SECTION 15

EMERGENCY PREPAREDNESS

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SECTION STATEMENT

The renal healthcare administrator is responsible for emergency and natural or human-made disaster preparedness and response for situations that potentially may or do impact the facility. Dependent on the ownership, setting and location of the facility this duty may be fulfilled under the direction of and/or as a component of a systemic plan or, for independent and small dialysis organizations, in totality from the development of the basic plan through testing, implementation and after-action reporting. Partnership and collaboration with the Medical Director and local, regional, State and Federal agencies is essential to the development and execution of a robust emergency plan that meets the health and safety needs of their patient population. This section reviews emergency preparedness in End-Stage Renal Disease (ESRD) facilities and provides strategies for developing an emergency program and plan. (cross reference; Regulatory and Accreditation)

OBJECTIVES

Upon completion of this section, the learner will be able to:

- Describe the elements of the Center for Medicare & Medicaid Services (CMS) Emergency Preparedness Rule fo ESRD facilities.
- Identify required components of a dialysis facility emergency plan.
- Define the process for an all-hazards approach to planning.
- Identify different types of emergencies and disasters.
- List CMS requirements for emergency preparedness policies and procedures.
- Identify critical components of an emergency preparedness communication plan.
- Provide strategies for emergency preparedness training, education and testing of staff and patients.
- List resources and references for emergency preparedness information and tools.

I. Centers for Medicare & Medicaid Services (CMS) *Emergency Preparedness Rule* (Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance, 2017)

A. On September 8, 2016, the Federal Register posted the final rule *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers.* The regulation went into effect on November 16, 2016 for ESRD providers and suppliers and was updated on November 29, 2019. (Emergency Preparedness Rule, 2021)

B. The purpose of this rule is to establish national emergency preparedness requirements to ensure adequate planning for both natural and human-made disasters, and coordination with Federal, State, Tribal, regional and local emergency preparedness systems.

The following information applies:

1. Requirements apply to all ESRD facilities.
2. Each facility will have its own Emergency Preparedness program incorporated into its set of conditions or requirements for certification.
3. Must be in compliance with Emergency Preparedness regulations to participate in the Medicare or Medicaid program.

II. CMS Required Elements of Emergency Preparedness Program (Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance, 2017)

A. The Emergency Preparedness Program is a facility's comprehensive approach to meeting the health and safety needs of their patient population and provides facilities with guidance on how to respond to emergency situations that could impact the operation of the facility, such as natural or human-made disasters. It includes four core elements:

1. Emergency plan that is based on an all-hazards risk assessment.
2. Development and implementation of policies and procedures.
3. Communication plan.
4. Training and testing program.

III. Emergency Plan (Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance, 2017)

A. An emergency plan is one part of a facility's emergency preparedness program and provides the framework which includes conducting facility-based and community-based risk assessments that will assist a facility in addressing patient needs along with the continuity of business operations. Additionally, a plan will support, guide and ensure a facility's ability to collaborate with local emergency preparedness officials. The plan must:

1. Be written.
2. Be reviewed at least annually and as needed.
3. Identify essential business functions.
4. Include a facility-based and community-based risk assessment using an "all-hazards" approach.

EMERGENCY PREPAREDNESS RESOURCES

- **American Kidney Fund (AKF) Disaster Relief Program: *https://gms.kidneyfund.org/***
- **ASPR Technical Resource, Assistance Center, and Information Exchange (TRACIE): *https://asprtracie.hhs.gov/technical-resources***
- ***DC Coronavirus Disease 2019 (COVID-19) Outpatient Dialysis Facility Preparedness Assessment Tool***
- ***CMS Emergency Preparedness for Dialysis Facilities: A Guide for Chronic Dialysis Facilities***
- ***CMS Preparing for Emergencies: A Guide for People on Dialysis* (Available in English and Spanish)**
- **EMResource (Healthcare Resource Management) is an online system that is used in many states for tracking hospital capacity, EMS services and in some states ESRD facility status**
- **ESRD Networks**
- **FEMA: *www.Ready.gov***
- **KCER: *www.kcercoalition.com***
- **National Hurricane Center: *www.nhc.noaa.gov***
- **Pet Disaster Preparedness: *www.aspca.org/pet-care/general-pet-care/disaster-preparedness***
- **Wisconsin Department of Health Services *CMS Emergency Preparedness Rule Toolkit: End-Stage Renal Disease Facilities (Dialysis)***

5. Include strategies to address events identified in the risk assessment, plans for evacuating or sheltering in place, working with other providers in the area.
6. Address the needs of patients with ESRD, including:
    a. Modality requirements (HD, PD, home HD and transplanted)
        i) Dialysis equipment.
        ii) Dialysis supplies.
    b. Pediatric specific needs
        i) Special blood lines or dialyzers.
        ii) Blood or albumin extracorporeal prime.
        iii) Nutritional needs.
    c. Geriatric specific needs
        i) Communication with long-term care facilities.
        ii) Home health services.
    d. Transportation needs.
7. Include a continuity of operations plan.
8. Include a process for cooperation/ collaboration with local, Tribal, regional, State or Federal Emergency Preparedness officials to ensure an integrated response.
9. Include a process for contacting the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency.

B. CMS' *EMERGENCY PREPAREDNESS FOR DIALYSIS CENTERS A Guide for Chronic Dialysis Units* can be used has a template.

IV. All-Hazards Approach (Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance, 2017)

A. An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies and a human-made emergency (or both) or natural disaster.

B. This approach:
    1. is specific to the location of the facility and considers the hazards most likely to occur in their areas.
    2. includes collaboration with other entities, such as public health agencies, emergency management agencies and regional healthcare coalitions.

C. All-hazard concepts are outlined in the National Preparedness System published by the United States Department of Homeland Security's Federal Emergency Management

Agency (FEMA), as well as guidance provided by the Agency for Healthcare Research and Quality (AHRQ).

V. Types of Emergencies and Disasters

A. Definition of a disaster: An event that can affect the facility internally as well as the overall target population or the community at large (Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance, 2017).

B. The risk assessment should identify potential hazards and analyze what could happen if a hazard occurs and plan for response. Examples are:

1. Human-made Hazards — Events that are caused by humans and occur in or close to human settlement. The events leading up to a human-made hazard may be the result of deliberate or negligent human actions, but their impact can be equally as devastating. (Man-Made Hazards Information)

a. Active shooter — an individual who is engaged in shooting or attempting to shoot or kill people in a confined and populated area (Man-Made Hazards Information). The staff should be taught different ways to protect the lives of patients and staff during an active shooter event:

i) Run: If possible, use emergency disconnect procedures and escape quickly and quietly. Call 9-1-1 when safe.

ii) Hide: If it's not possible to safely escape, hide. Block entry to the hiding place. Turn off lights, lock the door, hide behind a large item, silence cell phones and stay quiet. Call 9-1-1 when it is safe. If you can't talk, leave the line open so the dispatcher can hear what is happening.

iii) Fight: As an absolute last resort, act aggressively. Throw items, improvise weapons and yell. Commit to your actions.

iv) Immediately after an incident:

a) Wait for Local Law Enforcement officers to assist evacuation.

b) When law enforcement arrives display empty hands with open palms.

b. Bomb-threat — These usually occur over the phone, but can be received via written note or email (Bomb Threat Procedures, 2014). If a bomb threat is received by phone:

i) Remain calm. Keep the caller on the line for as long as possible. DO NOT HANG UP, even if the caller does.

ii) Listen carefully. Be polite and show interest.

iii) Try to keep the caller talking to learn more information.

iv) If possible, write a note to a colleague to call the authorities or, as soon as the caller hangs up, immediately notify them yourself.

v) If your phone has a display, copy the number and/or letters on the window display.

a) Write down as much detail as you can remember. Try to get exact words.

b) Immediately upon termination of call, DO NOT HANG UP, but from a different phone, contact authorities immediately with information and await instructions.

c. Cyber-attack — is a deliberate attempt to maliciously retrieve or change computer code, data, or logic. It can occur both at home and in the workplace

(IBM Services). Homeland Securities outlines strategies and tips to protect your personal or work computer (Department of Health and Safety, 2019):

i) Never click on links in emails.
ii) Never open attachments.
iii) Do not give out personal information.
iv) Set secure passwords and do not share them with anyone.
v) Keep the operating system, browser, anti-virus and other critical software up to date.
vi) Verify the authenticity of requests from companies or individuals by contacting them directly.
vii) Pay close attention to the website uniform resource locator (URL).
viii) For email, turn off the option to automatically download attachments.
ix) Be suspicious of unknown links or requests sent through email or text message.

Risk assessment should identify potential hazards, analyze what could happen if a hazard occurs and plan for response.

d. Terrorism — is the use of force or violence against a person or property in violation of the criminal laws for purpose of intimidation, coercion, or ransom (e.g., September 11, 2001). Things to consider when developing an emergency preparedness plan for terrorism (Man-Made Hazards Information):
   i) There could be many casualties.
   ii) There could be significant damage to buildings and the community's infrastructure.
   iii) Health and mental health resources in the affected communities could be strained to the limits.
   iv) There could be heavy law enforcement involvement at local, State and Federal levels due to the event's criminal nature.
   v) An area might have to be evacuated.
   vi) Workplaces and schools might be closed, and there might be restrictions on domestic and international travel.
   vii) Cleanup might take months.
   viii) Public fear could continue for a prolonged period.
e. Workplace violence (Rau-Foster, 1999)
   i) Three categories of patients who may become violent toward staff:
      a) Individuals with no history of violence who become overwhelmed with their own illness or that of a family member
      b) Individuals with active mental illness
      c) Individuals engage in antisocial behavior or are unable to control their anger
   ii) Warning signs of a person who may become violent:

a) Verbal, non-verbal or written threats or intimidation
b) Fascination with weaponry and/or acts of violence
c) Expressions of a plan to hurt him or herself or others
d) Externalization of blame
e) Unreciprocated romantic obsession
f) Taking up much of supervisor's (employee) or staff members time with behavior or performance problems
g) Fear reaction among coworkers/other patients
h) Drastic change in belief systems
i) Displays of unwarranted anger
j) New or increased source of stress at home or work
k) Inability to take criticism
l) Feelings of being victimized
m) Intoxication from alcohol or other substances
n) Expressions of hopelessness or heightened anxiety
o) Productivity and/or attendance (work or dialysis) problems
p) Violence towards inanimate objects
q) Steals or sabotages projects or equipment
r) Lack of concern for the safety of others

iii) Train staff to handle violence in the workplace. Training should include:

a) Recognition of signs and symptoms of a patient with elevated frustration or anger.
b) Methods to de-escalate potentially violent situations. These methods include:
   - maintaining the proper distance (3-6 feet) from the patient.
   - maintaining a relaxed yet attentive posture.
   - projecting calmness and listening to the patient.
   - acknowledging that the patient is upset and asking his or her recommendations for correcting the problem.
   - establishing ground rules if unreasonable behavior persists.
   - calmly describing the consequences of any violent behavior.

c) Recognition of the negative effect of certain actions,

gestures, words and communication styles that may result in a hostile or violent reaction by the patient.

d) Techniques for understanding and properly managing their own frustration and anger.

e) The proper methods of communication and interaction with patients as a tool to reduce the presence of conflict (and its impact) in the dialysis setting.

f. War — conventional, biological, chemical, nuclear

2. Natural Disasters — Acts of nature that create a catastrophic situation in which day-to-day patterns of life are disrupted resulting in people needing food, clothing, shelter, medical and nursing care, other necessities of life and protection against unfavorable environmental factors and conditions (Assar, 1971)
   a. Avalanche
   b. Drought
   c. Extreme temperatures
   d. Earthquake
   e. Flash flooding
   f. Flooding (e.g., Hurricane Harvey August 2017)
   g. Hail/heavy thunderstorms
   h. High winds
   i. Hurricanes (e.g., Hurricane Katrina August 2005)
   j. Mud/rockslides
   k. Severe winter weather
   l. Tidal wave/tsunami
   m. Tornados
   n. Volcano eruption
   o. Wildfire
3. Pandemics — Global disease outbreak (e.g., Coronavirus Disease 2019) (cross reference; Infection Prevention)
   a. *Coronavirus Disease 2019 (COVID-19) Outpatient Dialysis Facility Preparedness Assessment Tool* is a document that facilities can use in planning during a pandemic which can be found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
   b. As part of routine infection control, outpatient dialysis facilities should have established policies and practices to reduce the spread of contagious respiratory and other pathogens (Interim Additional Guidance for Infection Preventions and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Outpatient Hemodialysis Facilities Dialysis Facilities, 2020). (cross-reference; Infection Prevention).
      i) Implement universal source control measures:
         a) Masks for every staff member, patient and visitor in the facility, even if they do not have symptoms of the disease except for young children under the age of 2, anyone who has trouble breathing or anyone who is unconscious.

b) Healthcare personnel should also wear a gown, gloves and eye protection at all times while caring for patients on the treatment floor.

c) N95 mask is preferred for staff caring for a person under investigation (PUI), or for aerosol generating procedures.

ii) Screening, triage and management of individuals with suspected or confirmed infection

a) Implement processes for identifying and triaging individuals before they enter the building and/or treatment floor (e.g., questionnaire inquiring if they a have signs and symptoms of the disease and have had recent contact with someone with the disease, obtain temperature).

b) Instruct staff and patients to call ahead if they:

1) are experiencing signs and symptoms of the disease.

2) have been in close contact with someone with the disease.

c) Limit visitors on the treatment floor.

d) Properly manage people with the disease:

1) Staff should return home.

2) Visitors should be restricted from entering the building.

3) Patients should be immediately escorted to a predetermined isolation area or room.

Ensure patients are informed, ready to assist themselves, and are aware of facility procedures and resources.

iii) Placement of patients with suspected or confirmed infection

a) Cohort infected patients in the same waiting area and maintain six feet of separation with all other patients and staff.

b) Ideally infected patients should be treated in an isolation room with the door shut.

iv) Hepatitis B isolation rooms may only be used if the patient is hepatitis B surface antigen positive or the facility has no patients on the census with hepatitis B who require treatment in the room.

a) If a room is not available the infected patient should be placed end-of-row stations, away from the main flow of traffic and at least six feet from the nearest patient.

b) A separate facility or shift may be used to accommodate a cohort of COVID-19 infected patients.

v) Provide staff education on:
   a) Signs and symptoms of the infection.
   b) Importance of hand hygiene, cough etiquette and wearing a facemask.
   c) Use of personal protective equipment.
   d) Triage procedures and patient placement.
   e) Sick leave policies.
   f) Self-monitoring for respiratory symptoms including calling ahead when ill.
   g) How and to whom suspected and confirmed COVID-19 cases should be reported.

vi) Provide patient education on:
   a) COVID-19 (e.g., symptoms, how it is transmitted).
   b) Importance of informing a healthcare provider if they have a fever or feel ill.
   c) Actions they can take to protect themselves at dialysis and in the community (e.g., hand hygiene, covering their cough, maintaining social distancing and wearing a facemask or cloth face covering).
   d) Actions the facility is taking to keep them safe (e.g., visitor restrictions, changes in PPE).

4. Technological failures — non-acts of nature incidents involving disruption in a technology or resource infrastructure
   a. Equipment failure (e.g., reverse osmosis equipment not working)
   b. Electrical (brownouts, blackouts)
   c. Heating/cooling
   d. Information technology system
   e. Water supply issues (e.g., low pressure, no water)
5. Other incidents
   a. Care-related emergencies (e.g., patient becomes unconscious)
   b. Interruptions to normal supply of essential resources (e.g., water, fuel, food, medications and medical supplies)
   c. Community infrastructure breakdown (e.g., bridge collapse, dam break)
   d. Transportation failure
   e. Utility failure

VI. Policies and Procedures — CMS requires that ESRD facilities have a policy and procedure for each of the following: (Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance, 2017)

A. A process for contacting local public health and emergency management agency public official at least annually to confirm that the agency is aware of the ESRD facility's needs in the event of an emergency and know how to contact the agencies in the event of an emergency. A template letter can be found in Appendix A.

B. A system to track the location of staff and patients

1. In the event staff and patients are relocated, the facility must document the specific name and location of the receiving facility or other location for sheltered patients and on-duty staff who leave the facility during the emergency.
2. Identify who is responsible for compiling/securing patient records and what information is needed during tracking a patient throughout an evacuation.
3. Facilities are encouraged to leverage the support and resources available to them through local and national healthcare systems, healthcare coalitions and healthcare organizations for resources and tools for tracking patients.

C. A process for safe evacuation from the facility
   1. Include instructions for patients, staff members and families/patient representatives or other personnel on site.
   2. Address staff responsibilities during evacuations.
   3. Triaging system when coordinating the tracking and potential evacuation of patients.
   4. Must outline primary and alternate means for communication with external sources for assistance.

D. A means to shelter in place for patients, staff and volunteers who remain in the facility
   1. Aligns with the facility's risk assessment.
   2. In certain disaster situations (such as tornadoes), sheltering in place may be more appropriate as opposed to evacuation and would require a facility to have a means to shelter in place for such emergencies.
   3. Criteria for determining which patients and staff would be sheltered in place.
   4. Consider the appropriate facilities in the community to which patients could be transferred in the event of an emergency.

E. A system of medical documentation that preserves patient information, protects confidentiality of patient information and secures and maintains the availability of records. Ensure that patient records are:
   1. Secure.
   2. Readily available to support continuity of care during emergency.

F. The use of volunteers in an emergency
   1. Determine how best to utilize volunteers during an emergency if such utilization is in accordance with State law, State scope of practice rules and facility policy.
   2. Ensure the volunteer has appropriate safety training for scope of the assignment (e.g., bloodborne pathogen exposure).

G. The development of arrangements with other ESRD facilities to receive patients in the event of limitation or cessation of operation
   1. Prearranged transfer agreements, which may include written agreements or contracted arrangements with other facilities.

2. Describe roles in providing care at alternate care sites during emergencies.

H. How emergency medical system assistance can be obtained when needed
   1. Medical system assistance can be considered but not limited to: outside assistance such as from a nearby hospital or other ESRD facilities including personnel to assist during a single-facility disaster.

I. A process by which the staff can confirm that emergency equipment and drugs are:
   1. Always on the premises and immediately available.
   2. In working order always in accordance with the manufacturer instructions.
   3. Equipment includes:
      a. Defibrillator/Automated External Defibrillator (AED) – maintained per manufacturer's instructions.
      b. Glucose meter-calibrated daily and maintained per manufacturer's instructions.
      c. Oxygen – tested daily.
   4. Emergency drugs should not be out of date and should be stored and maintained based on the manufacturer instructions.

J. Back up water/electrical infrastructure.

K. Operating plans to provide care if facility is not operable.

VII. Communications Plan (Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance, 2017). The plan must:

A. Be reviewed every two years and updated as needed.

B. Contain how the facility coordinates patient care
   1. within the facility.
   2. across healthcare providers.
   3. with state and local public health departments.

C. Include how facility interacts and coordinates with emergency management agencies and systems to protect patient health and safety.

D. List updated contact information for:
   1. Staff
   2. Physicians
   3. Entities providing service under agreement:
      a. Electrical
      b. Municipal water
      c. Emergency Medical Services (EMS)
      d. Critical vendors
   4. Other ESRD facilities
   5. Community resources
   6. Volunteers

A communications plan should be reviewed every two years and updated as needed."

E. Provide alternate means of communication – landlines and mobile phones are prone to overload during emergencies.

1. Critical event management platform (e.g., Everbridge®, AlertFind®, AlertMedia®)
2. Email
3. Posting to social media sites. See figure for examples.
4. Posting on a facility website
5. Amateur radio operators' systems (e.g., ham radio)
6. Satellite phones
7. Short-wave radios
8. Walkie-talkies
9. Local newspapers
10. Public Service Announcements (PSA) via radio and/or television

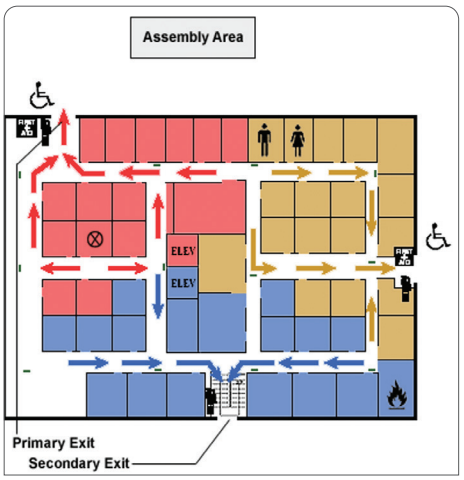
F. Detail Command Center structure and include:
   1. Telephone tree.
   2. Staff assignments — identify which staff would assume specific roles in another's absence through succession planning and delegations of authority.

G. Identify the back-up dialysis facilities and map of those facilities
   1. One within 50 miles and one more than 50 miles away.
   2. Facilities caring for pediatric patients should consider partnering with an adult facility if there is not another facility that can support care for this population within 50 miles. An agreement between the facilities may include:
      a. Opening a shift in the back-up facility dedicated to the care of the pediatric patients during an emergency.
      b. Sending pediatric-trained staff to care for patients in the back-up facility during an emergency.
      c. Providing special equipment (e.g., smaller dialyzers and lines) to the back-up facility.
      d. Ensuring the crash cart at the back-up facility is supplied with pediatric-specific equipment during an emergency.
      e. Periodically simulating an emergency with the back-up facility.

VIII. Training and Education Should:

A. Staff
   1. Reflect the risks identified in the facility's risk assessment.
   2. Be provided at orientation and annually and as needed.

3. Include and maintain training documentation.
4. Conduct training on policies and procedures whenever they are significantly updated.
5. Content of staff training includes:
6. Demonstrating knowledge of emergency procedures. Demonstration may include:
    a. Simulation
    b. Participation in exercise drills
    c. Written test
    d. Return demonstration
7. Staff ability to inform patients of:
    a. What to do during an emergency.
    b. Where to go during evacuation. It is best to clearly define an area and provide a picture of the meeting place (e.g., assembly area meeting place is in the parking lot north of the building next to the tree).
    c. Whom to contact if an emergency occurs while patient is not at the facility, including:
        i) Alternate emergency phone number for facility if it is unable to receive calls during an emergency.



    d. How to disconnect themselves from the dialysis machine if an emergency occurs.
8. CPR certified
9. Proper use of emergency equipment (e.g., automated external defibrillators [AED], backboard, suction machine, Ambu® bag) by nurses and technicians
10. Use of emergency medications by nurses

B. Patient Training/Education must:
1. Be provided at admission and annually and as needed.
2. Ensure patients are informed, ready to assist themselves and are aware of the facility procedures and resources (e.g. Kidney Community Emergency Response (KCER) that can provide up to date information during and after an emergency.
3. Include:
    a. How they would be notified of an emergency.
    b. What particular procedures they are expected to follow.
    c. Communication protocols for contacting the ESRD facility.
    d. Identifying an alternate location for their treatment in the event of a facility, closure as well as shelter-in place.
    e. How they would evacuate the facility if required.
    f. Location of potential transfer sites.
    g. How to safely disconnect from the machine.

IX. Emergency Plan Testing (Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance, 2017). The facility must conduct exercises to test the emergency plan that:

A. Reflects the risks identified in the facility's risk assessment.

B. Is fully documented.

C. Includes these types of exercises:

1. Tabletop Exercise (TTX) is a group discussion led by a facilitator, using narrated, clinically-relevant emergency scenarios, and a set of problem statements, directed messages or prepared questions designed to challenge an emergency preparedness plan. It involves key personnel discussing simulated scenarios, including computer-simulated exercises, in an informal setting. TTXs can be used to assess plans, policies and procedures.
    - i) Sources for tabletop exercises
        - a) KCER
        - b) State emergency operations agency/division
2. Full-Scale Exercise is a multi-agency, multi-jurisdictional, multi-discipline exercise involving functional (for example, joint field office, emergency operation centers) and "boots on the ground" response (for example, firefighters decontaminating mock victims).
    - i) Examples for partnering opportunities
        - a) State Health Department
        - b) City/county/State emergency operations agency/division
3. Facility-Based Functional Exercise is similar to a tabletop exercise in that it challenges an emergency plan, policies and procedures; however, unlike the tabletop exercise, staff members are expected to simulate response as if it were a real emergency.
    - i) Sources for facility-based exercises
        - a) Federal Emergency Management Agency (FEMA)
        - b) Kidney Community Emergency Response (KCER)
        - c) Community Emergency Response Team (CERT)

Outpatient dialysis facilities should have established policies and practices to reduce the spread of contagious respiratory and other pathogens.

D. Participation in an exercise must be performed at least annually, including:

1. Participation in a full-scale exercise that is community-based every two years;
    a. When a community-based exercise is not accessible, conduct a facility-based functional exercise every two years; or

b. If the facility experiences as actual natural or human-made emergency that requires activation of the emergency plan, the ESRD facility is exempt from engaging in the next required community-based or individual facility-based functional exercise for one year following the onset of the event.
    i) Must be able to demonstrate this through written documentation.

2. Participation in an additional exercise at least every two years opposite the year of the full-scale or functional exercise. The exercise may include:
    a. A second full-scale exercise that is community-based or individual, facility-based functional exercise; or
    b. A mock disaster drill; or
    c. A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated clinically relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
    d. When an event occurs within the facility, completion of an after action report (AAR) may also fulfill required exercises (e.g., cardiac, or respiratory arrest, electronic medical record interruption, water, or supply chain interruption).
3. Completion of an after-action review process to help develop an actionable AAR. AAR examples can be found at:
    a. CMS AAR Template — https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Templates-Checklists
    b. Homeland Security Exercise and Evaluation Program (FEMA) — https://www.fema.gov/emergency-managers/national-preparedness/exercises/hseep
    c. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) TRACIE — https://asprtracie.hhs.gov/technical-resources
    d. KCER:
        i) Includes recorded webinar, presentation slides and simplified AAR template for dialysis facilities
        ii) Access at https://www.kcercoalition.com/en/events/2020/july-2020/dialysis-facilities-the-basics-of-preparing-an-after-action-report-for-an-incident-or-disaster/
    e. The process includes a roundtable discussion that includes leadership, department leads and critical staff who can identify and document lessons learned and necessary improvements in an official AAR. The AAR, at a minimum, should determine:
        i) what was supposed to happen.
        ii) what occurred.
        iii) what went well.
        iv) what the facility can do differently or improve upon.
        v) a plan with timelines for incorporating necessary improvement.

E. Engage with area Health Care Coalitions (HCCs) to explore integrated opportunities.
    1. HCCs are public and private partnerships between healthcare, public health, EMS, KCER and emergency management who collaborate to ensure each member has what it needs to respond to emergencies and planned events.

2. ESRD Networks may sponsor/coordinate e.g., Texas Emergency ESRD Coalition (TEEC) https://quality.allianthealth.org/nw14-teec/

F. Facilities that are a part of a healthcare system can elect to participate in their system's integrated and unified emergency preparedness program and exercises

X. Preparing for an Emergency or Disaster

A. Preparing patients

1. Encourage patients to update contact information regularly.
2. Encourage patients to regularly refill medications and to always maintain a seven-day minimum supply on-hand.
3. Provide a disaster packet to patients which includes:
   a. *Preparing for Emergencies: A Guide for People on Dialysis*
   b. A document (e.g., face-sheet) that reviews a patient's information. It should include:
      i) Demographic information.
      ii) Contact and emergency contact details.
      iii) Insurance information.
      iv) A brief medical history.
      v) Allergies.
   c. Treatment prescription
      i) Facility hotline number – offering specialized information
      ii) Dialysis solution rate
      iii) Dialyzer type
      iv) Bloodline size, if applicable
      v) Needle size, if applicable
      vi) Treatment time
      vii) Acid bicarbonate
      viii) Anticoagulation type and amount
      ix) Access type
   d. Current medication list
   e. Contact information for:
      i) Home dialysis facility
      ii) ESRD Network- find applicable number at https://esrdncc.org/en/ESRD-network-map/
      iii) Back-up facility
      iv) Alternate means of communication
      v) American Kidney Fund (AKF) Disaster Relief Program provides grants to patients to assist after a disaster. A local fund is usually obtained from AKF by the dialysis facility and administered locally by the facility.

Definition of a disaster: *An event that can affect the facility internally as well as the overall target population or the community at large.*

f. Resources for age-specific and family disaster plans and support are available from: https://www.ready.gov

4. Encourage patients to work with interdisciplinary team
   a. Social Worker – assess needs of the patients and aid with:
      i) Shelter information
      ii) Mental health assistance
      iii) Transfer to another facility
      iv) Governmental agency evacuation/ transportation
   b. Dietitian – Implementation of an emergency diet plan
      i) Non-perishable food
      ii) Fluid restrictions
   c. Child Life Specialist (in pediatric facilities) – Provide information, support and guidance at the child's developmental age

B. Preparing staff
   1. Encourage staff to put together an emergency plan which includes (https://www.ready.gov/):
      a. How to receive emergency alerts and warnings
      b. A shelter plan
      c. An evacuation route
      d. A family/household communication plan
      e. A list of necessities:
         i) Medications
         ii) Dietary needs
         iii) Cultural needs
         iv) Age-specific items
   2. Encourage staff to make an emergency kit
   3. Encourage staff to practice their plans with their families

XI. Emergency Preparedness Resources

A. **American Kidney Fund (AKF) Disaster Relief Program** (https://www.kidneyfund.org/get-assistance/disaster-relief-grant-program) assists kidney patients through disaster relief grants that:
   1. Replace lost medications and special renal diet foods.
   2. Pay for temporary housing and transportation to treatment.
   3. Replace clothing and personal essentials lost in a natural disaster.

B. **ASPR Technical Resource, Assistance Center, and Information Exchange (TRACIE):**

https://asprtracie.hhs.gov/

1. Self-service collection of disaster medical, healthcare and public health preparedness materials, searchable by keywords and functional areas.
2. Access to Technical Assistance Specialists for one-on-one support.
3. Peer-to-peer discussion board that allows open discussion in near-real time.

C. **CDC *Preparing Your Dialysis Facility for Coronavirus Disease 2019 (COVID-19)***
https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

1. Highlights important areas CDC recommends outpatient dialysis facilities review in preparation for pandemic (COVID-19).

D. **CMS *Emergency Preparedness for Dialysis Facilities: A Guide for Chronic Dialysis Facilities***
https://www.cms.gov/medicare/End-Stage-Renal-Disease/ESRDNetworkOrganizations/Downloads/EmergencyPreparednessforFacilities2.pdf

1. Hazard assessment tool or hazard vulnerability analysis
2. Hazard mitigation
3. Communication planning
4. Record management
5. Employee and patient training
6. Exercise drills

E. **CMS *Preparing for Emergencies: A Guide for People on Dialysis* (Available in English and Spanish)**
https://esrd.ipro.org/wp-content/uploads/2023/03/CMSPreparingforEmergencies_508-compliant-_updated-3.2023.pdf

1. Getting ready for an emergency or disaster
2. Emergency Go-kit checklist
3. Medical supplies checklist
4. Personal information form
5. 3-day emergency diet plan
6. How to disinfect water
7. Evacuation assistance
8. Emergency take-off procedure
9. Emergency hotline

F. **Disaster Resistant Communities Group:** Established to provide a host of disaster planning and preparedness, response, recovery and mitigation services to local, regional, State and national agencies and departments as well as community and faith-based organizations.

G. **EMResource (Healthcare Resource Management)** is an online system that is used in many states for tracking hospital capacity, EMS services and, in some states, ESRD facility status.
   1. Real-time data source
   2. Communication between dialysis facilities and Emergency Operations
   3. Alerts
   4. Evacuation planning
   5. Mapping
   6. Resource availability
   7. Locating treatment (in some states)
   8. During an evacuation event, in states using EMResource, it is the responsibility of each facility to:
      a. utilize EMResource to update its vacancy data (hospital-based dialysis facilities need to report as a separate entity from the hospital).
      b. identify potential partners able to accept evacuees.
      c. make resident-transfer arrangements with those partners.
      d. update their facility status when the facility evacuates and/ or closes.

H. **ESRD Networks**
   1. Sample disaster plans
   2. Regional coalitions
   3. Partnership for exercises
   4. Assist in locating facilities for treatment
   5. Collaboration with State Health Departments and emergency operations

I. **FEMA:** https://www.Ready.gov
   1. Toolkits for emergency preparedness
   2. Set-by-step instructions to developing and executing a family emergency plan
   3. Links to learn what to do before, during and after different types of emergencies

J. **KCER:** https://www.kcercoalition.com
   1. KCER is under contract with CMS, provides technical assistance to ESRD Networks, kidney organizations and other groups to ensure timely and efficient disaster preparedness, response and recovery for the kidney community
   2. Program's disaster preparedness resources help save lives, improve outcomes, empower patients and families, educate healthcare workers, build partnerships with stakeholders, promote readiness in the community and support the ESRD Networks.
   3. Tools and resources:
      a. Drills
      b. After-action report (AAR)
      c. Ready business toolkits for
         i) Business Emergency Preparedness social media policy
         ii) Earthquake QuakeSmart®
         iii) Hurricane

iv) Inland flooding

v) Severe wind/tornado

d. KCER Kids – age-appropriate materials to help prepare children for emergencies

e. Patients' disaster education

4. Just-in-time (JIT) Disaster Training — videos found in the library cover disaster related mitigation, preparedness, response and recovery training for a wide variety of areas.

K. **National Hurricane Center:** http://www.nhc.noaa.gov

L. **Pet Disaster Preparedness** – https://www.aspca.org/pet-care/general-pet-care/disaster-preparedness – Steps to follow to make sure pets are ready for a disaster

M. **Wisconsin Department of Health Services** *CMS Emergency Preparedness Rule Toolkit: End-Stage Renal Disease Facilities (Dialysis)* https://www.dhs.wisconsin.gov/preparedness/toolkits.htm has tools and templates for policies and procedures; training and testing; and a communication plan.

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APPENDIX A: TRAINING THE TESTING

Instructions for Completing the Annual Notification Letter and EOC Visits

(Copied from CMS' *Emergency Preparedness for Dialysis Centers – A Guide for Chronic Dialysis Units*)

CMS requires ESRD facilities to contact local EOCs and/or healthcare coalitions annually in an effort to achieve a cohesive community emergency plan.

DOs should strive to build positive and collaborative working relationships with local EOCs and other healthcare coalitions. The first step is to call the EOC and request a meeting ***IN PERSON*** to introduce yourself and your facilities capabilities. You also want to understand the EOCs capabilities during a disaster. The attached letter should be hand delivered to document the visit.

The letter needs to be printed on facility letterhead and modified to provide each facility's specific information:

- Name of local EOC
- Facility name and address
- Facility contact person name and phone#
- Approximate number of patients served for all modalities.
- Whether you have Generator or Automatic Transfer Switch
- If neither, state your facility does not have an alternate energy source and will have to transfer patients to a back-up facility until commercial power can be restored

Additional information to discuss with the EOC may include:

- Name of local Healthcare Coalitions that you can join
- Schedule of any community wide and /or table top disaster drills
- Location of community shelters
- Patient registration requirements for special needs shelters
- Obtain copies of community flood zones, these can change annually
- Re-entry requirements into evacuation zones. Some EOCs have specific requirements such as registration lists.

Determine how the EOC can help by engaging or providing lead contacts with local Sheriff's Office, National Guard, Coast Guard and volunteer groups to assist with patient transportation to/from dialysis during a disaster. EOCs normally cannot provide any specific resources during a disaster nor can they provide priority power restoration. DOs will need to contact your local utility companies and request power restoration priority for your facilities.

Document the outcome of the visitation and the letter in QAI and place a copy of the letter (signed by the EOC) in the meeting notes and a copy in the facility emergency manual. If the EOC does not sign the letter, document who you spoke with, topics of discussion and any specific action items and then file this in your emergency plan.

(On Facility Letterhead)

DATE: 00/00/2020

ENTER NAME AND ADDRESS OF LOCAL EMERGENCY OPERATIONS CENTER

Re: Annual Notification Requirement – Local Emergency Operations Center (EOC)

Dear (ENTERNAME):

Recent changes to the federal Medicare regulations governing the operations of dialysis facilities (CMS § 494.62 CfC Emergency Preparedness of the Federal Regulations, "Conditions for Coverage for Suppliers of End-Stage Renal Disease Services") require Medicare certified dialysis facilities to establish initial and ongoing annual communication with the local Emergency Operations Center (EOC). I would like the opportunity to meet with you to determine how our team at (ENTER FACILITY NAME AND ADDRESS) can work together with your organization during a disaster. We provide life maintenance dialysis services service for approximately ____ ESRD patients with incenter hemodialysis. We also provide support services for patients who perform home dialysis.

Our facility has an Emergency Plan and staff is trained and drills are performed to prepare for emergency disruption of service. Our facility is/is not equipped with an emergency backup generator AND/OR Automatic Transfer Switch (ATS) to connect to a mobile generator. We have contracts OR supply arrangements with local water supply companies to provide tanker water if needed. We also have back up agreements with other nearby clinics to serve our patients if we cannot operate.

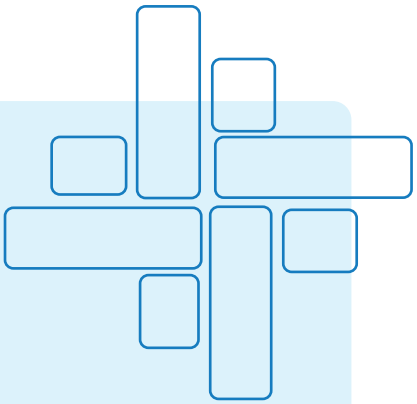
Clearly our interest is to be able to continue to provide life sustaining dialysis and support services to our patients. This letter is to advise you of our capabilities and to understand how we can work together in the community during a disaster. We also would like to participate in any community wide drills that are coordinated through your center.

Should you have questions, please feel free to contact me at (ENTER FACILITY TELEPHONE) NUMBER. In order to comply with Federal regulations, we request that you sign below to document the local EOC's receipt and understanding of this communication.

Sincerely,

Name Title

EOC Representative:



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