

HOME CARE
Emergency Preparedness 101
June 1, 2011

PART I Basics

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LEARNING OBJECTIVES

By the end of this session, you should understand:

- Basic home health care emergency planning
- The importance of knowing your agency's plan
- The value of having your own plan
- The importance of your patients' preparedness

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THE BASICS

- Home Care Agencies are required to plan for emergencies of all types (All-Hazards)
- As part of that planning, staff must be oriented to the plan and understand their role in responding to a disaster
 - Regulation - State
 - Conditions of Participation
 - Accrediting Bodies (Joint Commission)
- Plan should be based on risk assessment (HVA)
- Plus - Informal expectations by counties, cities, other providers, even patients

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GOALS OF AN EMERGENCY PLAN

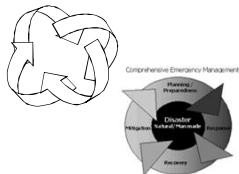
- Maintain continuity of care to agency patients
- Maintain agency ability to continue operations
- Ensure patient and staff safety
- Mitigate harm; reduce damage
- Maintain staff cooperation
- Ensure appropriate utilization of resources
- Ensure orderly response to emergency situations within community effort
- Provide legal protection for agency
- **Meet government and accrediting requirements**

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FOUR STAGES OF EMERGENCY MANAGEMENT

- Mitigation - reducing risk
- Preparedness - planning activities, training, drills
- Response
- Recovery



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**FRAMEWORK OF
EMERGENCY PLANNING**

1. Hazard/Risk Analysis
2. Develop Plan & Educate
3. Test, Evaluate & Update

**SO – WHAT
DOES THIS ALL
MEAN?**

Key
Concepts
You Need to
Know

HAZARD VULNERABILITY ASSESSMENT

- Guides development/review of plan
- Identifies critical risks
- Agency/community/patient
- Plan should be customized to appropriate levels of risk
- Each branch/site should have an individualized plan based on their specific location & risk factors
- What are NY's highest risks?

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COOP & CEMP

- **COOP - Continuity of Operations Plan**
 - ensures agency will be able to continue to provide services
 - involves administrative, operational, financial, clinical and HR
 - might be called business continuity plan
- **CEMP – Comprehensive Emergency Management Plan**
 - contains all aspects of agency's emergency preparedness, response, and recovery plan

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BROAD ASSUMPTIONS

In a large scale event...

- Staff will be called in according to agency policy
- Your agency will most likely prioritize patients by need for service delivery and discharge others near end of their episode to get ready for a "surge" in new patients
- Certain regulatory requirements will be waived or reduced
- Your job duties may change
- You and other staff will have your own plans for family responsibilities and safety

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STAFF CALL DOWN

- Agency must have a system in place to contact staff in case of a disaster
- Once agency emergency plan is activated, staff will be notified
- Often called phone tree

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PATIENT PRIORITIZATION

- Patients are reviewed to establish which ones must be seen as usual; which ones can safely receive a lesser degree of care or receive phone calls; which ones can be discharged

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HOME HEALTH AGENCY PATIENT CLASSIFICATION LEVELS

- **LEVEL 1 - High Priority** Patients in this priority level need uninterrupted services. The patient must have care. In case of a disaster or emergency, every possible effort must be made to see this patient. The patient's condition is highly unstable and deterioration or inpatient admission is highly probable if the patient is not seen. Examples include patient requiring life sustaining equipment or medication, those needing highly skilled wound care, and unstable patients with no caregiver or informal support to provide care.
- **LEVEL 2 - Moderate Priority** Services for patients at this priority level may be postponed with telephone contact. A caregiver can provide basic care until the emergency situation improves. The patient's condition is somewhat unstable and requires care that should be provided that day but could be postponed without harm to the patient.
- **LEVEL 3 - Low Priority** The patient may be stable and has access to informal resources to help them. The patient can safely miss a scheduled visit with basic care provided safely by family or other informal support or by the patient personally.

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SURGE CAPACITY – “BOUNTY” HYPOTHESIS

- Also called “medical aftershock”
- Refers to the ability of the health care system to rapidly absorb large numbers of additional patients by
 - discharging low priority patients
 - altering standards of care
 - reorganizing staff
 - reducing time for paperwork
 - operating under waived regulations
- Home care is often looked to as capable of absorbing countless patients (the “bounty” hypothesis)

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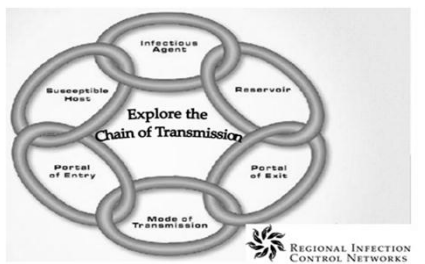
SURGE IN HOME CARE

- Many variables:
 - Patient roster/ability to downsize
 - Specific event and resulting barriers to service
 - Staff availability
 - Travel ability
 - Prior commitments
 - Acuity of new patients

Do you have an... INFECTION CONTROL PLAN

- Hand washing (gel?)
- Isolation precautions
- Community transmission
- Personal protective equipment (PPE)
- Identification of most vulnerable patients

IMMUNIZATION - BREAK THE CHAIN



THE PARTNERSHIP

Emergency planning for home care patients is a patient and family centered partnership that includes the patient, your agency, patient caregivers, the community, local and State emergency planners and responders

AGENCY RESPONSIBILITY TO PATIENTS

- Continuity of care
- Communication
- Home care agency may be the link between patient and other services
- Planning Guidance - responsibility to provide planning and educational support to your patients

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AGENCY RESPONSIBILITY TO STAFF

- Orientation to plan
- Training
- Education
- Communication
- Safety & security to the extent possible

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TYPES OF EVACUATION

- **Emergency Evacuation** – Immediate departure due to life or safety threat
- **Urgent Evacuation** – Commences within four hours
- **Planned Evacuation** – At least 48 hours to prepare
- **Transportation Assistance Levels** – how much help is needed?
- **** Remember...**in some cases, such as storms, postponing evacuation may be dangerous as bridges close, roads and transportation means may shut down – you will have to wait it out

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INCIDENT COMMAND SYSTEM (ICS)

- **Agency will have Emergency Operations Center (EOC) or equivalent**
- **Agency will have an Emergency Communications Center (ECC) or equivalent**
- **Disaster command or incident management system required by guidelines but ICS not yet a survey item**
- **Home care must have established chain of command**
- **Should be familiar with terminology and concepts of ICS**
- **Should know your role within the agency during disaster; who to call; expected duties**

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PART II

**NYSDOH
Survey
Elements**

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MAY 10, 2005 NYSDOH DAL

- Home care and hospice providers must be able to rapidly identify patients at risk within the affected area. They should be able to call down their staff, have ready access to reliable event specific information and be able to work collaboratively with their local emergency manager, local health department or other community partners. In order to accomplish these objectives, the following critical elements must be included in the provider's emergency preparedness plans:

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NYSDOH CRITICAL ELEMENTS

Internal Operations

1. 24/7 contact info
2. Call Down List
3. Patient Roster
4. Information requests
5. HCS Account & Coordinator (s)
6. Annual policy update & staff training

External Collaboration

7. Community Partner Contact List
8. Pre-planning with those Partners
9. Drills

Pan Flu Plan Surge Plan

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1. 24/7 CONTACT LIST

Required

- Identification of a 24/7 emergency contact telephone number and e-mail address of the emergency contact person and alternate which must also be indicated on the Communications Directory of the HPN;

Best Practice Suggestions

- Second alternate
- Make sure everyone has a paper copy



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2. CALL DOWN LIST

- A call down list of agency staff and a procedure which addresses how the information will be kept current;

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3. PATIENT ROSTER

- A current patient roster that is capable of facilitating rapid identification and location of patients at risk. It should contain, at a minimum:
 - Patient contact information
 - Patient Priority Level
 - ID of Patients on Life Support Equipment
 - Family/caregivers emergency contact #s
 - Other specific information critical to first responders

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PATIENT ROSTER

- Best Practices
 - Patient registered with local emergency services or SNP registries, if available
 - Patient registered with utility company
 - Shelter needs identified
 - Patient and family educated—discuss plans at admission; update every six months.
 - "Go" kit with all medical & contact information
 - Transportation Assistance Levels ID'd

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4. REQUESTS FOR INFORMATION

Policies and Procedures to respond to or initiate requests for information or resources;

Policy

During an emergency incident, all incoming and outgoing requests for information or help will be routed (e.g.):

- through the communications center or
- through the office of the administrator.

All requests must be approved by the incident commander (or administrator) prior to implementation.

5. POLICIES AND PROCEDURES FOR HPN/HCS

Policy defining the agency's twenty-four hour, seven-day a week coverage, or coverage consistent with the agency's hours of operation, shall be created and reviewed no less than annually.

- Obtain/maintain account
- "Sufficient" HPN Coordinators
- Update Communications Directory monthly

Your ability to access the HCS will always be tested by a surveyor!

6. UPDATING PLAN AND STAFF ORIENTATION

- Policy that requires an annual review and update of emergency plan
- Policy that addresses staff orientation to the plan and defines their roles during an emergency
- (What's YOUR role?)



7. COMMUNITY PARTNER CONTACT LIST

- Policy that addresses how this information will be kept current
- List of local health department, local emergency management, emergency medical services and law enforcement and other partnering health organizations

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8. COLLABORATION & PLANNING WITH PARTNERS



- Evidence of pre-arrangements with community partners; including agency's role and responsibilities in the city, town or county's emergency response plan
 - Do you know what is expected of you?
 - What documentation do you have to show collaborative efforts?

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COLLABORATION WITH PARTNERS

Policy that ensures that the home care agency is an active participant in community emergency planning efforts, demonstrated by:

- Formal MOU or contract;
- Attendance at community emergency planning meetings etc.;
- Basic knowledge of who's who in the community; and
- Outline or explanation of agency's specific role and responsibilities during an emergency.
- DOH quote: "The emergency preparedness guidelines that were sent to agencies in the December 2002 DAL provide a template to follow in ensuring the agency's written disaster plan has the essential elements to demonstrate that it has collaborated through pre-determined roles, lines of authority, and chain of command and communication. This should be included in agencies' procedures."

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9. DRILLS

- **Policies** that address participation in agency specific drills or community-wide drills and exercises.
- Do you have a strategic exercise plan containing evaluation and updating components?
- Although using actual weather events as drills fulfills some requirements, it doesn't prepare you for the "unknown."



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IMPORTANT NOTE

- Policies & procedures must exist to "flesh out" call down lists, contact lists, proof of drills, etc.

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HOME CARE/HOSPICE GUIDELINES

December 2002 DAL

- SURVEILLANCE
- RESPONSE
- COMMUNICATIONS
- SECURITY
- EDUCATION

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HOME CARE/HOSPICE GUIDELINES

SURVEILLANCE

- Identify key diagnostic clues that may activate further investigation or activation of the disaster plan
- Ensure all staff is educated on the surveillance indicators, the chain of command, the reporting protocol and the legal responsibility to report

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RESPONSE

- Define the circumstances under which the plan is activated and terminated
- Develop or enhance a protocol for mobilizing the necessary emergency workers, staff and possible volunteers
- Establish a designated assembly point for staff to report (if alternate site is needed)
- Ensure the availability of agency site basic emergency disaster supplies and equipment (i.e. generators, batteries, blankets, person protective equipment (PPE), water source, emergency documentation packets, tracking of staff, recall listings, service area maps, etc.)
- Ensure that essential patient specific information is available that provides patient prioritization and information that is pertinent in the continuance of ongoing medical care, as well as family contact information
- Identify transportation alternatives (i.e. mass transit unavailable for staff use, the use of local law enforcement, the use of personal vehicles)
- Consider the use of service area maps for staff to geographically provide services (coinciding with their residential location to lessen travel)
- Ensure the availability of potential additional equipment needs, PPE and supplies for off-site staff (required for each event)
- Ensure the education of all staff on appropriate infection control precautions for each type of event and the proper use of the personal protective equipment

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RESPONSE CONTINUED

- Establish a plan for patient prioritization for response and/or evacuation environmental decontamination in conjunction with community partners that includes the area, facility or portable device to be used, a protocol for the decontamination and who is responsible to perform the function
- Develop a system for the identification, tracking, admission and discharge of mass casualties/victims
- Develop a contingency plan when reaching surge capacity for admissions in partnership with the local emergency management agency, county health departments, emergency management services and other health care delivery systems. The plan should describe methods to increase admission capacity, facilitate rapid transfers and /or discharges, the implementation of diversion plans and identifying additional staffing
- Determine needs for specialized equipment and supplies (ventilators, personal protective equipment, and pharmaceuticals) based on each type of event and current inventory. The plan should include methods to access additional supplies if needed
- Develop protocols for placement of patient, type of precautions and or isolation (if required) and other infection control measures for each type of event and a plan to educate staff
- Develop a plan for the safe handling, storage, tracking and preparation of bodies post mortem. This may include arrangements with the county and emergency management agency or other health care delivery systems partners to appropriate sites, space and / or additional supplies and resources needed for infection control purposes.
- Establish contacts for pet placement/evacuation

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COMMUNICATIONS

The 24 hour, 7 day per week communication network should include internal and external components

Internal

- A notification protocol to ensure that all relevant agency staff is rapidly notified in the event of a disaster. This requires 24-hour contact information for all key staff, including home telephone, pagers, cell phones and electronic mail as well as a telephone tree system or emergency notification software to ensure the ability to rapidly contact staff to mobilize for duty.

External

- Notification plans to ensure all outside agencies are notified. This requires the maintenance and distribution of an updated list of all key agencies (i.e. New York City Department of Health, if applicable, the New York State Department of Health (regional), local emergency management services and City /County Emergency Management Office.
- Provision of staff support/debriefings ongoing throughout all phases of disaster plan
- Ensure the disaster plan addresses the communication to families with provision of support services, counseling, information updates and referrals

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SECURITY

- Develop or enhance a plan for rapid identification of staff and emergency workers responding to a disaster
- Consider a plan for the pre-hospital triage / decontamination for routing potentially contaminated victims to the appropriate areas prior to entering the hospital

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EDUCATION

- Develop disaster education tools and plan for all staff members defining roles and responsibilities
- Develop educational tools defining specific biological/chemical/nuclear exposure symptoms, care and specific PPE for each
- Ongoing exercise/drill of disaster plan

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RESOURCES

- Your Local or "County 'OEM' "
- State - NY State Office of Emergency Management Organization <http://www.dhSES.ny.gov/oem/>
- Federal - Federal Emergency Management Agency (FEMA - www.fema.gov)
- Department of Homeland Security (DSH) www.dhs.gov
- Health Commerce System - <https://commerce.health.state.ny.us/hpn/>
- NY-Alert - <http://www.nyalert.gov/?Audit=true>
- Home Care Prepare: www.homecareprepare.org.

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WHAT YOU CAN DO...

- Listen to the news, stay alert - sign up for warning systems such as NY-Alert (<http://www.nyalert.gov/>)
- Talk to your agency, family, and patients about preparedness, especially if you know an event is imminent
- Understand your own personal and agency responsibilities
- Have a plan for you and your family

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TAKE AWAY LIST...YOU SHOULD HAVE

- Personal and family plan
- General Knowledge of:
 - Community risk factors
 - Agency's plan and your role
 - Ethics in emergency response
 - Community partners and their plans
 - Sources of information
 - Sheltering types
 - Your responsibilities
- Enough general knowledge to pick up on "red flags" that may indicate a health crisis (syndromic surveillance)

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