility HVA, (2) Updates to the facility EOP 12.5.3.3.9.7 – Opportunities for improvement identified in critiques shall be incorporated in the facility's improvement plan. 12.5.3.3.9.8 – The facility shall modify its EOP in response to critiques of exercises.	
We propose at § 482.15(b)(1) that a hospital's policies and procedures would have to address the provision of subsistence needs for staff and patients, whether they evacuated or sheltered in place, including, but not limited to, at (b)(1)(i), food, water, and medical supplies. (EPR-011)	NFPA 99 2012 - 12.5.3.3.6.2 (5) & (6) The facility shall plan for the following during an emergency: (5) Managing staff support activities, such as housing, transportation, incident stress debriefing, sanitation, hydration, nutrition, comfort, morale and mental health. (6) Managing staff family support needs, such as child care, elder care, pet care, and communication to home.	NFPA 99-2012 requires planning for the housing, transportation, incident stress debriefing, sanitation, hydration, nutrition, comfort, morale, and mental health of patients, visitors, staff, family members, pets and emergency response personnel. These requirements support a sheltering-in-place strategy. A hospital initiates an evacuation when it can no longer provide for staff and patients. Therefore, a requirement to provide for subsistence for staff and patients is only meaningful if it requires the evacuating hospital to ensure that the alternate care site will be able to provide for these minimal needs. The proposed language implies that the initial facility will maintain responsibility for its transferred patients, which will create a conflict with the receiving facility since it won't accept patients without taking responsibility for them. Without the transfer of the responsibility, conflict could develop between the facilities involved regarding patient care and treatment and the fiscal responsibility for services provided. This proposal might be meaningful if it required the evacuating hospital to ensure the alternate care site could provide subsistence needs for patients and others prior to exchange of the individuals.
Therefore, we are proposing that a hospital's policies and	No requirement	NFPA 99-2012 requires planning for the housing, transportation, incident stress debriefing, sanitation,

procedures also address how the subsistence needs of patients and staff who were evacuated would be met during an emergency. (EPR-012)		hydration, nutrition, comfort, morale and mental health of patients, visitors, staff, family members, pets and emergency response personnel. These requirements support a sheltering-in-place strategy. A hospital initiates an evacuation when it can no longer provide for staff and patients. Therefore, a requirement to provide for subsistence for staff and patients is only meaningful if it requires the evacuating hospital to ensure the alternate care site will be able to provide for these minimal needs. The proposed language implies the initial facility will maintain responsibility for patients, which will create a conflict with the receiving facility since it won't accept patients without taking responsibility for them. Without the transfer of responsibility, conflict could develop between the facilities involved regarding patient care and treatment and the fiscal responsibility for services provided. This proposal might be meaningful if it required the evacuating hospital to ensure the alternate care site could provide subsistence needs for patients and others prior to exchange of the individuals.
Although we propose requiring only that each hospital addresses subsistence needs for staff and patients, we recommend that hospitals keep in mind that volunteers, visitors, and individuals from the community may arrive at the hospital to offer assistance or seek shelter and consider whether the hospital needs to maintain a store of extra provisions. We are soliciting public comment on this proposed requirement. (EPR-013)	NFPA 99 2012 - 12.5.3.3.6.2 (5) & (6) The facility shall plan for the following during an emergency: (5) Managing staff support activities, such as housing, transportation, incident stress debriefing, sanitation, hydration, nutrition, comfort, morale and mental health. (6) Managing staff family support needs, such as child care, elder care, pet care, and communication to home.	NFPA 99-2012 requires facilities to plan for support activities for staff, family, elders, pets, and emergency personnel. The language proposed by CMS only recommends planning for these types of activities. Making this a recommendation rather than a requirement will reduce the current standard and cause confusion and opportunity for conflicts in standards. This proposal also includes a recommendation that hospitals keep sufficient provisions for individuals from the community who may seek shelter. This proposed requirement would place a burden on hospitals to provide food, water, clothing, and other items for the community at large. This would not only be overwhelming to plan for but also an extreme fiscal burden likely to result in repeated waste. Since it is not known when a disaster might strike, the hospital would need to store sufficient provisions for every member of its community at all times. Because some of these provisions would be perishable, they would have to be replaced over

		time, causing an undue burden on the hospital.
at § 482.15(b)(1)(ii) we also propose that the hospital have policies and procedures that address the provision of alternate sources of energy to maintain: (1) temperatures to protect patient health and safety and for the safe and sanitary storage of provisions; (2) emergency lighting; (3) fire detection, extinguishing, and alarm systems. (EPR-014)	NFPA 99 2012 - 12.5.3.3.6.5 Essential Utilities - The facility shall plan for the following during an emergency: 1) Electricity, 2)Potable H_2O, 3) Nonpotable H_2O, 4) HVAC, 5) Fire Protection Systems, 6) Fuel required for building operations, 7) Fuel for essential transportation, 8) Medical gas & Vacuum systems if applicable 12.5.3.3.6.6 Exterior Connections – For essential utility systems in Category 1 facilities only and based on the facility HVA consideration shall be given to the installation of exterior building connectors to allow for the attachment of portable emergency utility modules. NFPA 99 6.4.2.2.3.2 The life safety branch shall supply power for lighting, receptacles, and equipment as follows: (1) Illumination of means of egress in accordance with NFPA *101, Life Safety Code* (2) Exit signs and exit directional signs in accordance with NFPA *101, Life Safety Code* (3)*Hospital communications systems, where used for issuing instruction during emergency conditions (4) Generator set location as follows: (a) Task illumination (b) Battery charger for emergency battery-powered lighting unit(s) (c) Select receptacles at the generator set location and essential electrical system transfer switch locations (5) Elevator cab lighting, control, communications, and signal systems (6) Electrically powered doors used for building egress (7) Fire alarms and auxiliary functions of fire alarm combination systems complying with *NFPA 72, National Fire Alarm and Signaling Code* 6.4.2.2.3.3 Alarm and alerting systems (other than fire alarm systems) shall be connected to the life safety branch or critical branch. 6.4.2.2.3.4 Loads dedicated to a specific generator, including the fuel transfer pump(s), ventilation fans, electrically operated louvers, controls, cooling system, and other generator accessories essential for generator operation, shall be connected to the life safety branch or the output terminals of the generator with overcurrent protective devices. 6.4.2.2.3.5 No functions other than those in 6.4.2.2.3.2, 6.4.2.2.3.3, and 6.4.2.2.3.4 shall be connected to the life safety branch, except as specifically permitted in 6.4.2.2.3. 6.4.2.2.4* Critical Branch. 6.4.2.2.4.1 The critical branch shall be permitted to be subdivided into two or more branches. 6.4.2.2.4.2 The critical branch shall supply power for task illumination, fixed equipment, select receptacles, and select power circuits serving the following areas and functions related to patient care: (1) Critical care areas that utilize anesthetizing gases, task illumination, select	NFPA 99 details the utilities a facility must plan to continue providing during an emergency, including the equipment that must be included on the essential electrical system, which consists of the life safety, critical, and equipment branches. The explanation for the proposed CMS ruling on policies and procedures for alternate power sources states, "These proposed requirements concern assuring the continuity of the power source for the fire detection, extinguishing and alarm systems and are an essential prerequisite for successful implementation of existing requirements during emergencies that result in loss of regular power. These proposed requirements are more in line with best practice rather than mere sufficiency." If this is intended to be a best practice rather than a requirement, it could be misinterpreted and conflict with current standards. A major concern with this proposal is that it will increase the requirements for what must be included on essential electrical systems and require existing facilities to upgrade their systems to meet the increased requirements. Facilities do not often have the capability to provide total climate control and refrigerated storage of perishables with emergency power (5kv chillers, hundreds of horsepower requirements for pumps and fans). Temperature control as it relates to air conditioning is a serious issue. This may require substantial retrofit of buildings to ensure they can continue to operate after a disaster. A clear definition of what the expectations are is necessary. Also, alternative sources for sewage and waste disposal could be made available without power requirements.

Comment [pjb1]: Addition okay? Seemed NFPA went much broader than CMS as well as gave more detail.

Comment [pjb2]: Is this right? This proposed rule is only about alternate power sources?

Comment [pjb3]: Still don't think this one is clear. The difference between what is required by the CMS and the NFPA language needs to be explained better.

	receptacles, and fixed equipment (2) Isolated power systems in special environments (3) Task illumination and select receptacles in the following: (a) Patient care rooms, including infant nurseries, selected acute nursing areas, psychiatric bed areas (omit receptacles), and ward treatment rooms (b) Medication preparation areas (c) Pharmacy dispensing areas (d) Nurses' stations (unless adequately lighted by corridor luminaires) (4) Additional specialized patient care task illumination and receptacles, where needed (5) Nurse call systems (6) Blood, bone, and tissue banks (7) *Telephone equipment rooms and closets (8) Task illumination, select receptacles, and select power circuits for the following areas: (a) General care beds with at least one duplex receptacle per patient bedroom, and task illumination as required by the governing body of the health care facility (b) Angiographic labs (c) Cardiac catheterization labs (d) Coronary care units (e) Hemodialysis rooms or areas (f) Emergency room treatment areas (select) (g) Human physiology labs (h) Intensive care units (i) Postoperative recovery rooms (select) (9) Additional task illumination, receptacles, and select power circuits needed for effective facility operation, including single-phase fractional horsepower motors, which are permitted to be connected to the critical branch 6.4.2.2.5.3* Equipment for Delayed-Automatic Connection. (A) The following equipment shall be permitted to be arranged for delayed-automatic connection to the alternate power source: (1) Central suction systems serving medical and surgical functions, including controls, with such suction systems permitted to be placed on the critical branch (2) Sump pumps and other equipment required to operate for the safety of major apparatus, including associated control systems and alarms (3) Compressed air systems serving medical and surgical functions, including controls, with such air systems permitted to be placed on the critical branch (4) Smoke control and stair pressurization systems (5) Kitchen hood supply or exhaust systems, or both, if required to operate during a fire in or under the hood (6) Supply, return, and exhaust ventilating systems for the following: (a) Airborne infectious/isolation rooms (b) Protective environment rooms (c) Exhaust fans for laboratory fume hoods (d) Nuclear medicine areas where radioactive material is used (e) Ethylene oxide evacuation (f) Anesthetic evacuation (B) Where delayed-automatic connection is not appropriate, the ventilation systems specified in 6.4.2.2.5.3(A) (6) shall be permitted to be placed on the critical branch. 6.4.2.2.5.4* Equipment for Delayed-Automatic or Manual Connection. The following equipment shall be permitted to be arranged for either delayed-automatic or manual connection to the alternate power source	

	(alsoseeA.6.4.2.2.5.3): (1) Heating equipment used to provide heating for operating, delivery, labor, recove1y, intensive care, coronary care, nurseries, infection/isolation rooms, emergency treatment spaces, and general patient rooms; and pressure maintenance jockey or make-up) pump(s) for water-based fire protection systems (2)*Heating of general patient rooms during disruption of the normal source shall not be required under any of the following conditions: (a) Outside design temperature is higher than -6.7°C (+20°F) (b) Outside design temperature is lower than -6.7°C (+20°F), where a selected room(s) is provided for the needs of all confined patients [then only such room(s) need be heated]. (3) Elevator(s) selected to provide service to patient, surgical, obstetrical, and ground floors during interruption of normal power (4) Supply, return, and exhaust ventilating systems for surgical and obstetrical delivery suites, intensive care, coronary care, nurseries, and emergency treatment spaces (5) Hyperbaric facilities (6) Hypobaric facilities (7) Autoclaving equipment, which is permitted to be arranged for either automatic or manual connection to the alternate source (8) Controls for equipment listed in 6.4.2.2.4 (9)*0ther selected equipment	
We are also proposing at § 482.15(b)(1)(ii)(D) that the hospital develop policies and procedures to address provision of sewage and waste disposal. We are proposing to define the term "waste" as including all wastes including solid waste, recyclables, chemical, biomedical waste and wastewater, including sewage. (EPR-015)	NFPA 99 2012 - 12.5.3.3.6.5 Essential Utilities - The facility shall plan for the following during an emergency: 3) Nonpotable H2O	NFPA 99-2012 requires the facility to plan for [disposal of?] nonpotable water during an emergency. The CMS proposal would require the facility to address the disposal of all waste, including solid waste, recyclables, chemical, biomedical waste, and wastewater, including sewage. This requirement could be interpreted to require a facility to be able to meet all disposal requirements during an emergency. In a large scale disaster, this would mean a facility might be responsible for properly treating sewage and disposing of solid waste. This would be a significant issue for all facilities. Treating sanitary sewage on-site if the municipal system is disrupted would require the installation of an on-site sewage treatment plant. Logistically, this would be impossible for almost all facilities. To properly dispose of solid waste would require a facility to have the capability to incinerate solid waste, which again would be impossible for almost all facilities and would directly impact the efforts of the Environmental Protection Agency to reduce the use of incineration at hospitals. In a major emergency situation, it is likely the ability to remove waste will not be available for an extended period. Having a secure area in which to store the

Comment [pjb4]: Not clear what NFPA 99 is requiring re: nonpotable water.

		waste until it can be disposed of is critical. As written, this requirement does not have sufficient detail as to what is required and could lead to significant misinterpretation and confusion.
We are proposing at § 482.15(b)(2) that the hospital 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. (EPR-016)	NFPA 99 2012 - 12.5.3.3.6.4 Clinical Support Activities shall plan for the following during an emergency: (9) Documentation & tracking of patient location & patient clinical information	NFPA 99-2012 requires documentation and tracking of patient location and patient clinical information. This function would be included in evacuation plans and addressed under the Hospital Incident Command System (HICS) Planning Section. HICS has a position for patient tracking in the Planning Section, and NFPA 99 requires backup systems and alternate means of patient documentation and tracking of electronic records. The tracking of staff and volunteers is included in the HICS resources planning section. The proposal as written requires additional tracking of staff and patients after an emergency; however, the language is vague and does not indicate when the tracking responsibility would end. NFPA's requirement to track patient locations during an emergency clearly indicates when this mode of tracking is to cease. As written in NFPA 99, an emergency has established phases, one of which is the recovery phase. For the recovery phase, a facility's plans must include measures to restore operational capability to pre-disaster levels when the emergency has ceased and normal operations are once again established.
Therefore, we would recommend that a hospital using an electronic database consider backing up its computer system with a secondary source. (EPR-017)	No requirement	This recommendation, although not a required standard, is a standard best practice for technology systems.
We propose at § 482.15(b)(3) that hospitals have policies and procedures in place to ensure the safe evacuation from the hospital, which would include standards addressing consideration of care and treatment needs of evacuees;	NFPA 99 2012 - 12.5.3.4.7 When conditions approach untenable, the command staff, in combination with community emergency response agencies, shall determine when to activate the facility evacuation plan	NFPA 99-2012 requires facilities to plan for evacuations so that their plans can be activated when conditions approach untenable status in coordination with community emergency response agencies. Although this proposal cites more detailed considerations, it does not require coordination with community emergency response agencies. This could lead to significant

Comment [pjb5]: How is sthis different from the "position for patient tracking in the Planning Section" that you mention above? I don't know what "position" means in that sentence. It seems to me this sentence isn't necessary in addition to the previous sentence about HICS, except that you took the volunteers out there and have them here.

staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. (EPR-018)		misinterpretation and confusion between standards.
We propose at § 482.15(b)(4) that a hospital must have policies and procedures to address a means to shelter in place for patients, staff, and volunteers who remain in the facility. We expect that hospitals would include in their policies and procedures both the criteria for selecting patients and staff that would be sheltered in place and a description of the means that they would use to ensure their safety. (EPR-019)	NFPA 99 2012 - 12.5.3.3.6.2 Resources and Assets. The facility shall plan for the following during an emergency: (1) Acquiring medical, pharmaceutical, and nonmedical supplies (2) Replacing medical supplies and equipment that will be used throughout response and recovery (3) Replacing pharmaceutical supplies that will be consumed throughout response and recovery (4) Replacing nonmedical supplies that will be depleted throughout response and recovery (5) Managing staff support activities, such as housing, transportation, incident stress debriefing, sanitation, hydration, nutrition, comfort, morale, and mental health (6) Managing staff family support needs, such as child care, elder care, pet care, and communication to home (7) Providing staff, equipment, and transportation vehicles needed for evacuation	NFPA 99-2012 requires facilities to plan for sheltering in place and provides significant detail for this requirement. The language of this proposal is fairly general regarding what is required. The NFPA 99 requirements have been established using a multidisciplinary consensus process that allows for detailed input and discussion from subject matter experts and interested parties. This process has allowed for the development of detailed, accurate requirements that provide the greatest opportunity to protect lives during emergencies. Providing a proposal that generalizes the effort could lead to reduced effort on the part of hospitals and make for less-effective verification of adherence to the generalized requirement. Also, language that mimics the current standard can cause misinterpretation and lead to conflict between regulations as they are interpreted and changed over time.
We propose at § 482.15(b)(5) that a hospital have policies and procedures that would require a system of medical documentation that would preserve patient information, protect the confidentiality of patient information, and ensure that patient records were secure and readily available during an emergency. (EPR-020)	NFPA 99 2012 - 12.5.3.3.6.4 Clinical Support Services (7) Transportation of patients, and their medications and equipment, and staff to an alternative care site when the environment cannot support care, treatment, and services, (8) Transportation of pertinent patient information, including essential clinical and medication-related information, to an alternative care site when the environment cannot support care, treatment and services, (9) Documentation and tracking of patient location and patient clinical information	NFPA 99-2012 requires facilities to plan for transportation of patient information during an emergency. Although the language of this proposal would provide for protection of confidentiality of patient records is still fairly general regarding the other requirements to be addressed. NFPA 99-2012 requires facilities to plan for the transportation of pertinent patient information and documentation and tracking of patient location and clinical information. Although NFPA 99-2012 doesn't directly address protection of patient information, these requirements are addressed in other required standards such as the Health Insurance Portability and Accountability Act (HIPAA). Providing a proposal that generalizes the effort required will allow for reduced effort and make for less-effective verification of adherence to the

		generalized requirement.
In addition to the current hospital requirements for medical records located at § 482.24(b), we are proposing that hospitals be required to ensure that patient records are secure and readily available during an emergency. (EPR-021)	NFPA 99 2012 - 12.5.3.3.6.4 Clinical Support Services (8) Transportation of pertinent patient information, including essential clinical and medication-related information, to an alternative care site when the environment cannot support care, treatment and services, (9) Documentation and tracking of patient location and patient clinical information	NFPA 99-2012 requires facilities to plan for transportation of patient information during an emergency. Although the language of this proposal provides for protection of confidentiality of patient records, it is fairly general regarding the other requirements to be addressed. Although NFPA 99-2012 doesn't directly address protection of patient information, these requirements are addressed in other required standards such as the Health Insurance Portability and Accountability Act (HIPAA). Providing a proposal that generalizes the effort will allow for reduced effort and make for less-effective verification of the adherence to the generalized requirement.
We propose at § 482.15(b)(6) that facilities would have to have policies and procedures in place to address the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of state or federally designated health care professionals to address surge needs during an emergency. (EPR-022)	NFPA 99 2012 - 12.5.3.4.5 The organization shall make provisions for emergency credentialing of volunteer clinical staff. 12.5.3.4.5.1 At a minimum, a peer evaluation of skill shall be conducted to validate proficiency for volunteer clinical staff. 12.5.3.4.5.2 Prior to beginning work, efforts shall be made to verify identities of other volunteers offering to assist during response activities. 12.5.3.4.5.3 Personnel designated or involved in the EOP of the facility shall be supplied with a means of identification, which shall be worn at all times in a visible location	NFPA 99-2012 requires facilities to plan for emergency credentialing and evaluation of volunteer clinical staff. Although the language of this proposal provides for the integration of state or federally designated health care professionals to address surge needs during an emergency, it is fairly general regarding the other requirements to be addressed. NFPA 99 requires the health care organization to make provisions for emergency credentialing of volunteer clinical staff that, at minimum, includes a peer evaluation of skill to validate proficiency. In addition, NFPA 99 requires that prior to beginning work organizations must verify the identities of volunteers. Providing a proposal that generalizes the effort to verify volunteers and to ascertain clinical proficiency will allow for reduced effort and could lead to acceptance of unqualified clinical volunteers and the lack of identification of other types of volunteers. Additionally, generalization of these requirements will make for less-effective verification of adherence to the generalized requirement.
We propose at § 482.15(b)(7) that hospitals would have to have a process for the development of arrangements with other	NFPA 99 2012 - 12.5.3.3.6.1 (6) Cooperative planning with other local or regional health care facilities, including the following: (a) Exchange of information relating to command	NFPA 99-2012 requires facilities to undertake cooperative planning with other local or regional health care facilities to plan for (a) Exchange of information relating to command operations, including contact information; (b) Staffing and

hospitals and other providers to receive patients in the event of limitations or cessation of operations at their facilities, to ensure the continuity of services to hospital patients. (EPR-023)	operations, including contact information (b) Staffing and supplies that could be shared (c) System to locate the victims of the event	supplies that could be shared; and (c) System to locate the victims of the event. The CMS proposal provides for a more general development of arrangements with other hospitals and providers who can receive patients in the event of limitations or cessation of operations at their facilities. Although this proposal does specify that arrangements must be made, the requirements of these arrangements are general in nature. Providing a proposal that generalizes the effort will allow for reduced effort and make for less-effective verification of the adherence to the generalized requirement.
We also propose at § 482.15(b)(8) that hospital policies and procedures would have to address the role of the hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Act, for the provision of care and treatment at an alternate care site (ACS) identified by emergency management officials. We propose this requirement for inpatient providers only. We would expect that state or local emergency management officials might designate such alternate sites, and would plan jointly with local providers on issues related to staffing, equipment and supplies at such alternate sites. This requirement encourages providers to collaborate with their local emergency officials in such proactive planning to allow an organized and systematic response to assure continuity of care even when services at their facilities have been severely	NFPA 99 2012 - 12.5.3.4.7 When conditions approach untenable, the command staff, in combination with community emergency response agencies, shall determine when to activate the facility evacuation plan. 12.5.3.4.8 Evacuation to the alternative care site shall follow the planning conducted during the preparedness phase. 12.5.3.4.9 Planning efforts shall minimize to the greatest extent feasible the planned reduction of clinical care. 12.5.3.4.10 The decision to reduce medical care shall be conducted with the full knowledge and concurrence of community leadership.	NFPA 99-2012 requires planning for the use of alternate care sites (ACSs) in cooperation with community emergency response agencies. This proposal requires a hospital to provide care at ACSs that is determined by emergency management officials, which could lead to significant conflicts in the community. ACS sites should be planned for and selected by the hospital with coordination and cooperation with local community emergency response agencies as required by NFPA 99 since ACSs must be selected based on required clinical services. This proposal as written is in direct conflict with the current standard.

disrupted. (EPR-024)		
We propose at § 482.15(c) that the hospital be required to develop and maintain an emergency preparedness communication plan that complies with both federal and state law. The hospital would be required to review and update the communication plan at least annually. (EPR-025)	NFPA 99 2012 - 12.5.3.3.6.1 The facility shall plan for the following during an emergency: (1) Initial notification and ongoing communication of information and instructions to staff (2) Initial notification and ongoing communication with the external authorities (3) Communication with the following: (a) Patients and their families (responsible parties) (b) Responsible parties when patients are relocated to alternative care sites (c) Community and the media (d) Suppliers of essential materials, services, and equipment (e) Alternative care sites (4) Definition of when and how to communicate patient information to third parties (5) Establishment of backup communications systems (6) Cooperative planning with other local or regional health care facilities, including the following: (a) Exchange of information relating to command operations, including contact information (b) Staffing and supplies that could be shared (c) System to locate the victims of the event	NFPA 99 2012 requires facilities to develop a detailed communications plan that includes the following: (1) Initial notification and ongoing communication of information and instructions to staff; (2) Initial notification and ongoing communication with the external authorities; (3) Communication with the following: (a) Patients and their families (responsible parties), (b) Responsible parties when patients are relocated to alternative care sites, (c) Community and the media, (d) Suppliers of essential materials, services, and equipment, (e) Alternative care sites; (4) Definition of when and how to communicate patient information to third parties; (5) Establishment of backup communications systems; (6) Cooperative planning with other local or regional health care facilities, including the following: (a) Exchange of information relating to command operations, including contact information, (b) Staffing and supplies that could be shared, (c) System to locate the victims of the event. This proposal significantly generalizes the requirement for a communication plan. Providing a proposal that generalizes the effort will allow for reduced effort and make for less-effective verification of the adherence to the generalized requirement.
We propose at § 482.15(c)(2) requiring hospitals to have contact information for federal, state, tribal, regional, or local emergency preparedness staff and other sources of assistance. (EPR-026)	NFPA 99 2012 - 12.5.3.3.6.1 (2) – Initial notification and ongoing communication with the external authorities	NFPA 99-2012 requires facilities to provide notification and ongoing communication with external authorities, including contact information based on the facilities command structure. The language of this proposal mimics the current standard, which can cause misinterpretation and lead to conflict between regulations as the regulations change over time.
We propose to require at § 482.15(c)(3) that hospitals have primary and alternate means for communicating with the hospital's staff and federal, state, tribal, regional, or local emergency management agencies (EPR-027)	NFPA 99 2012 - 12.5.3.3.6.1 (5) – Establishment of backup communications systems	NFPA 99-2012 already requires the establishment of backup communications systems.

Under this proposed rule, we would also require at § 482.15(c)(4) that hospitals have a method for sharing information and medical documentation for patients under the hospital's care, as necessary, with other health care providers to ensure continuity of care. (EPR-028)	NFPA 99 2012 - 12.5.3.3.6.1 (3) Communication with the following: (a) Patients and their families (responsible parties) (b) Responsible parties when patients are relocated to alternative care sites (c) Community and the media (d) Suppliers of essential materials, services, and equipment (e) Alternative care sites (4) Definition of when and how to communicate patient information to third parties	NFPA 99-2012 requires facilities to develop a detailed communications plan with specific requirements to plan for communicating with: (a) Patients and their families (responsible parties); (b) Responsible parties when patients are relocated to alternative care sites; (c) Community and the media; (d) Suppliers of essential materials, services, and equipment; (e) Alternative care sites; (4) Definition of when and how to communicate patient information to third parties. The CMS proposal for hospital communication with other health care providers to ensure continuity of care for patients is more general. Providing a proposal that generalizes the effort will allow for reduced effort and make for less-effective verification of the adherence to the generalized requirement.
We propose at § 482.15(c)(5) that hospitals have a means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510 of the HIPAA Privacy Regulations. (EPR-029)	NFPA 99 2012 - 12.5.3.3.6.4 (8) Transportation of pertinent patient information, including essential clinical and medication-related information, to an alternative care site when the environment cannot support care, treatment and services	NFPA 99-2012 requires facilities to develop a detailed communications plan with specific requirements to plan for the transportation and communication of patient information. Although NFPA 99 does not specifically require adherence to HIPAA regulations, HIPAA regulations are already a requirement that hospitals must maintain at all times.
We propose at § 482.15(c)(6) requiring hospitals to have 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) of the HIPAA Privacy Regulations. (EPR-030)	NFPA 99 2012 - 12.5.3.3.6.1 (4) Definition of when and how to communicate patient information to third parties	NFPA 99-2012 requires facilities to develop a detailed communications plan with specific requirements to define when and how to communicate patient information. This requirement allows hospitals to evaluate all necessary criteria, such as HIPAA regulations, while planning for communication of patient information to third parties. Although NFPA 99 does not specifically require adherence to HIPAA regulations, HIPAA regulations are already a requirement that hospitals must maintain at all times.
We propose at § 482.15(c)(7) that a hospital have a means of providing information about the hospital's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee. (EPR-031)	NFPA 99 2012 - 12.5.3.3.6.1 (2) Initial notification and ongoing communication with the external authorities	NFPA 99-2012 requires facilities to provide notification and ongoing communication with external authorities, which would include providing information about the hospital's occupancy, needs, and ability to provide assistance.
We propose at § 482.15(d) that a	12.5.3.3. 7 Staff Education.	NFPA 99-2012 edition facilities to provide staff education and

hospital develop and maintain an emergency preparedness training and testing program. We would require the hospital to review and update the training and testing program at least annually. (EPR-032)	12.5.3.3.7.1 Each facility shall implement an educational program in emergency management. 12.5.3.3.7.2 The educational program shall include an overview of the components of the emergency management program and concepts of the ICO. 12.5.3.3.7.3 Individuals who are expected to perform as incident commanders or to be assigned to specific positions within the command structure shall be trained in and familiar with the ICO and the particular levels at which they are expected to perform. 12.5.3.3.7.4 Education concerning the staff's specific duties and responsibilities shall be conducted. 12.5.3.3.7.5 General overview education of the emergency management program and the ICO shall be conducted at the time of hire. 12.5.3.3.7.6 Department-/staff-specific education shall be conducted upon appointment to department/staff assignments or positions and annually thereafter. 12.5.3.3.8 Testing Emergency Plans and Operations. 12.5.3.3.8.1 The facility shall test its EOP at least twice annually, either through functional or full-scale exercises or actual events. 12.5.3.3.8.2 Exercises shall be based on the HVA priorities and be as realistic as feasible. 12.5.3.3.8.3 For Category 1 only, an influx of volunteer or simulated patients shall be tested annually, either through a functional or full-scale exercise or an actual event. 12.5.3.3.8.4 Annual table top, functional, or full-scale exercises shall include the following: (1) Community integration (2) Assessment of stand-alone capability	testing of emergency plans and operations with specific details regarding the education and testing programs. NFPA 99-2012 requirements have been established by a multidisciplinary consensus process allowing for detailed input and discussion from subject matter experts and interested parties. This process has allowed for development of detailed, accurate requirements that provide the greatest opportunity to protect lives during emergencies. The requirements of this proposal are more general. Providing a proposal that generalizes the effort of the consensus process will allow for reduced effort and make for less-effective verification of the adherence to the generalized requirement.
We propose at § 482.15(d)(1) that hospitals provide such training to all new and existing staff, including any individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain	NFPA 99 2012 - 12.5.3.3.7.1 Each facility shall implement an educational program in emergency management. 12.5.3.3.7.4 Education concerning the staff's specific duties and responsibilities shall be conducted. 12.5.3.3.7.5 General overview education of the emergency management program and the ICO shall be conducted at the time of hire. 12.5.3.3.7.6 Department-/staff-specific education shall be	NFPA 99-2012 requires facilities to establish a staff education program in emergency management that requires: an overview of the components of the emergency management program and concepts of the ICO; training for individuals who are expected to perform as incident commanders or to be assigned to specific positions in the command structure; education concerning the staff's specific duties and responsibilities; general overview of the emergency

documentation of such training. We propose that the hospital ensure that staff can demonstrate knowledge of emergency procedures, and that the hospital provides this training at least annually. (EPR-033)	conducted upon appointment to department/staff assignments or positions and annually thereafter. 12.5.3.4.5* The organization shall make provisions for emergency credentialing of volunteer clinical staff. 12.5.3.4.5.1 At a minimum, a peer evaluation of skill shall be conducted to validate proficiency for volunteer clinical staff. 12.5.3.4.5.2 Prior to beginning work, efforts shall be made to verify identities of other volunteers offering to assist during response activities. 12.5.3.4.5.3 Personnel designated or involved in tl1e EOP of the health care facility shall be supplied with a means of identification, which shall be worn at all times in a visible location.	management program and the ICO to be conducted at the time of hire; and department-/staff-specific education to be conducted upon appointment to department/staff assignments or positions and annually thereafter. NFPA 99-2012 also requires a facility to implement training during an emergency with the minimum of a peer evaluation of skill to validate proficiency for volunteer clinical staff. This proposal's requirements are more general in nature. Providing a proposal that generalizes the effort of the consensus process will allow for reduced effort and make for less-effective verification of the adherence to the generalized requirement.
We propose at § 482.15(d)(2)(i) requiring hospitals to participate in a community mock disaster drill at least annually. If a community mock disaster drill is not available, we would require the hospital to conduct an individual, facility-based mock disaster drill at least annually. (EPR-034)	NFPA 99 2012 – 12.5.3.3.8 Testing Emergency Plans and Operations. 12.5.3.3.8.1 The facility shall test its EOP at least twice annually, either through functional or full-scale exercises or actual events. 12.5.3.3.8.2 Exercises shall be based on the HVA priorities and be as realistic as feasible. 12.5.3.3.8.3 For Category 1 only, an influx of volunteer or simulated patients shall be tested annually, either through a functional or full-scale exercise or an actual event. 12.5.3.3.8.4 Annual table top, functional or full-scale exercises shall include the following: (1) Community integration (2) Assessment of stand-alone capability	NFPA 99-2012 requires facilities to perform exercises at least twice a year either through functional or full-scale exercises or actual events. These exercises are to be based on the HVA priorities and to be as realistic as feasible to add credibility and meaning to the exercises; use of "canned" exercises is to be avoided. These exercises must include community integration and assess the facility's stand-alone capability. This CMS proposal only requires a single disaster drill annually.
However, we propose at § 482.15(d)(2)(ii) that if a hospital experienced an actual natural or man-made emergency that required activation of the emergency plan, the hospital would be exempt from engaging in a community or individual, facility-based mock disaster drill for 1 year following the actual event. (EPR-035)	NFPA 99 2012 - 12.5.3.3.8.1 The facility shall test its EOP at least twice annually, either through functional or full-scale exercises or actual events	NFPA 99-2012 allows facilities to use an actual event as required tests. The language of this proposal exempts a facility from required texting for 1 year following an actual event, which could allow a facility to avoid a second testing of the EOP. This is in direct conflict with the current standard.
We propose at § 482.15(d)(2)(iii) requiring a hospital to conduct a	NFPA 99 2012 - 12.5.3.3.8.4 Annual table top, functional or full-scale exercises shall include the following: (1)	NFPA 99-2012 requires 2 exercises annually and allows facilities to use tabletop exercises to meet this requirement.

Comment [pjb6]: "Is "during" the right word here? Surely they aren't requiring training in the midst of an emergency.

paper-based, tabletop exercise at least annually. (EPR-036)	Community integration (2) Assessment of stand-alone capability	The language of this proposal actually requires a tabletop exercise, which would discourage facilities from performing other types of exercises.
We propose at § 482.15(d)(2)(iv) that hospitals analyze their response to and maintain documentation on all drills, tabletop exercises, and emergency events, and revise the hospital's emergency plan as needed. (EPR-037)	NFPA 99 2012 - 12.5.3.3.9 Scope of Exercises. 12.5.3.3.9.1 Exercises shall be monitored by at least one designated evaluator who has knowledge of the facility's plan and who is not involved in the exercise. 12.5.3.3.9.2 Exercises shall monitor the critical functions. 12.5.3.3.9.3 The facility shall conduct a debriefing session not more than 72 hours after the conclusion of the exercise or the event. 12.5.3.3.9.4 The debriefing shall include all key individuals, including observers; administration; clinical staff, including a physician(s); and appropriate support staff. 12.5.3.3.9.5 Exercises and actual events shall be critiqued to identify areas for improvement. 12.5.3.3.9.6 The critiques required by 12.5.3.3.9.5 shall identify deficiencies and opportunities for improvement based upon monitoring activities and observations during tile exercise. 12.5.3.3.9.7 Opportunities for improvement identified in critiques shall be incorporated in the facility's improvement plan. 12.5.3.3.9.8 The facility shall modify its EOP in response to critiques of exercises. 12.5.3.3.9.9 Improvements made to the EOP shall be evaluated in subsequent exercises. 12.5.3.6.2 The facility shall maintain written records of drills, exercises, and training as required by this chapter for a period of 3 years.	NFPA 99-2012 requires detailed monitoring and documentation of exercises. NFPA 99 requires that the critical functions of a facility's exercises be monitored by at least one designated evaluator who has knowledge of the facility's plan and who is not involved in the exercise; that the facility conduct a debriefing session not more than 72 hours after the conclusion of the exercise or the event; that the debriefing includes all key individuals, including observers, administration, clinical staff, including a physician(s), and appropriate support staff; that exercises and actual events be critiqued to identify areas for improvement; that critiques identify deficiencies and opportunities for improvement; that identified opportunities for improvement be incorporated in the facility's plan; and that improvements made to the EOP be evaluated in subsequent exercises. In addition, NFPA 99 requires the facility to maintain written records of drills, exercises, and training as required by this chapter for a period of 3 years. This proposal's requirements are more general in nature. Providing a proposal that generalizes the effort of the consensus process will allow for reduced effort and make for less-effective verification of the adherence to the generalized requirement.
Finally, we propose at §482.15(e)(1)(i) that hospitals must store emergency fuel and associated equipment and systems as required by the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).	NFPA 99 2012 - 12.5.3.3.6.5 (6) Fuel required for building operations, (7) Fuel for essential transportation, (8) Medical gas & Vacuum systems if applicable NFPA 110-2013 has changed both requirements and recommendations for fuel oil. There are numerous requirements in Section 7.9 FUEL SYSTEM and numerous newly developed recommendations in Annex paragraphs	NFPA 99-2012 and referenced NFPA 110 requirements require facilities to plan for fuel storage for building operations and associated fuel systems. This proposal requires hospitals to store emergency fuel per the 2000 edition of NFPA 101: Life Safety Code (LSC). This is an incorrect citation since these requirements are established in NFPA 110 and 99, not in NFPA 101. The language of this

(EPR-038)	A.7.9.1.2 and A.7.9.3.1. Paragraph 8.3.8 requires an annual fuel quality test using appropriate ASTM standards (ASTM D975, now mentioned in paragraph A.8.3.8, contains test methods for existing diesel fuel.)	proposal can cause confusion and misinterpretations.
We propose that hospitals test their emergency and stand-by-power systems for a minimum of 4 continuous hours every 12 months at 100 percent of the power load the hospital anticipates it will require during an emergency. (EPR-039)	NFPA 110-2013 requires a 4-hour load test every 3 years. According to NFPA 110-2013: "8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. 8.4.9.5.1 For a diesel-powered EPS, loading shall be not less than 30 percent of the nameplate kW rating of the EPS. A supplemental load bank shall be permitted to be used to meet or exceed the 30 percent requirement. 8.4.9.5.2 For a diesel-powered EPS, loading shall be that which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. 8.4.9.5.3 For spark-ignited EPSs, loading shall be the available EPSS load. NFPA 99 2012 - 6.4.4.1.1.4 Inspection and Testing. Criteria, conditions, and personnel requirements shall be in accordance with 6.4.4.1.1.4(A) through 6.4.4.1.1.4(C). (A) Test Criteria. Generator sets shall be tested 12 times a year, with testing intervals of not less than 20 days nor more than 40 days. Generator sets serving essential electrical systems shall be tested in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 8. (B) Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. (C) Test Personnel. The scheduled tests shall be conducted by competent personnel to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.	Several NFPA documents establish requirements for testing of generators, and the current requirements are for monthly testing with a 4-hour load test every 3 years. This proposal would add two additional annual tests beyond the current requirement. As well, the language of this proposal could cause significant confusion due to the requirement for the annual test to be “at 100 percent of the power load the hospital anticipates it will require during an emergency.“ This load requirement does not match any existing requirements and is extremely difficult to meet since the power requirements for a facility can differ significantly depending on the time of year and even the time of day. This not only is problematic to a facility but also to an authority having jurisdiction since load requirements vary. Also, this additional 4-hour run may impact a facility’s emissions permitting, especially if the facility has several generators on-site.
We have also proposed the same emergency and standby power requirements for CAHs and LTC facilities. As such, we request information on this proposal and in particular on how we might	"NFPA 110-2013 does not address type of occupancies. NFPA 110 addresses requirements pertaining to the "LEVEL" of EPSS as follows: "4.4* Level. This standard recognizes two levels of equipment installation, performance, and maintenance. 4.4.1* Level 1 systems shall be installed where failure of the	In NFPA 110-2013, essential electrical system (EES) requirements are not addressed in relation to the occupancy type but rather on the type of health care services that are provided. This proposal establishes requirements based on the

Comment [pjb7]: This looks like repeated language of what is included in the ASHE comments column. Shouldn't it be deleted?

better estimate costs in light of the existing LSC and other state and federal requirements. (EPR-040)	equipment to perform could result in loss of human life or serious injuries. 4.4.2* Level 2 systems shall be installed where failure of the EPSS to perform is less critical to human life and safety. 4.4.3 All equipment shall be permanently installed. 4.4.4* Level 1 and Level 2 systems shall ensure that all loads served by the EPSS are supplied with alternate power that meets all the following criteria: (1) Of a quality within the operating limits of the load (2) For a duration specified for the class as defined in Table 4.1(a) (3) Within the time specified for the type as defined in Table 4.1(b)" "CAH's with OR's or ICU's required to meet same – see EPR-H039	licensing or occupancy of the building. This would provide opportunities for conflict with the current requirements in NFPA 110.
Also, the LSC (NFPA 110) states that the rooms, shelters, or separate buildings housing the emergency power supply shall be located to minimize the possible damage resulting from disasters such as storms, floods, earthquakes, tornadoes, hurricanes, vandalism, sabotage and other material and equipment failures. (EPR-041)	NFPA 110-2013 section 7.2 addresses Location. That section contains the following portions as well as other requirements: "7.2.4* The rooms, enclosures, or separate buildings housing Level 1 or Level 2 EPSS equipment shall be designed and located to minimize damage from flooding, including that caused by the following: (1) Flooding resulting from fire fighting (2) Sewer water backup (3) Other disasters or occurrences 7.2.5* Minimizing the possibility of damage resulting from interruptions of the emergency source shall be a design consideration for EPSS equipment."	NFPA 110 requires that rooms, enclosures, or separate buildings housing Level 1 or Level 2 EPSS equipment be designed and located to minimize damage from flooding, including that caused by the following: (1) Flooding resulting from firefighting; (2) Sewer water backup; (3) Other disasters or occurrences and that minimizing the possibility of damage resulting from interruptions of the emergency source must be a design consideration for EPSS equipment. These requirements in NFPA 110 only apply to the location of EPSS equipment in new construction installations. By including this reference to NFPA 110 in the proposed rule for both new and existing generators, the rule essentially supersedes the guidance given in the NFPA documents and could require relocation of many existing hospital generators and fuel tanks. The burden for this change could cost facilities millions of dollars.