<table>
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<th>PROPOSED RULE</th>
<th>NATIONAL STANDARD</th>
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| 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/ | 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 |
1.2.5.3.1 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

The emergency preparedness plan would have to be reviewed and updated at least annually. (EPR-003)

| NFPA 99 2012 - 12.5.3.6 Administration. | 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. | 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 program. 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

| clients (3) Health, safety, and security of persons in the affected area (4) Support of staff (5) Property, facilities, and infrastructure (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. 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 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) | 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 program. 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
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
7. Economic and financial conditions
8. Regulatory and contractual obligations
9. Reputation of, or confidence in, the facility

The facility shall prioritize the hazards and threats identified in the HVA with input from the community.

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 better training, direction, and involvement of staff, better preparing them for response efforts and thus protecting the lives of more patients, visitors, and staff.

Based on NFPA 99 facilities conduct a risk assessment by each hospital performing a hazard vulnerability analysis (HVA). The HVA does not include 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. This process allows the hazards most applicable to a particular organization to rise to the top of the list. Detailed response procedures are then prepared for the hazards that rank high on the list for each hospital.

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
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.

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

By creating a requirement that the emergency plan include strategies for addressing emergency events identified by the risk assessment, CMS will greatly reduce the guidance and direction for emergency planning thus allowing facilities to establish broad general emergency plans.

NFPA 99 2012 edition clearly addresses the areas for which facilities need to properly evaluate and prepare emergency management plans. 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.
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<th>12.5.3.6 Critical Function Strategies. During the development of the EOP, the facility shall consider the strategies required in 12.5.3.6.1 through 12.5.3.6.8 in order to manage critical functions during an emergency within the facility.</th>
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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)

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<th>12.5.3.6.4 Clinical Support Activities. The facility shall plan for the following during an emergency:</th>
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<tr>
<td>(1) Clinical activities that could need modification or discontinuation during an emergency, such as patient scheduling, triage, assessment, treatment, admission, transfer, discharge, and evacuation</td>
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<tr>
<td>(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)</td>
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<td>(3) Patient cleanliness and sanitation</td>
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<td>(4) Behavioral needs of patients</td>
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<td>(5) Mortuary services</td>
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<td>(6) Evacuation both horizontally and, when required by circumstances, vertically, when the environment cannot support care, treatment, and services</td>
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<td>(7) Transportation of patients, and their medications and equipment, and staff to an alternative care site(s) when the environment cannot support care, treatment, and services</td>
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<tr>
<td>(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</td>
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<tr>
<td>(9) Documentation and tracking of patient location and patient clinical information</td>
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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 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 proposal greatly reduces the details for the planning to address patient populations during an emergency. The NFPA 99 2012 edition requires that the plan address not only the patient population and persons at-risk as outlined in the CMS proposed rule but also requires that the potential impact of care, health, safety and security for new and existing patients, residents and clients be
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 edition clearly addresses the areas for which facilities need to properly evaluate and prepare emergency management plans for clinical support including planning for the types of services that 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 be supported from the outside for extended periods, and alternative treatment sites to meet the needs of patients.

In regard to emergency 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)

NFPA 99 2012 - 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 recovery phases, including the authority and

This proposal actually reduces what is required by the current standard due to the general nature of the language and the lack of the requirement to include the coordination with the community. NFPA 99 2012 edition clearly addresses the coordination of the facility's command structure with the community which is vital for the appropriate communication during an emergency.
| We are proposing at § 482.15(b) that a hospital be required to develop and implement emergency preparedness policies and procedures based on 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 | 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 | NFPA 99 2012 requires the detailing of the emergency management program including all four phases: mitigation, preparedness, response and recovery and also requires an annual review of the overall emergency management program and plan via the annual review of the EOP, HVA and in 2015, |
| 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 with 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 edition requires a facility to cooperate and collaborate with federal, state and local emergency response agencies throughout the standard. This proposal mimics that language but fails to include the recovery of operation portion of an emergency and does not provide the same level of detail for the cooperation during the response phase of an emergency. 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. |
policies and procedures would be reviewed and updated at least annually. We are soliciting public comment on the timing of the updates. (EPR-010)

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.

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) the resource inventory. In addition to this the requirement to incorporate opportunities for improvements that are identified in test critiques require a limited review of the program two additional times each year. This proposal requires policies and procedures 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 change over time. By creating a requirement for an annual review and update CMS will create the opportunity for facilities to reduce the number of times a plan is to be reviewed and the depth to which these reviews will be performed.
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.

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, (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 for the planning of 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 are a sheltering in place strategy. The reason to initiate a hospital evacuation is that the hospital 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 the responsibility of the patient which will create a conflict with the receiving facility since the receiving facility won’t accept a patient without taking responsibility that patient. Without the transfer of the responsibility...
conflict could develop between the various facilities involved regarding the care and treatment of the patient, the fiscal responsibility for services provided and many other aspects of the care and treatment of the patient. This proposal might be meaningful if it required the evacuating hospital to ensure that 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 procedures also address how the subsistence needs of patients and staff who were evacuated would be met during an emergency. (EPR-012)

No requirement

NFPA 99 2012 requires for the planning of 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 are a sheltering in place strategy. The reason to initiate a hospital evacuation is that the hospital 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 the responsibility of the patient which will create a conflict with the receiving facility since the receiving facility won’t accept a patient without taking responsibility that patient. Without the transfer of the responsibility conflict could develop between the various facilities involved regarding the care and treatment of the patient, the fiscal responsibility for services provided and many other aspects of the care and treatment of the patient. This proposal might be meaningful if it required the evacuating hospital to ensure that 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

NFPA 99 2012 requires facilities to plan for support activities for staff, family, elders, pets 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)

Managing staff support activities, such as housing, transportation, incident stress debriefing, sanitation, 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 - 12.5.3.6.5 Essential Utilities - The facility shall plan for the following during an emergency:**

- Electricity
- Potable H₂O
- Nonpotable H₂O
- HVAC
- Fire Protection Systems
- Fuel for essential transportation
- Medical gas & vacuum systems if applicable

**NFPA 99 2012 details those items that are to be included on the essential electrical system which consists of the Life Safety, Critical and Equipment Branches. The explanation for the proposed ruling states: These proposed requirements 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. Since this is intended to be a best practice it could be misinterpreted causing confusion and conflicts with the current standards. The major concern with implementation of these provisions for every member of the community. Since some of these provisions for every member of 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)

This proposal also includes a recommendation that hospitals keep sufficient provisions for individuals from the community who may seek shelter. In doing this CMS is placing a burden on hospitals to be able to provide provisions for the entire community at large. This would not only be overwhelming to plan for but also an extreme fiscal burden that most likely will result in repeated waste. Since a hospital cannot determine when a disaster might strike in order to be able to provide provisions for the community at large the hospital would need to keep in store sufficient provisions for every member of the community. Since some of these provisions would no longer be usable and need to be replaced causing undue burden to the hospital.

**12.5.3.6.6 Exterior Connections – For essential utility systems in Category 1 facilities only and based on the installation of exterior building connectors to allow for the attachment of portable emergency utility modules.**

**The language proposed by CMS makes the planning for these types of activities only a recommendation and not a requirement. This recommendation will reduce the current standard and cause confusion and opportunity for conflicts in standards.**
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 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 increasing the requirements on essential electrical systems will be the major impact to existing facilities since these facilities will be required to upgrade essential electrical systems in order 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 that they can continue to operate after a disaster. A clear definition of what the expectations are is necessary.
(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. The following equipment shall be permitted to be arranged for delayed-automatic connection to the alternate power source:

(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 (also see A.6.4.2.2.5.3):

(1) Heating equipment used to provide heating for operating, delivery, labor, recovery, 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) Other 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 water |
| NFPA 99 2012 requires the facility to plan for the nonpotable water during an emergency. This 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 indicate that a facility could possibly be responsible to properly treat sewage and properly dispose 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 onsite 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 that the |
| **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 edition requires the 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 requires a person designated for patient tracking in the Planning Section and NFPA 99 requires for 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 Section and requires staff and volunteer hours be tracked and documented. The proposal as written also requires the tracking of staff and patients after an emergency. This language is too vague and does not indicate a time in which the tracking is to terminate. As written this could be interpreted to require a facility to track the location of staff and patients for the remainder of their life which would be inappropriate and evasive. As written in NFPA 99 an emergency has established phases one of which is the recovery phase. In regards to the recovery phase a facility’s plans shall reflect measures needed to restore operational capability to pre-disaster levels which is the indication that the emergency has ceased and normal operations are once again established. By requiring the tracking of patient locations during an emergency NFPA clearly indicates when this mode of tracking is to cease.**

Therefore, we would recommend that a hospital using an electronic database consider backing up its... | **No requirement** | **This recommendation, although not a required standard, is a standard best practice for technology**
<p>| <strong>We propose at § 482.15(b)(3)</strong> 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; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. (EPR-018) | <strong>NFPA 99 2012 - 12.5.3.4.7</strong> When conditions approach untenable, the command staff, in combination with community emergency response agencies, shall determine when to activate the facility evacuation plan. | <strong>NFPA 99 2012</strong> requires facilities to plan for these requirements in a manner such that plans can be activated when conditions approach untenable status and that these activities shall be coordinated with the community emergency response agencies. This proposal, although having more detailed considerations, does not require the coordination with community emergency response agencies. This could lead to significant misinterpretation and cause confusion between standards. |
| <strong>We propose at § 482.15(b)(4)</strong> 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) | <strong>NFPA 99 2012 - 12.5.3.3.6.2</strong> 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. | <strong>NFPA 99 2012</strong> requires facilities to plan for sheltering in place with significant detail. The language of this proposal is fairly general regarding the requirements to be addressed. The NFPA 99 2012 edition requirements have been established by a multidisciplinary consensus process allowing for detailed input and discussion of 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 will allow for reduced effort and make for less effective verification of the adherence to the generalized requirement. Also language that mimics the current standard can cause misinterpretation and lead to conflict between regulations as the various regulations change over time. |
| <strong>We propose at § 482.15(b)(5)</strong> 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) | <strong>NFPA 99 2012 - 12.5.3.3.6.4</strong> 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 systems. | <strong>NFPA 99 2012</strong> requires facilities to plan for patient information transportation during an emergency. The language of this proposal although providing for the protection of confidentiality or patient records is still fairly general regarding the other requirements to be addressed. The NFPA 99 2012 edition requires that facilities plan for the... |</p>
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<tr>
<th><strong>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)</strong></th>
<th><strong>NFPA 99 2012 - 12.5.3.6.4 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</strong></th>
<th><strong>Although the NFPA 99 2012 edition doesn’t directly address the 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.</strong></th>
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<tr>
<td><strong>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)</strong></td>
<td><strong>NFPA 99 2012 - 12.5.3.4.5 The organization shall make provisions for emergency credentialing of volunteer clinical staff.</strong></td>
<td><strong>NFPA 99 2012 requires facilities to plan for patient information transportation during an emergency. The language of this proposal although providing for the protection of confidentiality or patient records is still fairly general regarding the other requirements to be addressed. Although the NFPA 99 2012 edition doesn’t directly address the 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.</strong></td>
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<tr>
<td>12.5.3.4.5.1 At a minimum, a peer evaluation of skill shall be conducted to validate proficiency for volunteer clinical staff.</td>
<td>NFPA 99 2012 requires facilities to plan for emergency credentialing and evaluation of volunteer clinical staff. The language of this proposal although providing for the integration of state or federally designated health care professionals to address surge needs during an emergency is still fairly general regarding the other requirements to be addressed. The NFPA 99 requires that the organization make provisions for emergency credentialing of volunteer clinical staff and at a minimum a peer evaluation of skill be conducted to validate proficiency. Additionally,</td>
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<tr>
<td>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.</td>
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<td>Clause</td>
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<td>12.5.3.4.5.3</td>
<td>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.</td>
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**NFPA 99** requires that prior to beginning work organizations shall 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 possibly 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 the 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 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)

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 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 plan for the cooperative planning with other local or regional health care facilities including the (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. The CMS proposal provides for a more general development of arrangements with other 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. Although this proposal does specify that arrangements must be made the requirements of these arrangements are much more 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

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

NFPA 99 2012 edition requires the planning for the use of alternate care sites (ACS) in cooperation with community emergency response agencies. This proposal requires a hospital to provide care at ACS that is determined by emergency management officials which could lead to significant conflicts within the community. ACS sites should be planned for and selected by the hospital with coordination and cooperation with local community emergency response agencies.
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 disrupted. (EPR-024)

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<th>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)</th>
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<td>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</td>
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<tr>
<td>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 of 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.</td>
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<th>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)</th>
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<tr>
<td>NFPA 99 2012 - 12.5.3.3.6.1 (2) – Initial notification and ongoing communication with the external authorities</td>
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<td>NFPA 99 2012 edition requires facilities to provide notification and ongoing communication with the external authorities which would include contact information based on the facilities command</td>
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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 |

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 generalizes the communication for patients under the hospital’s care, as necessary, with other health care providers to ensure continuity of care. 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 the adherence to HIPAA regulations HIPPA 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

| 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
164.510(b)(4) of the HIPAA Privacy Regulations. (EPR-030)

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<td>We propose at § 482.15(c)(7)</td>
<td>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)</td>
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<tr>
<td>NFPA 99 2012 - 12.5.3.3.6.1 (2)</td>
<td>Initial notification and ongoing communication with the external authorities</td>
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<th>Requirement</th>
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<td>We propose at § 482.15(d)</td>
<td>that a 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)</td>
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<tr>
<td>NFPA 99 2012 edition requires facilities to provide notification and ongoing communication with the external authorities which would include providing information about the hospital's occupancy, needs, and its ability to provide assistance.</td>
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<td>12.5.3.3.7 Staff Education.</td>
<td>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</td>
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<td>NFPA 99 2012 edition requires facilities to provide staff education and testing of the emergency plans and operations with specific details of the education and testing programs. The NFPA 99 2012 edition requirements have been established by a multidisciplinary consensus process allowing for detailed input and discussion of 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. This proposal’s requirements 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.</td>
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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

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 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)

| 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 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) | 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 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 the 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. | NFPA 99 2012 edition 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 within the command structure to be trained in and familiar with the ICO and the particular levels at which they are expected to perform; education concerning the staff's specific duties and responsibilities; general overview education of the emergency 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 edition also requires a facility to verify credentialing 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 edition requires facilities to perform annual 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 be as realistic as feasible adding credibility and meaning to the exercises and helping to avoid the use of “canned” exercises. These exercises shall include community integration and assesses the facility’s stand-alone capability. This 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 edition allows for facilities to use an actual event as required tests. The language of this proposal actually exempts a facility for 1 year following the 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 paper-based, tabletop exercise at least annually.  (EPR-036) | NFPA 99 2012 - 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 edition allows facilities to perform table top exercises and requires 2 exercises annually. The language of this proposal actually requires a tabletop exercise which would discourage facilities in 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 | NFPA 99 2012 edition requires detailed monitoring and documentation of exercises. NFPA 99 2012 edition 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 shall include all key individuals, including observers; administration; clinical staff, including a |
individuals, including observers; administration; clinical staff, including a physician(s); and appropriate support staff.

12.5.3.9.5 Exercises and actual events shall be critiqued to identify areas for improvement.

12.5.3.9.6 The critiques required by 12.5.3.9.5 shall identify deficiencies and opportunities for improvement based upon monitoring activities and observations during the exercise.

12.5.3.9.7 Opportunities for improvement identified in critiques shall be incorporated in the facility’s improvement plan.

12.5.3.9.8 The facility shall modify its EOP in response to critiques of exercises.

12.5.3.9.9 Improvements made to the EOP shall be evaluated in subsequent exercises.

12.5.6.2 The facility shall maintain written records of drills, exercises, and training as required by this chapter for a period of 3 years.

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). (EPR-038)

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 99 2012 edition along with referenced NFPA 110 require facilities to plan for fuel for building operations and the associated fuel systems. This proposal requires hospitals to store emergency fuel per the 2000 edition of the NFPA 101, Life Safety Code (LSC). This is an incorrect citation since these requirements are established in NFPA 110 and 99. The language of this 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

As noted several NFPA documents establish the requirements for testing of generators with the current requirements being monthly testing with a 4-hour load test every 3 years. This proposal would add an additional two annual tests over the current
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.

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 better estimate costs in light of the existing LSC and other state and federal requirements. (EPR-040)

NFPA 110 1999 Edition

2-2.1* General. The function of the EPSS is to provide a source of electrical power of required capacity, reliability, and quality to loads for a given length of time within a specified time following loss or failure of the normal power supply. This standard specifies requirements for the EPSS as a

NFPA 110-2013 does not address the type of occupancies nor licensure but addresses the level of an essential electrical system (EES) based on the type of healthcare services that are provided through the impact of the equipment to perform could result in loss of human life or serious injuries. This proposal establishes requirements based on the licensing or occupancy of the building. This will provide opportunities for conflict with the current
complete functioning system in terms of types, classes, and levels. It is not the intent of this standard to recommend the EPSS most suitable for any given application.

2-2.2 Type. Type defines the maximum time, in seconds, that the EPSS will permit the load terminals of the transfer switch to be without acceptable electrical power. Table 2-2.2 provides the types defined by this standard.

Table 2-2.2 Types of EPSSs
Type U - Basically uninterruptible (UPS systems)
Type 10 - 10 seconds
Type 60 - 60 seconds
Type 120 - 120 seconds
Type M - Manual stationary or nonautomatic — no time limit

2-2.3* Class. Class defines the minimum time, in hours, for which the EPSS is designed to operate at its rated load without being refueled. (See Table 2-2.3)

Table 2-2.3 Classification of EPSSs
Class 0.083 - 0.083 hours (5 minutes)
Class 0.25 - 0.25 hours (15 minutes)
Class 2 - 2 hours
Class 6 - 6 hours
Class 48 - 48 hours
Class X - Other time, in hours, as required by the application, code, or user

2-2.4 Level. It is recognized that EPSSs are utilized in many different locations and for many different purposes. The requirement for one application might not be appropriate for other applications. Therefore, this standard recognizes two levels of equipment installation, performance, maintenance, and testing.
2-2.4.1* Level 1 defines the most stringent equipment performance requirements for applications where failure of the equipment to perform could result in loss of human life or serious injuries. All Level 1 equipment shall be permanently installed.

2-2.4.2* Level 2 defines equipment performance requirements for applications where failure of the EPSS to perform is less critical to human life and safety and where it is expected that the authority having jurisdiction will exercise its option to allow a higher degree of flexibility than provided by Level 1. All Level 2 equipment shall be permanently installed.

2-2.4.3 It is the intent of Level 1 and 2 systems to ensure that loads provided with an EPSS are supplied with alternate power of a quality essentially equal to commercial power or acceptable for the load, within the time specified for the type and for a duration specified for the class.

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, tornados, hurricanes, vandalism, sabotage and other material and equipment failures. (EPR-041)

| 2-2.4.1* Level 1 defines the most stringent equipment performance requirements for applications where failure of the equipment to perform could result in loss of human life or serious injuries. All Level 1 equipment shall be permanently installed. | 2-2.4.2* Level 2 defines equipment performance requirements for applications where failure of the EPSS to perform is less critical to human life and safety and where it is expected that the authority having jurisdiction will exercise its option to allow a higher degree of flexibility than provided by Level 1. All Level 2 equipment shall be permanently installed. |
| 2-2.4.3 It is the intent of Level 1 and 2 systems to ensure that loads provided with an EPSS are supplied with alternate power of a quality essentially equal to commercial power or acceptable for the load, within the time specified for the type and for a duration specified for the class. | 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 firefighting; (2) Sewer water backup; (3) Other disasters or occurrences and that minimizing the possibility of damage resulting from interruptions of the emergency source shall be a design consideration for EPSS equipment. |

NFPA 110 requires that 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 firefighting; (2) Sewer water backup; (3) Other disasters or occurrences. These requirements within NFPA 110 only apply to new construction installations regarding location. By including this reference in the proposed rule for both new and existing generators, the rule essentially supersedes the guidance given in the NFPA documents and could require the relocation of many existing hospital generators and fuel tanks. The burden for this change could cost facilities...
millions of dollars.