HOME CARE EMERGENCY PREPAREDNESS
A Handbook to Assist Home Care Providers in Emergency Preparedness Planning
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HCA Education and Research is a subsidiary of the Home Care Association of New York State (HCA).

HCA is a statewide not-for-profit organization representing nearly 400 health care providers, allied organizations and individuals committed to the advancement of quality home care services in New York State. HCA and its home health provider members work to promote excellence and support high-quality, cost-effective home care and community services to several hundred thousand individuals who have Medicaid, Medicare, and/or private insurance coverage.

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More APPENDICES are at www.homecareprepare.org
Introduction and Overview

The purpose of this handbook – developed by the Home Care Association of New York State (HCA) with grant funding from the State Department of Health – is to assist New York home care provider agencies in writing, improving and evaluating their emergency preparedness plans.

An emergency plan, in the most basic sense, is a guiding document that outlines in detail the systems and protocols which an organization has in place to: ensure the safety of staff and patients, operate within the larger emergency management system, and maintain continuity of services to patients during and after an emergency. Some of these protocols, as outlined in this handbook, are required by law and others are best-practices recommended by HCA through consultation with providers working in the home care field.

The types of emergency events covered by an emergency plan could include natural events like flooding, hurricanes, or winter weather conditions; infectious disease outbreaks; man-made disasters or accidents which cause widespread exposure or dangerous conditions; and others outlined further in this handbook.

For home care providers, like all health services organizations, preparedness is a critical part of your operation for ensuring patient care and safety, staff security, continuity of business operations and your reputation. While state regulations outline a very basic legal framework and guideline structure for emergency planning, the most effective preparedness and response plans are comprehensive, agency-wide initiatives that provide explicit protocols requiring all organizational staff and departments to work together under a shared understanding and collaborative effort.

Format

This handbook has several sections, including background on New York State Department of Health (DOH) regulations governing emergency preparedness, a section to assist providers in assessing the strength of their preparedness plans, an in-depth look at various protocol areas that should be considered in your plan.
development, and tools for ongoing evaluation of your plan’s effectiveness. The four basic sections are as follows:

- **New York Regulations.** This section provides information on three distinct sources of regulation: 1) Title 10 of New York State law; 2) additional state guidelines issued in 2002; and 2) an emergency preparedness Dear Administrator letter (DAL) issued by the Department of Health in 2005. (Please see Appendix A.) Together, these three items form the basic core regulatory framework governing home care emergency planning in New York State. These regulations, together with best-practices developed from providers in the field, make for the elements of a comprehensive emergency plan directing your organization’s response and post-incident activities to ensure safety, continuity of care, and continuity of your business operation.

- **Step 1: Hazard Vulnerability or Risk Assessment.** Preparedness Assessment is the process of determining the various risks and threats your agency and patients might face. It involves estimating the impact of both historical and potential events on your business and clinical operations.

- **Step 2: Plan Development.** This is the most in-depth and extensive section of the handbook, outlining the various factors that an agency should take into consideration as it develops or improves its emergency plan. This section of the handbook is divided into a series of topical themes that include such important planning elements as business continuity, surge capacity policies, expectations during an evacuation order, sheltering information, community partnerships, infection control and more. Agencies should read this section carefully and then use the draft policies, available in Appendix B of this handbook, for model protocol language for use in addressing these topics within your emergency plan.

- **Step 3: Plan Evaluation.** Routine evaluation is a critical part of making sure your agency’s plan reflects your ability to safely and effectively respond to and recover from a disaster. This section provides information and tools to assist providers in plan evaluation, including protocols for “paper” review and making updates to your emergency plan, drills, and use of after-action reports (AARs).

In addition to these core elements of the handbook, HCA has also provided a series of appendices with more tools to assist providers. These appendices and other emergency planning information are available on HCA’s emergency preparedness website: www.homecareprepare.org. Please consult this website regularly for planning tips, educational programs, resources and more.
Home Care Emergency Preparedness Overview

Emergency preparedness in health care is the capability of public health and health care systems, communities, and individuals to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those whose scale, timing, or unpredictability threatens to overwhelm routine capabilities.

As a provider, you are likely well aware of the unique role that home care plays in response to events like these: a role that reflects your unique niche within the health care system as a whole.

This handbook will help you establish protocols for meeting the needs of your patients while maintaining continuity of operations through a coordinated and continuous process of planning and implementation that relies on measuring performance and taking corrective action.

All disasters begin “locally,” and it is important to remember that the response to an emergency can affect not just your agency, but also an entire community. Emergencies of any size can involve numerous medical and public health entities, including health care provider systems, public health departments, emergency medical services, medical laboratories, individual health practitioners, medical support services and transportation authorities.

This handbook will outline the critical steps your home care agency should take in creating, evaluating and updating your emergency plan. This plan should establish the role of your agency within the structure of emergency response, providing clear instructions and best-practices for how each level of your staff prepares for and activates in response to an emergency.

By state regulation – and, in many cases, to maintain accreditation – agencies are required to have an emergency plan in place. But beyond compliance with state regulations, there are many other very compelling reasons to maintain an emergency plan that is as comprehensive as possible. These reasons include:

- Ensuring the safety and well-being of patients and staff;
- Maintaining continuity of care to patients;
- Ensuring agency financial viability and continuity of business operations;
- Providing legal protection for your agency;
- Ensuring appropriate utilization of resources; and
- Supporting your community and community partners during a disaster.
Home care agencies are required to plan for emergencies of all types (what is known as “all-hazards” planning). As part of that planning, staff must be oriented to the plan and understand their role in responding to a disaster.

As you begin to formulate your plan, it will be helpful for you to remember that emergency planning for home care is a patient and family centered partnership that includes the patient and family or patient caregivers, your agency and staff, the community, and local and state emergency planners and responders.
New York State Regulatory Background

As noted in the introduction, the state regulatory framework for home care emergency preparedness consists of three basic documents: 1) Title 10 New York regulations; 2) additional state guidelines issued in 2002; and 3) a Dear Administrator letter issued by the State Department of Health in 2005.

The first of these documents consists mainly of communications requirements related to the state’s Health Commerce System (formerly the Health Provider Network, or HPN). The other two guidance documents, meanwhile, provide more thorough information that will help guide the basic structure of your emergency plan as outlined later in this handbook.

Some important themes to look for in these state-issued documents include:

- Specific requirements for your organization and staff regarding access to the state’s Health Commerce System (HCS) and maintenance of your HCS accounts (for purposes of this handbook, all references to the Health Provider Network, or HPN, apply now to its successor system, the HCS);

- Protocols for communication with and education of your staff and patients, pre-identification of patients who are most vulnerable during an emergency situation, and maintenance of patient roster information that emergency management officials may request of you during an emergency;

- Establishment of a disaster planning committee to lead your agency’s creation of a disaster plan; and

- Methods for classifying the priority level of response and risk for various patient populations – in effect, this constitutes a form of “triage” standards that help you and emergency management officials prioritize outreach and use of resources during an emergency.
Title 10 Regulations

Under Title 10 of New York Regulations, all Article 36 providers must meet the same New York State Department of Health (DOH) requirements, provided in full below:

Section 763.11 – Governing authority and
Section 766.9 – Governing authority

(10)(c) ensure the development of a written emergency plan which is current and includes procedures to be followed to assure health care needs of patients continue to be met in emergencies that interfere with delivery of services, and orientation of all employees to their responsibilities in carrying out such a plan;

(f)(o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department’s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four-hour, seven-day a week contacts for emergency communication and alerts must be designated by each agency in the HPN Communications Directory. A policy defining the agency’s HPN coverage consistent with the agency’s hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency’s HPN accounts shall consist of, but not be limited to, the following:

(1) sufficient designation of the agency’s HPN coordinator(s) to allow for HPN individual user application;

(2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health;

(3) adherence to the requirements of the HPN user contract; and

(4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis.

In addition to these basic communications requirements, it should also be noted that many bills of patient rights generally include language stating that the patient has the right to be informed of what to do in an emergency. All credentialing, certifying and licensing bodies have specific requirements around emergency preparedness as well.

Additional patient education and outreach requirements are further spelled out in other state Department of Health guidance documents detailed in the next section.

In 2002, in the wake of the 2001 terrorist attacks, DOH released more comprehensive emergency preparedness guidelines for home care and hospice. These guidelines are published in full below and include a bulleted list of specific home care and hospice preparedness protocols.

Beyond the basic elements included in Title 10 for HCS access, this 2002 guidance further establishes very detailed requirements for creating a disaster-response team and plan, defining agency disaster-response personnel roles, communications protocols (including phone trees and call-down lists), conducting performance drills, fulfilling response and reporting requirements, education standards, surveillance requirements, and more. The state’s 2002 guidelines are as follows:

DOH Home Care/Hospice Preparedness Guidelines

- Establish an active, functional disaster response committee or team with an incident command (management system). The team should: consist of relevant members who can add specific expertise to each type of disaster event. Nursing, professional medical staff, allied health care providers, infection control, as well as key administrative staff, are vital to the overall plan.

- Ensure the agency has a written disaster plan that would include: a defined Incident or Disaster Command Team (disaster management team); and measures to respond to biological, chemical, nuclear/radiological and mass trauma events. In addition, the agency must work in partnership with local county health units and county Emergency Medical Services and the health care delivery network in the immediate or surrounding community to develop the disaster plan for both internal and external disasters.

- Define predetermined roles, lines of authority, and chain of command and communication. Alternates/backup for each role should also be assigned.

- Establish a protocol for the education of staff regarding the disaster response plan, including the role of the staff.

- Establish a 24/7 communications network with alternate communications systems identified, if the original network becomes disabled.

- Identify and plan for activation of the response plan if night-time or weekend activation is required.

- Establish a protocol for contacting staff, emergency resources and/or outside agencies in the event of a disaster.
• Maintain up-to-date contact lists of staff and key agency contacts such as local health unit, local emergency management team (shelter identification), local law enforcement and Regional, New York State Department of Health staff.

• Develop a system to rapidly notify and disseminate information to staff (telephone trees, broadcast fax, e-mail, community bulletin boards, etc.).

• Include disaster preparedness drills or exercises to test the efficacy of the plan in conjunction with the local partners included in the plan.

The overall plan should focus on the following elements:

Surveillance
Response
Communications
Security
Education

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.

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.

- 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.

Communications

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

• Internal communications: 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 communications: 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 the disaster plan.

• Ensure the disaster plan addresses the communication to families with provision of support services, counseling, information updates and referrals.

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.

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.
In 2005, DOH published a Dear Administrator Letter (DAL) that again outlined the elements of a home care emergency preparedness plan and reinforced the need for providers to access the Health Commerce System (HCS) and maintain HCS accounts.

Providers should read this DAL in full in the appendix section (Appendix A) and take note of two important corrections footnoted with the letter: the first correction relates to the address for our home care preparedness website, www.homecareprepare.org. The other update relates to the paragraph on DOH’s provider education sessions for the HPN, which no longer apply. Providers should read the current HCS regulations.

The letter otherwise outlines a series of guidelines (with some overlap of information from the 2002 guidance), stating that the Department’s regional office staff will assess compliance with regulations during recertification periods. Lastly, it references requirements in state regulations regarding agency access to the Health Commerce System (formerly known as the Health Provider Network, or HPN) and establishes important guidelines for classifying the risk level of patients, detailed later in this section.

Key passages of this letter are provided below.

In the case of a CBRNE event or natural disaster, 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:

- 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;
- A call down list of agency staff and a procedure which addresses how the information will be kept current;
- A contact list of community partners, including the local health department, local emergency management, emergency medical services and law enforcement and a policy that addresses how this information will be kept current. The HPN Communications Directory is a source for most of this information;
- Collaboration with the local emergency manager, local health department and other community partners in planning efforts, including a clear understanding of the agency’s role and responsibilities in the county’s comprehensive emergency management plan;
• Policies that require the provider to maintain a current Health Provider Network (HPN) account with a designated HPN coordinator(s) responsible for securing staff HPN accounts and completing and maintaining current roles based on contact information in the Communications Directory;

• A current patient roster that is capable of facilitating rapid identification and location of patients at risk. It should contain, at a minimum:
  - Patient name, address and telephone number
  - Patient classification Level (see enclosure)
  - Identification of patients dependent on electricity to sustain life
  - Emergency contact telephone numbers of family/caregivers
  - Other specific information that may be critical to first responders

• Procedures to respond to requests for information by the local health department, emergency management and other emergency responders in emergency situations;

• Policies addressing the annual review and update of the emergency plan and the orientation of staff to the plan;

• Participation in agency-specific or community-wide disaster drills and exercises.

Please also see the next section about requirements for classifying the risk levels of your patients, also spelled out in the 2005 DAL.

2005 DAL Requires Documentation of Patient Classification Levels

The primary goal of emergency planning is the provision of quality care while maximizing available resources. To support this goal, in the 2005 DAL, the Department of Health includes information on an important patient classification system which must be used to satisfy patient roster identification requirements.

Under such a system, patients are, in effect, categorized for “triage” according to their need of services, helping your agency determine how to stretch valuable staff and resources during an emergency event to ensure that the most vulnerable patients get the assistance they need.

These classifications levels are a required part of the emergency plan and must be included in the patient rosters maintained in accordance with your emergency plan.
They include the following priority levels, as defined by DOH:

- **Level 1 – High Priority.** These patients 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 patients 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.

**Maintaining Contact with DOH Regional Staff**

As part of your emergency preparedness coordination efforts, it is important that you are familiar with the Department of Health regional office staff in your region – a required part of your emergency planning and coordination efforts. During an emergency event, you will work with these staff to seek waivers or changes to your normal processes so that you may continue to serve your patients in the most appropriate manner. Regional DOH staff will also be seeking regular agency status reports during an event, including information on your ability to possibly admit additional patients should there be a large-scale event that requires hospitals to discharge extra patients (known as a surge event). The office locations and phone numbers are provided below.

- Western NY Regional Office
  584 Delaware Ave.
  Buffalo NY 14202
  (716) 847-4320

- Central NY Regional Office
  214 So. Salina St.
  Syracuse NY 13202
  (315) 477-8426

- Capital District Regional Office
  Frear Building
  One Fulton Street
  Troy NY 12180
  (518) 408-5413

- Metropolitan Area Regional Office
  90 Church Street
  New York NY 10007
  (212) 417-5888
Step 1: How Prepared Are You?

Now that you have looked at the state regulatory structure defining emergency preparedness, the next step involves assessing your agency against the regulations and best-practice benchmarks. Knowing, in advance, how your agency stacks up will make it easier to fill in any possible gaps in your emergency plan.

For purposes of this handbook, there are three basic steps that can be followed in developing your emergency plan:

Step 1: Conducting a hazard/risk analysis and determining planning priorities
Step 2: Plan development and education
Step 3: Plan evaluation and plan updates

This handbook will guide you through the process of developing or updating your emergency preparedness plan in later chapters. The focus of this chapter, however, is the process of conducting a hazard analysis and determining planning priorities in advance of actually developing your plan.

As part of this first step, we have identified two important tools for self-assessment: a hazard analysis worksheet and a comprehensive emergency management plan (CEMP) checklist.

Hazard Analysis Worksheet

Whether an agency is developing its first emergency plan, or updating an existing plan, it is important to understand both what your agency risks are and how prepared you are to respond successfully to any and all of those potential events. A separate analysis should be conducted for every office location, with differences being reflected in each location’s plan. This hazard/vulnerability:

- Guides development/review of your emergency plan
- Identifies critical risks
- Factors the agency/community/patient perspective
- Allows you to customize your emergency plan based on appropriate levels of risk
To perform the analysis, providers should evaluate potential events (such as natural events, infectious disease outbreaks, man-made disasters and others) in each of various categories of probability, vulnerability and preparedness. (Additional events can be included as necessary.)

There are several issues to consider when determining the probability of risk. These include but are not limited to:

1. Known risk
2. Historical data
3. Manufacturer/vendor statistics

Issues to consider for vulnerability include but are not limited to:

1. Threat to life and/or health
2. Disruption of services
3. Damage/failure possibilities
4. Loss of community trust
5. Financial impact
6. Legal issues

Issues to consider for preparedness include but are not limited to:

1. Status of current plans
2. Training status
3. Insurance
4. Availability of backup systems
5. Community resources

To assist you in this analysis, HCA has provided a Hazard Vulnerability Analysis Worksheet on the next page.

**Instructions**: Please review each potential event in the worksheet (next page) and assign numbers evaluating 1) the probability of that event happening, 2) how disruptive that event would be to your agency operations and 3) how prepared your agency is. Then, multiply the three ratings for a total score (as shown in the example).

This worksheet will help you prioritize and develop your plan based on the risks identified. For example, events that happen frequently, such as weather-related events, should be a priority in your plan. If your agency is near a nuclear power plant or a chemical plant, those are also most likely to be considered priorities in your planning efforts. The total values with the higher scores will represent the events most in need of organization focus and resources for emergency planning.
### Hazard Vulnerability Analysis Worksheet

#### All-Hazards

<table>
<thead>
<tr>
<th>Event</th>
<th>Probability</th>
<th>Level of vulnerability/ Degree of disruption</th>
<th>Preparedness</th>
<th>Total Score</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>High (3)</td>
<td>Mod (2)</td>
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<tr>
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<td>High (3)</td>
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<td></td>
<td>Poor (3)</td>
<td>Fair (2)</td>
<td>Good (1)</td>
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</tbody>
</table>

*Example*

- Ice/snow: 3
- Flooding: 2
- Earthquake: 2
- Fire: 3
- Hurricane: 2
- Hazardous Material Accident: 2
- Tornado: 3
- Nuclear/Radiation: 2
- Civil Disturbance: 2
- Mass Causality Event: 2
- Terrorist Attack: 2
- Other: 3
- Pandemic or Infectious disease: 2

$3 \times 2 \times 2 = 12$

#### Service Interruption

<table>
<thead>
<tr>
<th>Event</th>
<th>Probability</th>
<th>Level of vulnerability/ Degree of disruption</th>
<th>Preparedness</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Good (3)</td>
<td>Fair (2)</td>
<td>Poor (1)</td>
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- Electrical Failure: 3
- Communications failure: 2
- Information System Failure: 2
- Water failure: 3
- Transportation Interruption: 2
- DME Interruption: 2
- Other: 3
Hazard Vulnerability Planning Priorities

Review your hazard analysis and level of vulnerability (based on your responses in the worksheet on the previous page) and list your top threats below.

<table>
<thead>
<tr>
<th>Hazard</th>
<th>Score</th>
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<tbody>
<tr>
<td>1.</td>
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<td>9.</td>
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<td>10.</td>
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</table>

Add more if necessary:

Your plan should address how each of your major threats will be addressed.
Comprehensive Emergency Management Plan (CEMP) and Checklist

The Comprehensive Emergency Management Plan (CEMP) and Checklist is a framework for evaluating how complete your agency’s plan is or should be. It may be modified to suit an agency’s specific circumstances, but it is a good way to review your planning efforts.

This assessment can be conducted by looking at the agency’s preparedness according to broad general categories, keeping in mind the need to support both continuity of care and continuity of operations.

These categories may be scaled to agency size and complexity and folded into an all-hazards plan based on each agency’s level of risk. There are many parts that become “moving pieces” once a disaster hits. Those categories include:

- Administrative responsibilities
- Clinical care and documentation
- Patient safety
- Staff orientation, planning and training
- Transportation
- Supplies
- Utility considerations, including vehicle fuel
- Office integrity and patient record protection
- Finance
- Communication
- Community partnerships
- Patient plan and education
- Plan evaluation and update

If an agency has an existing plan, it should complete the comprehensive emergency management plan to assess its overall readiness and then cross check with the hazard analysis form to update your overall level of risk. Once the risk areas are identified and prioritized, the agency can focus on preparing for specific targeted areas.

It’s a good idea to review this list before you begin to draft your plan, as it may help you to organize your planning efforts.
## Comprehensive Emergency Management Plan Checklist

<table>
<thead>
<tr>
<th>ITEM</th>
<th>ITEM COMPLETED</th>
<th>REVISION DATE</th>
<th>PAGE NUMBER</th>
<th>COMMENTS</th>
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<tr>
<td><strong>ADMINISTRATIVE</strong></td>
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<tr>
<td>Emergency Response Committee or Team in place</td>
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<tr>
<td>Business Continuity Plan in place for recovery phase including offsite access to data &amp; data backup and office relocation (Logistical support in place to relocate office if necessary)</td>
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<tr>
<td>Incident Command System (ICS) – Emergency chain of command established. Pre-determined roles &amp; lines of authority established with backup for each role</td>
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<tr>
<td>Comprehensive Emergency Management Plan appropriate for “All-Hazards”</td>
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<tr>
<td>Protocol for training of staff in EP, ICS, and roles in emergency situations</td>
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<tr>
<td>Emergency contact/call down protocol in place for staff, with policies for updating contact information</td>
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<tr>
<td>Equipment and supplies – plan for alternate vendor arrangements necessary</td>
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<tr>
<td>Weekend/night time activation plan in place</td>
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<tr>
<td>Emergency services resource plan (loss of power, water, gas, etc.)</td>
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<tr>
<td>Maintain active enrollment on HCS with policies and procedures in place for maintenance of Communications Directory; daily access</td>
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<tr>
<td>Employee orientation/job descriptions explain staff roles and responsibilities in emergency situations</td>
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<tr>
<td>Surge Plan in place</td>
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<tr>
<td>COMMUNITY PARTNERSHIPS</td>
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<tr>
<td>Plan for identifying and developing potential partner agencies/facilities, organizations, volunteers</td>
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<tr>
<td>Partnership with EMS, local health department &amp; the health care delivery network in immediate/surrounding community is established</td>
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<tr>
<td>Contact established with Regional Resource Center (RRC)</td>
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<tr>
<td>Contact with Local Emergency Planning Office</td>
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<tr>
<td>Community Partnership list updated</td>
<td></td>
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<td></td>
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<tr>
<td>Evacuation coordination current</td>
<td></td>
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<table>
<thead>
<tr>
<th>POLICIES &amp; PROCEDURES</th>
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<tbody>
<tr>
<td>Protocols established to coordinate agency readiness with National Alert Levels</td>
</tr>
<tr>
<td>Procedures in place to identify &amp; review patient priority of care levels, including outstanding environmental risks or vulnerabilities</td>
</tr>
<tr>
<td>Measures in place to respond to:</td>
</tr>
<tr>
<td>1. Biological warfare or naturally occurring outbreak of disease</td>
</tr>
<tr>
<td>2. Chemical emergency</td>
</tr>
<tr>
<td>3. Nuclear or radiological emergency</td>
</tr>
<tr>
<td>4. Mass trauma event</td>
</tr>
<tr>
<td>5. Weather related event</td>
</tr>
<tr>
<td>6. Transportation-related event</td>
</tr>
<tr>
<td>7. Power outage</td>
</tr>
<tr>
<td>8. Quarantine/Isolation of patients; including mortalities</td>
</tr>
<tr>
<td>9. Evacuation coordination with community; patient location</td>
</tr>
<tr>
<td>Infection Control Plan developed &amp; staff trained</td>
</tr>
<tr>
<td>Personal protective equipment (PPE) plan &amp; equipment policy and procedure in place</td>
</tr>
<tr>
<td>Occupational Health – identified responsible person</td>
</tr>
<tr>
<td>SURVEILLANCE</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>ID key clues that require investigation or activation of disaster plan</td>
</tr>
<tr>
<td>Educate staff on syndromic surveillance and reporting procedures</td>
</tr>
<tr>
<td>Maintain access to Health Alert Network (HAN)</td>
</tr>
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<table>
<thead>
<tr>
<th>RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of the circumstances &amp; responsible parties under which the Emergency Plan is activated</td>
</tr>
<tr>
<td>Definition of the circumstances &amp; responsible parties under which the Emergency Plan is stepped-down</td>
</tr>
<tr>
<td>Ensure availability of patient data during power or computer failure</td>
</tr>
<tr>
<td>Identify transportation alternatives/maps available</td>
</tr>
<tr>
<td>Plan in place, if appropriate, for mass vaccination event</td>
</tr>
<tr>
<td>Emergency supplies available for business continuity (7-10 days)</td>
</tr>
<tr>
<td>Plan for decontamination/partners</td>
</tr>
<tr>
<td>Plan for pet evacuation/placement</td>
</tr>
<tr>
<td>Establish designated alternate/assembly point for staff</td>
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<table>
<thead>
<tr>
<th>PLAN EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular drills and exercises conducted to test EP in conjunction with local partners (minimum _____ per year)</td>
</tr>
<tr>
<td>After action report is created, reviewed and used to update plan</td>
</tr>
</tbody>
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<tr>
<th>SURGE CAPACITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surge capacity contingency plan</td>
</tr>
<tr>
<td>Staff acuity skill levels assessed &amp; filed</td>
</tr>
<tr>
<td>Patients prioritized by level of need of care</td>
</tr>
<tr>
<td>MOUs with community partners</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>COMMUNICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Communications Center/POC Designated</td>
</tr>
<tr>
<td>24/7 Communications Network with contingency plan if primary system disabled (cells, pagers, RACES, satellite phones, WPS Phones)</td>
</tr>
<tr>
<td>Electronic communication capability established with DOH via internet (HCS/HAN)</td>
</tr>
<tr>
<td>HOME CARE EMERGENCY PREPAREDNESS</td>
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<tr>
<td>----------------------------------</td>
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<tr>
<td></td>
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<tr>
<td>Policy for regular HCS</td>
</tr>
<tr>
<td>Communications Directory updates</td>
</tr>
<tr>
<td>24 hour contact information for</td>
</tr>
<tr>
<td>key staff</td>
</tr>
<tr>
<td>Notification plans to ensure</td>
</tr>
<tr>
<td>outside agencies/vendors are</td>
</tr>
<tr>
<td>given notice</td>
</tr>
<tr>
<td>Up-to-date contact information</td>
</tr>
<tr>
<td>of key agencies, local emergency</td>
</tr>
<tr>
<td>management offices, EMS, law</td>
</tr>
<tr>
<td>enforcement, NYSDOH</td>
</tr>
<tr>
<td>Physicians identified for</td>
</tr>
<tr>
<td>telephone support with 24/7</td>
</tr>
<tr>
<td>contact information available</td>
</tr>
<tr>
<td>Protocol for emergency mobilization</td>
</tr>
<tr>
<td>of staff/call down &amp; contact</td>
</tr>
<tr>
<td>information</td>
</tr>
<tr>
<td>Protocol to contact appropriate</td>
</tr>
<tr>
<td>key outside agencies (DOH, CDC,</td>
</tr>
<tr>
<td>OEM, counties, etc.)</td>
</tr>
<tr>
<td>Plan to communicate with patients</td>
</tr>
<tr>
<td>and families re: services,</td>
</tr>
<tr>
<td>counseling, updates &amp; referrals</td>
</tr>
<tr>
<td>Media/Risk Communication plan &amp;</td>
</tr>
<tr>
<td>responsible person (PIO)</td>
</tr>
<tr>
<td>SECURITY</td>
</tr>
<tr>
<td>Plan for rapid identification of</td>
</tr>
<tr>
<td>staff &amp; emergency workers</td>
</tr>
<tr>
<td>responding to a disaster</td>
</tr>
<tr>
<td>Plan for handling security</td>
</tr>
<tr>
<td>related to volunteers during an</td>
</tr>
<tr>
<td>event</td>
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<tr>
<td>Plan for essential worker</td>
</tr>
<tr>
<td>designation to ensure safe access</td>
</tr>
<tr>
<td>to patients</td>
</tr>
<tr>
<td>EDUCATION</td>
</tr>
<tr>
<td>Orientation plan for new</td>
</tr>
<tr>
<td>employees includes emergency</td>
</tr>
<tr>
<td>preparedness expectations &amp;</td>
</tr>
<tr>
<td>training</td>
</tr>
<tr>
<td>Plan for recurring education of</td>
</tr>
<tr>
<td>staff defining roles/responsibilities</td>
</tr>
<tr>
<td>All staff educated re: agency</td>
</tr>
<tr>
<td>emergency plan</td>
</tr>
<tr>
<td>Patient education – protocols</td>
</tr>
<tr>
<td>developed for educating patients</td>
</tr>
<tr>
<td>regarding agency emergency</td>
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<tr>
<td>procedures; shelter in place;</td>
</tr>
<tr>
<td>patient personal emergency plans</td>
</tr>
<tr>
<td>on file</td>
</tr>
<tr>
<td>EVACUATION</td>
</tr>
<tr>
<td>Patients registered with local</td>
</tr>
<tr>
<td>utilities/Local Emergency Services</td>
</tr>
<tr>
<td><strong>HOME CARE EMERGENCY PREPAREDNESS</strong></td>
</tr>
<tr>
<td>--------------------------------------</td>
</tr>
<tr>
<td><strong>Patients prioritized by shelter need/level of care</strong></td>
</tr>
<tr>
<td><strong>Current shelter list maintained if available; contacts known</strong></td>
</tr>
<tr>
<td><strong>Staff trained in evacuation procedures/alternate contact sites</strong></td>
</tr>
<tr>
<td><strong>Patient transportation coordinated with community resources, if needed</strong></td>
</tr>
<tr>
<td><strong>Communication link established with local OEM</strong></td>
</tr>
<tr>
<td><strong>MENTAL HEALTH</strong></td>
</tr>
<tr>
<td><strong>Provisions for support services &amp; counseling for patients, family and staff</strong></td>
</tr>
<tr>
<td><strong>VOLUNTEERS</strong></td>
</tr>
<tr>
<td><strong>If volunteers are used, plan for prior recruiting, training, orienting, and allocating during an emergency situation</strong></td>
</tr>
<tr>
<td><strong>Plan for handling spontaneous volunteers during an emergency</strong></td>
</tr>
<tr>
<td><strong>STAFF SAFETY</strong></td>
</tr>
<tr>
<td><strong>Staff trained in shelter-in-place &amp; evacuation procedures</strong></td>
</tr>
<tr>
<td><strong>EP addresses the needs of staff, families, worried well</strong></td>
</tr>
<tr>
<td><strong>System in place for staff to verify the safety status of their family members in the community</strong></td>
</tr>
<tr>
<td><strong>Staff have own emergency plans in place to ensure their availability and response during an emergency event</strong></td>
</tr>
<tr>
<td><strong>Staff immunized, if appropriate</strong></td>
</tr>
<tr>
<td><strong>PPE available; staff trained in safe work practices</strong></td>
</tr>
<tr>
<td><strong>BUSINESS CONTINUITY</strong></td>
</tr>
<tr>
<td><strong>COOP Plan in place and updated</strong></td>
</tr>
<tr>
<td><strong>Alternate Office/operations site identified</strong></td>
</tr>
<tr>
<td><strong>Data backup available/remotely</strong></td>
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</table>
Step 2: Developing Your Plan

Once you have completed the initial steps to assess your agency’s risk areas, the next step is to begin the process of plan development. This section of the handbook is divided into a number of key categories that will help drive your plan development. It should be noted, however, that these sections do not necessarily fall into a chronological order of development or a hierarchy of importance.

All major features of the emergency plan are of primary importance and, in many cases, can be prepared concurrently by your emergency preparedness planning team or committee, which should include a cross-section of staff roles, such as operations management, finance officers and clinical leadership.

If you are writing a new emergency management plan or improving a current plan, it is recommended that you convene a representative task force to delegate policies and protocols related to each respective staff role. For example, within this group, you might have a member of your finance team lead the development of your continuity of operations policy; a member of your clinical team lead development of your policy on patient communications, education, and surge planning; or community outreach staff develop your policy for partnerships with other organizations.

At this stage, as you convene staff to discuss and delegate the elements of your emergency plan, it may also be a good occasion to also assign emergency management roles to these staff representatives, including your agency’s incident commander, the individual responsible for dissemination of public information, your liaison officer and other logistical roles, as defined by state regulations and further detailed in the next section on required plan elements. This process would include establishing the hierarchy of your internal staff communications call-down list.

Planning Assumptions

Using New York’s guidelines as the basis for an emergency plan, the following points are valid assumptions in the emergency preparedness plan development:

- Your plan is based on assessed risk and is the framework for agency response. Agency staff will be educated to function as described in the plan.
• Agency staff will educate and assist patients to the greatest extent possible.

• Agency staff will **not** be sent into hazardous areas or be required to operate under hazardous conditions during emergencies or disasters.

• Local and regional news media outlets will provide warnings and updates of natural and man-made emergencies. Government authorities may issue supplemental warnings.

• Agency personnel will have access to and pay attention to warnings and updates.

• The time needed to get a response from local emergency services will increase in proportion to the nature, severity, and magnitude of the incident.

• The agency will develop mutual aid or other agreements with other organizations as appropriate to ensure the care of evacuated patients.

• In a major emergency, hospitals may be able to admit only those patients who need immediate life-saving treatment. Hence, the hospital makes the final determination of which patients will be admitted or sheltered.

• In an emergency, the usual utilities and services could be unavailable for several days. Patients on life support devices requiring electricity should be registered with the local utility company supplying power to the patient’s home.

• The agency will educate and encourage, **but cannot compel**, patients or their families to follow specific emergency plans and instructions. Patients have ultimate responsibility for planning appropriately. In the case of children, the parent or guardian has that responsibility.

• For their own safety and to support continuity of agency operations, all staff will create their individual emergency plans and update them annually.

Each of these basic themes is rooted in state regulation and guidance (please review the state regulation section of this handbook closely).

More specifically, the state’s requirements are again summarized below under several key categories.

**New York State Emergency Plan Required Elements**

Agencies must establish a written disaster plan that includes:

• A defined Incident or Disaster Command Team (disaster management team).
• Measures to respond to all possible events, including biological, chemical, nuclear/radiological and mass trauma events.

• Evidence of partnerships with local county health units, emergency medical services and the health care delivery network in the immediate or surrounding community. The agency should maintain a “phone book” or registry of all possible contacts, with individual names, roles, e-mails and phone numbers.

Operational Requirements

In the case of a CBRNE event or natural disaster, 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:

• **24/7 Contact Information.** The plan must include telephone numbers and e-mail addresses of the 24/7 emergency contact person as well as an alternate (a second alternate is recommended). These individuals should also be on the HCS. It is recommended that everyone have a paper copy of these lists.

• **Call Down List.** The plan must include an up-to-date call-down list or phone tree and policies and procedures to ensure its effectiveness, including who initiates calling, how calls are prioritized and how unanswered calls and callbacks are handled.

• **A Patient Roster** that includes: patient contact information, the patient’s priority level (i.e. Level 1, Level 2, Level 3); the ID of patients on life support equipment; family/caregivers’ emergency contact numbers; and other specific information critical to first responders. **It is also recommended** that a patient roster also include: patients registered with local emergency services or SNP registries, if available; patients registered with the utility company; any shelter needs that have been identified; transportation assistance levels identification; a note that the patient and family have been educated about emergency preparedness at admission (this record should be updated every six months); and a note that the patient has a “go” kit with all medical and contact information.

• **Policies and Procedures to Respond to or Initiate Requests for Information or Resources.** A sample policy would state:

  *During an emergency incident, all incoming and outgoing requests for information or help will be routed through the emergency communications center (555-1212; email@email.org) or through the office of the administrator. All requests for assistance or information must be approved by the incident commander (or administrator) prior to implementation. All incoming information will be relayed to: (..........) via (..........).*
- **Policies and Procedures for HCS Account and Coordinator(s):** There must be a policy defining the agency’s 24-hour, 7-day-a-week coverage, or coverage consistent with the agency’s hours of operation. It must be reviewed no less than once a year. Maintenance should include: obtaining account; ensuring sufficient HCS Coordinators; and maintaining current information in the Communications Directory (monthly).

- **Annual Policy Update and Staff Training:** The plan must include an annual review and update of the emergency plan and a policy that addresses staff orientation to the plan and defines staff roles during an emergency. It is also recommended that plans include evidence of staff education targeted at employees’ specific roles (paraprofessional, clinical, administrative, etc.)

**External Operations**

Emergency plans must include:

- **A Community Partner Contact List** of local health department, local emergency management, emergency medical services and law enforcement and other partnering health organizations as well as a policy that addresses how this information will be kept current.

- **Collaboration/ Planning with Partners.** This section should show evidence of pre-arrangements with community partners, including the agency’s role and responsibilities in the city, town or county’s emergency response plan, as well as a policy that ensures that the home care agency is an active participant in community emergency planning efforts, demonstrated by:
  - A formal memorandum of understanding (MOU) or contract;
  - Attendance at community emergency planning meetings;
  - Basic knowledge of who’s who in the community; and
  - An outline or explanation of the agency’s specific role and responsibilities during an emergency.

**Drills and Exercises**

Policies must be maintained that address participation in agency-specific drills or community-wide drills and exercises. As a best-practice, it is also recommended that agencies include in their plans evidence which shows planning for and participation in drills and exercises, plus evaluation and plan updates resulting from after-action reports.

**Gathering the Plan Elements**

What follows in the remainder of this chapter is an in-depth look at several categories of items that should be factored into your emergency plan. These areas include further information about required elements of your emergency plan as well as best-practices.
Again, as you develop your emergency plan, it may be helpful to divide these areas of development up among your emergency planning committee. We also recommend that you consult the sample policies in Appendix B to find draft language.

**Business Continuity**

Business continuity or continuity of operations is a vital part of agency preparedness and generally parallels your plan to continue patient care. Business continuity strategies focus on post-event business activities to ensure the agency is able to financially and operationally continue to provide services.

Your business continuity plan may contain documents, instructions, and procedures that enable you to respond to accidents, disasters, emergencies and/or threats without any stoppage or delays in key operations. Planning generally extends to finance, logistics, human resources and information technology.

Generally, business continuity implementation is one of the initial steps in the recovery process. Once an emergency situation becomes stable, business recovery takes over to ensure the agency remains financially viable.

Examples of COOP planning include alternate office site identification, remote data back up, telephony if no phone service is available, or billing and payroll capabilities if no internet service is available.

An example of a COOP planning checklist is available in the Appendices at www.homecareprepare.org.
Communication

Establishing effective communication within and outside the agency is one of the greatest challenges in emergency preparedness and requires both creative and redundant means of channel communication flow to everyone involved. Use of publicly available services such as radio or TV stations, NY-Alert (www.nyalert.gov/) and the Government Emergency Telecommunications Service (http://gets.ncs.gov/faq.html) can all fit into your efforts to build as many safeguards into your emergency communications plan as possible.

Your communications plan should include:

- Contact Information as required by HCS regulations;
- Plans for setting up an emergency communications center or point of contact;
- A call-down list and alternate means of contacting staff (phone, e-mail, text blast, etc.);
- A patient communications plan;
- A DOH communications plan;
- Local office of emergency management contact information and protocols; and
- Community partner information and plans.

Each plan should clearly detail who is responsible for implementing each specific section of the communications plan.

Patients, staff and community partners should know, in advance, what your agency’s communications plan is as it relates to them.

The Government Emergency Telecommunications Service (GETS) provides National Security/Emergency Preparedness (NS/EP) personnel a high probability of completion for their phone calls when normal calling methods are unsuccessful. It is designed for periods of severe network congestion or disruption, and works through a series of enhancements to the Public Switched Telephone Network (PSTN). GETS is in a constant state of readiness. Users receive a GETS “calling card” to access the service. This card provides access phone numbers, Personal Identification Number (PIN), and simple dialing instructions.

The only charge is for usage when making calls using a GETS card. GETS calls are billed at a rate of 7 cents or 10 cents per minute (depending on carrier and other factors) for calls within the United States and its territories, Canada, and most of the Caribbean. International calls are billed at commercial rates, though international calling privileges are restricted to those cards authorized by your organization's Point of Contact (POC) or alternate.
The website for GETS is http://gets.ncs.gov/index.html. Home care is eligible for the service under the public health category. You will need a letter from your regional Department of Health to be approved to use the system.

**Best Practices:**

- Determine what means of alternate communication is available during a power outage (e.g. hard-wired landlines, fax lines, website accessible from mobile phones, ham radio, etc.) and script out, if possible, the messages to be communicated;

- Keep a list of hard-wired and fax lines as well as cell phone numbers; and

- Be language savvy – identify language needs and literacy levels in advance, scripting out messages to make sure all pertinent information is included.
Community Partnerships

“All disasters are local” is a quote often used by emergency planners, and it is true that in seeking assistance outside of your agency, the first and best place to look is in your own neighborhood. Partnerships with others in your community can be a valuable resource and support.

It is important for all members of a community to meet and plan together to establish a joint response and clarify responsibilities. Like many health care providers, home care agencies are tied to other systems such as large hospitals or county health departments. However, their first responsibility is to serve their existing patients. Some planners make false assumptions about the availability of home care staff, so it is important to work with potential partners to make sure they fully understand your abilities and limitations.

Best Practices:

- Get Involved! Meet and network regularly with others that may be involved in your community response plans. Keep a notebook of contact information and roles. In a disaster, it is easier to work together when you know who else is involved.

- If your local authorities do not include you in planning efforts, reach out to them and document your efforts.
Patient Education

Patient preparedness is a vital part of safe emergency response. Agencies should have policies related to patient and family or caregiver education, as well as policies outlining patient communication before, during and after the emergency.

The agency should be aware as to what family and community supports the patient has access to during an emergency event. Likewise, the patient and/or family should know what to expect from the agency during a disaster.

There are many resources available online to assist with preparation for emergencies. It is recommended that patients all have “go-kits” containing easy-to-access information on emergency contacts, prescription medication needs, and supplies. In reality, however, most patients will not have these at hand. Patients, should, however, be at least aware of the “must-dos” such as having a several-day supply of medications and a med list. Patients should also be aware of the need to contact the agency if they decide to relocate prior to a pre-warned event, such as a hurricane, or if they change their plan from what was discussed with the agency.

**Best Practices:**

- Review the patient’s emergency plans at Start of Care, on a regular basis thereafter, and in advance of an event with pre-warning, such as a hurricane or snowstorm.
- Prepare a standard brochure or handout that outlines emergency procedures, patient responsibilities and expectations. Include agency contact numbers.
- Develop scripts for staff to use in patient communication before, during and after events to ensure patients receive the correct information in a uniform manner.
- Keep a file of downloads and handouts for events most likely to occur, ready to access as needed.

Staff Education

Staff education and preparedness are two of the most critical elements in emergency preparedness efforts. The availability and preparedness levels of your staff are vital to your overall emergency response efforts.

Staff must be oriented to your plan and understand their role, how to respond and what their responsibilities are to the agency, the patients and to their own safety.
Staff members must also understand that their role within the agency may change or shift, depending on the situation. For example, nurses that serve in administrative positions may have to re-enter field work.

Surveys show that while professional staff generally receive training, are oriented to the plan, and have made their own family plans, administrative staff and paraprofessional staff are far less prepared.

Yearly emergency preparedness in-services are a good way to ensure your paraprofessional staff is aware of policies, their role in a disaster, and the importance of having their own family plan.

Seasonal events, such as Hurricane Preparedness Week (first week of June) and Readiness Month (September) offer good opportunities to provide training.

The Red Cross offers extensive training in personal preparedness, and, in some cases, will do on-site training for home health agencies.

**Best Practices:**

- Include emergency preparedness in staff orientation programs, establishing it as part of their job responsibilities with the assurance they will not be asked to put themselves at risk as part of agency response;

- Hold regular briefings on seasonal threats, such as coastal storms, heat waves, or snowstorms;

- During staff education, incorporate basic lessons in ethics in emergency situations;

- Establish points of communication for staff via radio station, website, text message, etc., well in advance. Test their responses no less than once or twice a year.

www.homecareprepare.org includes a number of trainings and handouts that might be of assistance in training staff.
Evacuation and Mandatory Evacuation

Agencies must plan to communicate and work with patients should an evacuation situation occur. It is critical that all patients and their families or caregivers are aware of what to expect during an emergency when services may be changed or discontinued, or when they may have to evacuate their places of residence.

The agency/provider’s goal is to maintain continuity of care, ensure patient and staff safety, and mitigate harm. In order to provide continuity of care during an evacuation or sheltering situation, agency staff, patients and their families must be aware of current events, options, transportation needs and shelter access information.

In general, New York has a high incidence of events that may result in the need for evacuation. Agencies should have a policy for evacuation events since these have occurred and may occur in the future. Policies must include:

- Staff education and definition of their role in evacuation situations; and
- Procedures to be taken if a patient refuses to evacuate.

The following are some procedural considerations if a patient refuses to evacuate:

- Assessment and documentation of the patient's understanding of the impact of their choice and the patient's assuming responsibilities for that choice;
- Variations of response based on the patient's priority status (a Level 1 patient may require a different response than Level 3);
- Notification to local authorities (fire department, emergency management, police, etc.) and
- Notification to Adult Protective Service.

It is important that patients understand the need to evacuate when a warning is given. If they procrastinate, it may become too late. It is also important for staff to understand their responsibilities during a mandated event and how to manage a situation where a patient refuses to evacuate.

“Safe and Well” Database

The Red Cross offers a “Safe and Well” searchable database to enable friends and family members to locate each other after a disaster. The website is available at: https://safeandwell.communityos.org/cms/index.php.
**Best Practices:**

The agency should have policies and procedures regarding:

- What information is conveyed to patients and their family/caregivers about emergency preparedness at admission and the frequency of review for long-term patients;

- When and how patients will be notified of an impending emergency/disaster, when known;

- The provision of communication in the language and level of health literacy appropriate to the patient;

- What measures the agency will take during mandatory evacuation or shelter-in-place situations, including coordination of transportation assistance;

- What a patient can reasonably expect if he or she refuses to evacuate when mandated, including loss of aide services; and

- A process for tracking patient location should evacuation occur.

Many agencies pre-identify patients’ potential evacuation and transportation needs so they may be assisted more rapidly in the case of an actual event.
Health Commerce System (HCS)

In 2005, the New York State Department of Health (DOH) adopted emergency regulations related to the use of the Health Provider Network (HPN). In 2011, the HPN was renamed the Health Commerce System, or HCS. All providers must have access to the HCS, maintain a current organizational listing in the communications directory, and have sufficient HCS Coordinators to support DOH information and communication needs.

The regulations are as follows:

The governing authority or operator of an agency shall obtain from the Department’s Health Provider Network (HPN); HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts must be designated by each agency in the HPN Communications Directory. A policy defining the agency’s HPN coverage consistent with the agency’s hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency’s HPN accounts shall consist of, but not be limited to, the following:

(1) sufficient designation of the agency’s HPN coordinator(s) to allow for HPN individual user application;

(2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health;

(3) adherence to the requirements of the HPN user contract; and

(4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis.
**Immunizations**

Historically, preservation of the public health has been the primary responsibility of state and local governments, and the authority to enact laws relevant to the protection of the public health derives from the state’s general police powers. With regard to communicable disease outbreaks, these powers may include the enactment of mandatory vaccination laws that extend existing immunization requirements for health care workers.

During the 2009 influenza A (H1N1) pandemic, despite an extensive public education campaign, less than half of health care workers were vaccinated against pandemic influenza. In August 2009, the New York State Department of Health amended its regulations to require that health care workers at hospitals, in home health care agencies, and in hospice care be immunized against influenza viruses as a precondition to employment and on an annual basis. This order was challenged in court, and then rescinded due to a lack of available vaccine; however in the case of another communicable disease outbreak (whether related to natural occurrence or terrorism), it can be assumed that another order will be issued mandating immunization.

Under the 2009 mandate, all staff that had direct care responsibilities were required to be vaccinated. Providers should have a system in place to ensure and document that all direct care staff are immunized, if required.

Many home care providers are involved in organizing and staffing Points of Distribution (PODS). In such cases, agencies need to carefully assess their ability to manage POD support and patient support simultaneously. Each agency should address how they would quickly immunize staff, should such measures be necessary.
Infection Control

Your agency’s infection control plan should address issues related to rapid spread of disease from bioterrorism or natural causes such as pandemic influenza. The agency should have policies, procedures and/or memorandums of understanding (MOU) related to the rapid procurement of personal protective equipment. Agencies should have the ability to test or coordinate FIT testing for N95 masks. You may look to work/contract with a local hospital in their fit testing efforts. All staff with patient care responsibilities should be trained on donning and wearing N95, including knowing how to “user seal check.” User seal checks should be performed each time a mask is donned to ensure the respirator fits appropriately but it is not a substitute for FIT testing.

Administration should also track Health Department and Department Of Labor requirements related to the need for and responsibility to provide N95 masks if requested.

Beyond standard infection control training, professional staff should be trained in syndromic surveillance and reporting, and uploading pictures of infection symptoms of impacts to the HCS if necessary.

Infection control in-services for paraprofessional staff should include information on infection control during emergency events, including outbreaks of infectious disease.

Sample policies for infection control are available at www.homecareprepare.org.
Memorandums of Understanding

Durable Medical Equipment

Many home care agencies work with durable medical equipment (DME) vendors for the provision of critical patient supplies. Oxygen supplies are often limited during disasters. It is important that your agency has a memorandum of understanding with your DME vendors to ensure your patients get the supplies they need. If your DME is secured through a managed care organization (MCO), confer with the MCO or patient’s case manager in advance to establish the procedure for early delivery of critical medical supplies in advance of a known event, such as hurricane or blizzard.

Contractors – Staff

To support staff numbers during a disaster, it is important to have MOUs with any and all vendors that supply staff or services, such as clinical, operational or administrative.

Mutual Aid

Mutual Aid agreements are commonplace among health care providers and systems (see community partnerships) as a means of sharing staff and resources.
Mental Health – Staff Support

During and after an emergency event, it is common for people—including response workers and health care staff—in the affected region to experience distress and anxiety about safety, health, and recovery, as well as grief and loss.

Most people are to some degree personally prepared for an emergency and have access to pre-existing support systems that contribute to their own and their community’s resiliency, and thus they are likely to recover from disaster without behavioral health intervention. However, in an extended disaster, health care staff may be subjected to far greater stress both personally and professionally and become “secondary victims,” as they work long, hard hours under poor conditions. Some will become “burned out” and be unable to perform their duties.

In some cases, physical dangers might exist in their travel to visit patients, adding to their levels of stress. Supervisors, administrative organization and regulation often change with little warning, adding confusion and additional stressors as workers try to satisfy the needs of the patients and of the agency.

Organizational response as a whole will depend, to some extent, on the extent to which staff feel that management is attempting to ensure their safety, minimize their stress and offer overall support.

www.homecareprepare.org has a number of tools and resource lists that may be of assistance in outlining your mental health supports.
Resource Management

Although home care agencies generally do not maintain extensive inventories, it is important to have a plan or structure in place to manage assets in supplies, including any vehicles, personal protective equipment, medical supplies, laptops, durable medical equipment and office supplies.

This may include supplies delivered to patients’ homes and contracts with DME companies to supply oxygen and other critical resources.
**Safety and Security**

Your agency has an obligation to protect the security and safety of your staff. For example, staff should not be deployed just prior to the onset or during a hurricane or serious weather event. You may wish to appoint a safety and security office to identify and take steps to mitigate factors that affect the safety of staff.

Planning for security may include developing policies and procedures for:

1. Working with local authorities to ensure your staff has the appropriate identification and permissions to travel and access patients when conditions result in road or block closures;

2. Providing safe transport for staff when conditions warrant;

3. Facilitating rapid decontamination of staff;

4. Planning for safe evacuation of offices;

5. Locating all staff when a disaster is declared;

6. Providing appropriate personal protective equipment;

7. Providing winter “travel kits” for icy roads;

8. Ensuring your staff understands the limits of their role in providing services during a disaster (not putting themselves in danger).
Sheltering

It is important for agencies to understand what the different types of shelters are and where they might be located so that you can provide accurate guidance to your patients and ensure they receive the care they need should they be housed in a shelter.

There are several types of shelters identified according to their population or purpose:

- General Population;
- Functional and Medical (formerly called “Special Needs”);
- Pet/Animal;
- Temporary – warming or cooling; and
- Shelter-in-Place.

In New York, “mass” shelters are generally needed as a result of floods, snow or ice storms and extended power outages. Temporary warming and cooling shelters provide temporary respite but they do not offer meals or sleep facilities. In the case of localized events such as fires that destroy housing units, the Red Cross will put displaced residents up in hotels rather than open a small shelter.

An increasing number of “shelter complexes” are used in New York, often on school or college campuses. The complexes include all types of shelters in one location. In some areas, counties or cities combine efforts into a “multi-county” shelter. This is more common for Functional and Medical Needs Shelters, which have a smaller population, but require specific staff and supplies.

General Population Shelters

Most General Population Shelters are operated by the American Red Cross and are generally placed in schools. In some cases, local fire departments or churches may open shelters. During an event, your local radio and or TV station should announce which shelters are open.

General population shelters are not allowed to accept pets (other than service animals) and will not provide medical care unless they are co-located with a Functional and Medical Needs Shelter. You can search for open Red Cross Shelters by zipcode on their website: [http://www.redcross.org/nss/](http://www.redcross.org/nss/). It is advised that you keep this website handy. Information is updated every 30 minutes.

Medical, Functional and/or Special Needs

Medical Shelters may be opened by local authorities to take care of a population that needs medical, medication or ADL support but does not require hospital care. Many home care patients fit into this category. Each county or municipality may implement sheltering with a different approach depending on their resources and the scale of the event. As a provider, you should speak with your local officials about the process for medical, function or special needs shelter and understand what your agency’s role is in sheltering. In addition, your patients must be aware of what they should take with them to the shelter, including any assistive technologies, medications, special dietary food, etc.
Locations of Functional and Medical Needs Shelters should be available from your local county manager’s office, or on your county or municipality’s website.

FEMA now recommends that all shelters have personal care aides on hand to assist shelter residents if they should need assistance with daily living. This is not yet commonplace and patients should plan to have their own family or aide accompany them if they need assistance with ADLs.

**Pet Shelters**

Each county or locality is responsible for ensuring there are plans for sheltering pets. These shelters are usually run by local pet protection agencies under contract with the local authority. You should, on a regular basis, contact your local authorities to find out what arrangements are available for your patient’s pets. Shelters require pet owners to bring pet food, medications, and in some cases, health records.

**Warming and Cooling Shelters**

When power outages occur during periods of extreme heat or cold, municipalities may open heating or cooling shelters. These shelters are only a temporary respite and do not offer the services that General Population shelters do.

**Shelter-in-Place**

In certain circumstances – for example, when there is an incident such as a dirty bomb or unexpected gas release – it may be safer for patients and/or their staff to remain indoors. At other times, events might restrict evacuation or egress, forcing individuals to remain at home. Although most shelter-in-place situations are really a matter of hours, it is important for both staff and patients to be aware of the possibility of extended shelter in place and be prepared, within reason, to spend at least three days at home.

In the case where there is a dangerous event, “shelter in place” specifically means selecting an interior room or rooms within your home, or ones with no or few windows, and taking refuge there. In many cases, local authorities will issue advice via TV or radio regarding sheltering-in-place.

Local officials are the best source of information when determining whether to evacuate or shelter-in-place. In general, sheltering-in-place is appropriate when conditions require that you seek immediate protection in your home, place of employment, school or other location when disaster strikes.

Items for consideration, based on the situation:

- To go or to stay? Fight or flee?
- Warning/alerting staff
- Knowledge of possible health threats, immediate safety and counter measures
- Communication with patients
- Staff and family readiness
- Staff and patient education
HOME CARE EMERGENCY PREPAREDNESS

- Patient preparedness, including food and medication
- Office preparedness (how long can staff stay?)

Resources include:

The United States Department of Labor (OSHA)

The Red Cross

New York City Resources

If you provide services in New York City, you can find sheltering information on the NYC Office of Emergency Management website, by listening to the radio or through membership calls with the Home and Community Based Alliance (hbcalliance@gmail.com), an alliance of home care providers concerned with emergency preparedness issues.

If sheltering is needed during a coastal storm event, the City will ask all evacuees seeking public shelter to report to an evacuation center. These centers are located in all boroughs and are easily reached via public transportation. Some centers provide parking facilities.

Each evacuation center is associated with several hurricane shelters in what is known as its “solar system.” There are currently 65 such systems in the City, each of which can accommodate an average of 10,000 people.

Evacuation centers help ensure the number of people in each shelter is roughly the same to reduce overcrowding and underused facilities. At the evacuation center, evacuees will be assigned to a particular evacuation shelter and be transported by bus or van.

To find the location of your nearest evacuation center, use OEM’s Hurricane Evacuation Zone Finder to locate your evacuation zone, and the system will direct you to the proper facility. During an emergency, you can also obtain this information by calling 311.

Hurricane Shelters

If the mayor orders an evacuation of coastal areas, the City strongly recommends evacuees stay with friends or family outside evacuation zone boundaries. However, for those who have no alternative shelter, the City has identified hurricane shelters throughout the five boroughs.

All New Yorkers are welcome at NYC Evacuation Centers and Hurricane Shelters regardless of their immigration status.
The shelters are secure facilities with public safety personnel on site. They are designed to accommodate people with disabilities and special needs. Please bring bedding, toiletries, medication, and other personal items for you and your loved ones travelling with you.

The New York City emergency sheltering system is friendly to all pets but individuals are responsible for their care. Service animals that assist people with disabilities are allowed in hurricane shelters. Ideally, you should arrange to shelter other pets at a kennel or with friends or relatives outside the evacuation area. Legal pets with proper identification will be admitted into shelters with their owners. Owners should bring cleaning and food supplies with them, as well as containers and leashes.

Officials will notify evacuees when and if it is safe to return to their homes. Since hurricanes are highly destructive, residents may not be able to return home for weeks.

**Best Practices:**

- Identify, in advance, which patients and staff live in evacuation zones. A tool is available on the OEM website: [http://gis.nyc.gov/oem/he/index.htm](http://gis.nyc.gov/oem/he/index.htm).

Stepping Down the Response

One of the most overlooked parts of emergency planning is the process of “stepping down” or deactivating the plan and returning to normal. What is the transition plan? If patients are evacuated to shelters, for example, what is the process of returning them home and resuming services? And who decides when the emergency is over, who oversees the deactivation, who gives the order?

The step-down process can reach deep into your agency’s operations and might include:

- Abbreviated paper assessments being converted to full electronic format;
- Contact with the regional DOH office;
- Contact and collaboration with other providers, health care systems or community partners;
- Staff notification;
- Employee hours being updated in a system;
- Billing;
- Return to an office that was abandoned due to flooding or fire; and
- Reassessment of patient needs and possible return to original services.

The Comprehensive Emergency Management Plan provided earlier in this Handbook is a detailed checklist that might help you assess whether or not you have covered all your bases when stepping down your agency’s response.
Surge Plan

During a large-scale event, hospitals may need to discharge large numbers of patients due to an expected increase in admissions. In some cases, facilities or other providers may need to “relocate” their patients as a result of evacuations.

Home care is frequently viewed as a sound discharge plan for those patients being prematurely discharged.

Agencies should have policies and procedures related to:

- The ability to assess their current surge capacity at any given time, including their ability to manage patients on a continuing basis;
- Safely discharging and/or stepping down patient services as needed, using the patient risk assessment tool, to accommodate additional needs or respond to barriers to service created by an emergency;
- The use of an abbreviated admission form to facilitate rapid admission. (An example of an OASIS C Abbreviated assessment form is available at www.homecareprepare.org);
- Identifying current staff skills, capabilities and numbers, including administrative staff that may be able to take on a clinical role if necessary; and
- Working with community partners to pool resources, including staff.
Transportation Plan

Home care agency services require access to transportation. Your plan should include alternate transportation sources and plans for transit strikes, weather-related road closures and other events that may impede staff providing patient care. Staff should be trained in agency expectations and supports during an event that might impact travel.

NY-Alert

NY-Alert is a free service that provides emergency notifications, including travel alerts, road closures and updates to any selected areas in New York State. Notifications take the form of text messages, e-mails, faxes, pagers or direct calls, depending on recipient preference. In addition to alerts on life-threatening issues and travel warnings, subscribers may opt to receive routine warnings such as school closings. All employees should be aware of this free service, or any other service that specifically affects your service area. NY-Alert sign up is available at https://users.nyalert.gov/.

Advanced Warning System (AWS)

The New York City Office of Emergency Management (OEM) maintains the New York City Advanced Warning System, or AWS, which is designed to alert agencies that serve individuals with special needs regarding various types of hazards and emergencies in New York City.

Participating agencies will receive public preparedness and emergency information designed for use by individuals with special needs. Agencies can relay this information to their clients and contracted agencies, including:

- Targeted and specific emergency information during an actual event for populations with special needs; and
- Information on assistance and services available to populations with special needs during emergencies and periods of recovery.

More information about the AWS is available at: http://www.advancewarningsystemnyc.org/

Notify NYC

New York City has created a dedicated emergency notification office operating out of the Office of Emergency Management (OEM). Notify-NYC staff work in OEM Watch Command, where they constantly monitor emergency activity in New York City and the metropolitan area.

Registration in Notify NYC offers six options:

1. Emergency Alerts – messages about life-threatening events that may require immediate action. All registrants are automatically added to this list.
2. Significant Event Notifications – important information about emergency events, utility outages and other types of high-impact events in your ZIP code.

3. Public Health Notifications – information about important public health issues in your community.


6. CSO Waterbody Advisories – updates on combined sewer overflow advisories for NYC harbor waterbodies based on rainfall and predicted models.

**Best Practices:**

- Outreach to local county or municipality regarding home care workers’ being regarded as essential workers during emergency situations.

- Policies and procedures or MOUs for fuel procurement.
Quarantine and Isolation

While Quarantine and Isolation are not included in sheltering planning, it is possible that your agency will be affected by the quarantine or isolation of either your staff or your patients. The U.S. Centers for Disease Control and Prevention (CDC) applies the term “quarantine” to more than just people. It also refers to any situation in which a building, conveyance, cargo, or animal might be thought to have been exposed to a dangerous contagious disease agent and is closed off or kept apart from others to prevent disease spread.

The difference between quarantine and isolation can be summed up as follows:

- Isolation applies to persons who are known to be ill with a contagious disease.
- Quarantine applies to those who have been exposed to a contagious disease but who may or may not become ill.

Additional Definitions

- Infectious disease: a disease caused by a microorganism and therefore potentially infinitely transferable to new individuals. An infectious disease may or may not be communicable. An example of a non-communicable disease is one caused by toxins from food poisoning or infection caused by toxins in the environment, such as tetanus.

- Communicable disease: an infectious disease that is contagious and which can be transmitted from one source to another by infectious bacteria or viral organisms.

- Contagious disease: a very communicable disease capable of spreading rapidly from one person to another by contact or close proximity.
Waivers

During an emergency event, it may be necessary for regulatory bodies to issue waivers to health care providers to temporarily streamline the process and ensure patients have access to care. These waivers are time limited, but allow providers more flexibility in the way they provide services.

It is important to understand that federal waivers: (1) generally extend, but do not eliminate, deadlines and (2) do not waive any New York State Department of Health regulations, waivers for which much be requested individually through your Regional Department of Health Office.

Definition of an 1135 Waiver

When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the U.S. Department of Health and Human Services (HHS) Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to the Secretary’s regular authorities. For example, under section 1135 of the Social Security Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods and that providers who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse). Examples of these 1135 waivers or modifications include:

- Conditions of participation or other certification requirements
- Program participation and similar requirements
- Preapproval requirements
- Stark self-referral sanctions
- Requirements that physicians and other health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – State law governs whether a non-federal provider is authorized to provide services in the State without state licensure)
- Performance deadlines and timetables may be adjusted (but not waived)
- Limitations on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers

These waivers under section 1135 of the Social Security Act typically end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first
published unless HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.

**Best Practice:**

Identify potential needed waivers (such as aide supervision) in advance and assign responsibility to an individual for coordinating waiver needs and tracking issuance during an event. The abbreviated OASIS assessment, for example, can ONLY be used when an 1135 waiver is in effect.
Step 3: Test and Evaluate Your Plan

Emergency drills and exercises are a central part of the preparedness stage of the crisis planning cycle and should be utilized to evaluate not only the plan, but to familiarize staff with the plan and their expected response.

When faced with an emergency, people respond as they have trained – which is why firefighters and other emergency responders frequently participate in emergency drills and exercises. Practicing emergency responses and skills may someday save lives.

Exercises should be conducted to evaluate the capability to execute one or more portions of a Comprehensive Emergency Management Plan.

These exercises:

- Test and evaluate your plan, policies, and procedures.
- Reveal any weaknesses that may be in your plan and identify any resource gaps that may be present.
- Improve individual performance, organizational communication, and coordination.
- Train personnel and clarify roles and responsibilities.
- Satisfy regulatory requirements.

An effective exercise program is made up of progressively complex exercises, each one building on the previous, until the exercises are as close to reality as possible. When possible, the exercise program should involve a wide range of organizations to support your agency’s role in community response.

Exercises should be carefully planned to achieve one or more identified goals.
Remember: your plan is never complete. Writing your plan is only the beginning of preparedness. Testing it, looking for gaps and amending it are a critical and ongoing component of your emergency planning efforts.

**“Paper” Review**

Things change, often more quickly than we realize. You should review your plan for accuracy – places, people, numbers, current policies, etc. – at a minimum of once a year, with communication information being updated more frequently. Your call-down tree should be updated at least monthly, in coordination with HCS Communications Directory Requirements.

**Learning From Real Events**

Many agencies use “real events” to fulfill their drill or exercise requirements. While this is certainly understandable, it is important to use lessons learned from those events to review and update the existing emergency plan. “Hotwashes” or reviews while the emergency is winding down should be translated into after-action reports (AARs) that pinpoint areas the agency needs to work on to more successfully respond to future events. Once the AAR is completed, its conclusions can provide valuable insight into needed plan updates.

**All-Hazards Drills and Exercises**

There are different levels of drills and exercises. It is recommended that agencies develop a multi-year plan to assess their response capability in a comprehensive manner. Agencies will often use specific drills to test different parts of their plan and then fold those components into a larger, more complex exercise.

- **Orientation Seminar** – This is a low-stress, informal discussion in a group setting with little or no simulation. The orientation seminar is used to provide information and introduce people to the policies, plans and procedures in the organization’s Comprehensive Emergency Management Plan.

- **Drill** – This is the exercise organizations are most familiar with. The drill is a coordinated, supervised exercise used to test a single specific operation or function. Call downs are the most commonly used drill in home care.

- **Tabletop Exercise** – a facilitated group analysis of an emergency situation in an informal, stress-free environment. The tabletop is designed for examination of operational plans, problem identification, and in-depth problem solving.
• Hybrid Tabletop/Functional – This model is used in situations where it is not practical to do a completely functional exercise. For example, the emergency operations center and communications systems might be fully functional in a hurricane drill, but patient evacuation might be “on paper.”

• Functional Exercise – The functional exercise is a fully simulated interactive exercise that tests the capability of an organization to respond to a simulated event. This exercise focuses on the coordination of multiple functions or organizations and takes place in an Emergency Operations Center. The Functional Exercise strives for realism, short of actual deployment of equipment and personnel.

• Full-Scale Exercise – The full-scale exercise is a simulated emergency event, as close to reality as possible. It involves all emergency response functions and requires full deployment of equipment and personnel.

**Best Practice Recommendations:**

• Appoint a committee to analyze the agency’s vulnerabilities and build a progressive exercise and evaluation plan.

• While it’s “handy” to have a real event to document for regulatory or accreditation requirements, it might be wise to use a tabletop to explore your readiness for other events.

• Reach out to your community partners to see if you can participate in their drills.
After Action Report and Corrective Action Plan

HCA Education and Research Tabletop Drill

Exercise Overview:

Exercise Name:                                         Type of Exercise:

Exercise Start Date:

Exercise End Date:

Duration:  ____Hours

Location:

Agency Name:_______________________________________

Address: _______________________________________

Sponsor:

Program:

Mission:

Capabilities tested:   (communication, transportation, continuity of operations, etc.)

Scenario Type: (fire, earthquake, pan flu, etc)

Exercise Planning Team:

Agency Participants:

What went well:
1.
2.
3.

What didn’t go well:
1.
2.
3.
Analysis of Capabilities:

1) Planning
   a. Gaps
   b. Discussion
   c. Corrective Action Plan (Please include implementation timeframe)

2) Response
   a. Gaps
   b. Discussion
   c. Corrective Action Plan (Please include implementation timeframe)

3) Recovery
   a. Gaps
   b. Discussion
   c. Corrective Action Plan (Please include implementation timeframe)

4) Mitigation
   a. Gaps
   b. Discussion
   c. Briefly Describe Your Corrective Action Plan (Please include implementation timeframe).
## Corrective Action Plan

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**Resources and Exercises: Drills**

Emergency Response Resources. Centers for Disease Control and Prevention (CDC):  
http://www.cdc.gov/niosh/topics/emres/business.html

Exercising Your Continuity of Operations Plan. Seattle & King County (2008):  


Home Care Prepare Website:  www.homecareprepare.org

Homeland Security Exercise and Evaluation Program:  

Hospital Preparedness Exercises Atlas of Resources and Tools (2010)  
archive.ahrq.gov/prep/hospatlas/hospatlas.pdf

IS-139 Exercise Design: FEMA: http://training.fema.gov/EMIWeb/IS/is139.asp
Important Note: The following letter outlines important emergency preparedness policies for home care providers. However, providers should note that this letter has been corrected to update the current HCA emergency preparedness website address www.homecareprepare.org. HCA has also deleted language in the letter, regarding HPN education requirements. These requirements are no longer applicable, and providers should consult the current requirements, as outlined in the Home Care Emergency Preparedness Handbook.

DOH
STATE OF NEW YORK
DEPARTMENT OF HEALTH
161 Delaware Avenue Delmar, NY 12054-1393

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

May 10, 2005

Dear Home Care Services and Hospice Administrators:

The New York State Department of Health (NYSDOH) continues to enhance the state’s readiness to emergencies particularly for chemical, biological, radiological, nuclear and explosive events (CBRNE). The Department has longstanding regulations requiring Certified Home Health Agencies, Long Term Home Health Care Programs, Hospices and Licensed Home Care Services Agencies to meet patients’ health care needs in emergency situations. However, the specific requirements of these regulations have not been detailed. The purpose of this letter is to delineate what NYSDOH considers the essential elements of sound emergency preparedness planning.

As a step towards addressing this concern, the Department awarded a grant to the Home Care Association of New York State (HCA) to serve as a resource and to develop materials to assist home care agencies’ emergency preparedness planning. One valuable resource the, Homecare Emergency Preparedness Handbook, provides guidance to agencies on how to develop and enhance their emergency response plans. This handbook, as well as other valuable planning information, is posted on the HCA emergency preparedness website at http://www.homecareprepare.org.

In the case of a CBRNE event or natural disaster, 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:

- 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;

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

- A contact list of community partners, including the local health department, local emergency management, emergency medical services and law enforcement and a policy that addresses how this information will be kept current. The HPN Communications Directory is a source for most of this information;

- Collaboration with the local emergency manager, local health department and other community partners in planning efforts, including a clear understanding of the agencies role and responsibilities in the county’s comprehensive emergency management plan

- Policies that require the provider to maintain a current Health Provider Network (HPN) account with a designated HPN coordinator(s) responsible for securing staff, HPN accounts and completing and maintaining current roles based on contact information in the Communications Directory;

- A current patient roster that is capable of facilitating rapid identification and location of patients at risk. It should contain, at a minimum:
  - Patient name, address and telephone number;
  - Patient classification Level (see enclosure);
  - Identification of patients dependent on electricity to sustain life;
  - Emergency contact telephone numbers of family/caregivers;
  - Other specific information that may be critical to first responders

- Procedures to respond to requests for information by the local health department, emergency management and other emergency responders in emergency situations;

- Policies addressing the annual review and update of the emergency plan and the orientation of staff to the plan.

- Participation in agency specific or community-wide disaster drills and exercises.

Recently, regulations designed to facilitate rapid and efficient communication during emergency situations were enacted. These regulations require homecare agencies and other providers
to obtain a HPN account and to enter and maintain current information in the HPN Communication Directory.

All agency emergency plans must be revised to include the above referenced elements by July 1, 2005. After that date Regional Office staff will assess compliance during recertification surveys. In the intervening period, we encourage you to actively work with your NYSDOH Regional Office. We also encourage you to attend the NYSDOH HPN training sessions and to review the material on the Home Care Association website. Contact names and telephone numbers for the NYS DOH Regional offices are enclosed.

Thank you for your cooperation in this matter.

Sincerely,

Robert P. Dougherty Director
Division of Home and Community Based Care
Sample Emergency Preparedness Policy Language

NOTE: The policy language contained in this Appendix is not comprehensive and is not intended to provide a plan that fully meets New York State requirements. The model language in this appendix is provided to assist providers in crafting their own individualized plans. We strongly recommend you check your policies and procedures against those required by the May 10, 2005 New York State Department of Health Dear Administrator Letter to ensure your plan meets New York State regulations. Please use these sample policies as a basis for developing your agency-specific policies in each of the covered areas.

All-Hazard Emergency Preparedness Policy and Goals

Sample Language:

This plan uses the term “all hazard” to address all types of incidents. An incident is an occurrence, caused by either humans or a natural phenomenon, which requires or may require action by home care and emergency service personnel to prevent or minimize loss of life or damage to property and/or the environment.

Examples of incidents include:

- Fire, both structural and wildfire
- Weather related emergencies including snow, ice storms, heat and flooding
- Hazardous materials accidents
- Technology failures
- Power outages
- Transit and worker strikes
- Natural disasters
- Terrorist/WMD events.
- Incidents of naturally occurring disease outbreak
- Planned Public Events, such as political conventions, sports events

The goal of this plan is to allow smooth transition of patient services, ensure continuity of care for all patients served by this agency, provide for the safety and security of staff and maintain continuity of business operations during an emergency.

Objectives

- To identify the chain of command /Incident Command System
- To identify primary and alternative command centers
- To allow for the timely identification of the patients who are affected in the case of an emergency.
- To provide those patients with the care and assistance that they need in the event of an emergency
- To be readily available to assist emergency responder personnel in first aid care for those in the community
• To assess patient’s home environment for safety and assist them to a safe environment if needed

• To coordinate Agency staff members in patient care and evaluation, as well as any Agency personnel assistance with care of those in the community who are affected by the emergency

• To identify staff roles and responsibilities

**Plan Deactivation**

*Sample Language:*

The _____________, who serves as the Incident Commander, has the authority to activate and deactivate this Emergency Preparedness Plan based on information known to her/him at the time, which indicates such need. If the _____________ is not available, the Assistant _____________, and then the ____________ will have the authority to activate/deactivate the response plan.

**Sample Organizational Chart for Plan Activation**
You can assign roles by person or by organizational role.

<table>
<thead>
<tr>
<th>Position</th>
<th>Examples of Organizational Role</th>
<th>Responsibilities</th>
<th>Assigned to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident Commander (IC)</td>
<td>Administrator</td>
<td>Establish/maintain command</td>
<td></td>
</tr>
<tr>
<td>Support Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Information Officer</td>
<td>1.</td>
<td>Central Point for Information dissemination</td>
<td></td>
</tr>
<tr>
<td>2. Liaison Officer</td>
<td>2.</td>
<td>Point of Contact for other agencies</td>
<td></td>
</tr>
<tr>
<td>3. Safety and Security</td>
<td>3.</td>
<td>Anticipates, detects, and corrects unsafe situations</td>
<td></td>
</tr>
<tr>
<td>Operations</td>
<td>VP Operations</td>
<td>Directs all incident tactical operations</td>
<td></td>
</tr>
<tr>
<td>Planning &amp; Intelligence</td>
<td>Deputy Administrator</td>
<td>Collects, analyzes key information; Formulates Incident Action Plan;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maintains documents, prepares for demobilization</td>
<td></td>
</tr>
<tr>
<td>Logistics</td>
<td>Human Resources, facilities</td>
<td>Responsible for acquisition and maintenance of facilities, staff, equipment,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>department</td>
<td>materials</td>
<td></td>
</tr>
<tr>
<td>Finance/Administration</td>
<td>Comptroller</td>
<td>Monitors costs, contracts, financial and time reporting</td>
<td></td>
</tr>
</tbody>
</table>
Incident Command Center

Sample Language:

Unless the emergency renders the agency office unusable, the Incident Command Center will be located at the main office (… address). The alternative site will be at the branch office (… address).

Both offices will maintain data backup through remote data servers, hard wired phones, and emergency generators.

Planning – Administration

Sample Language

- Each office will keep and maintain a current list of contact information for staff, staff family members, vendors, emergency services, hospitals and other appropriate community resources. Said list should include phone numbers, alternate phone numbers, emails and text capabilities.

- The Director will ensure the existence of an incident command system and/or comparable emergency response team to respond to an emergency situation.

- The agency will participate in and document evidence in community planning efforts.

- All staff shall receive emergency preparedness training appropriate for their position during orientation and on a yearly basis, at a minimum.

- All staff will receive guidance and education on establishing their own personal and family response plan.

Patient Care and Planning

Sample Language:

- On admission, the admitting nurse will assign each patient a priority code, dictating that patient’s emergency rating. The admitting nurse will obtain a list of contact numbers, and discuss emergency planning options with the patient and family. All information will be kept in the patient’s chart and shall be kept in paper as well as electronic format. At that time, each patient will be given a planning checklist, resource materials, and a list of items to have prepared and available for use in the event of an emergency.

- Any patients requiring power for life support equipment will be registered with the local utility companies and with local emergency offices. Each patient and family will receive education that will assist them in managing emergencies.

- A list of vendors who supply each patient’s medical supplies will be obtained and kept in the patient’s chart.
Plan Activation – Emergency Call Down Procedure

Sample Language:

Once the emergency response plan is activated, the Director will notify the Assistant Director and Office Manager to initiate the staff call down procedure.

- The Office Manager will notify ____________, and then each will notify persons listed below them on the calling list. If they are unable to reach an employee on the telephone, the will proceed to the next listed person on the list. The Office Manager and Secretary will call the office and list the employees available for assistance then come to the office. Upon arrival, every five (5) minutes, Office Manager and Secretary will try those employees not found with the first call attempt and notify the Disaster Supervisor(s) of any other employees found to available to be on standby. They will also manage calls upon arrival at the office. If Office Manager is not able to reach the Secretary, Office Manager will notify all persons under Secretary on the calling list.

- If phones are not available, the information officer will contact two (2) prearranged radio stations (Wxxx; Wxxx) with an announcement for staff and patients. Additional efforts to contact staff will be made by email, text blast.

- Assignments
  - The (____________) will have power to assign staff to specific tasks, and with the coordinator will work with appointed Team Leaders to assist in pinpointing patients affected by the emergency and assigning clinical staff members to check on those patients by utilizing the pre-arranged priority classification system. (see last page).
  - After Office Manager and Secretary have called and put a staff member on alert, that staff member will wait for an Emergency Supervisor to call back with their assignment and where to meet their partner or security escort, if assigned.

Security

Sample Language:

The Security Officer’s role is to insure the safety of staff and patients, and support the security of agency operations.

- The Security Officer will make assessments regarding the security of the command center, the safety and travel conditions for staff and make arrangements for relocation of the command center, transportation and/or safety escorts as needed.
- The Security Officer will also ensure all staff have needed identifying badges and/or uniforms which will allow them access to their agency.
- The Security Officer will work with agency leadership and local/county officials to insure safe passage and access to patient homes when roads are closed.
Internal Communications

Sample Language:

The agency will maintain an updated contact list of all staff, which will … (supplied to all supervisory personnel, posted on the agency internal intranet, etc.).

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.

External Communications and ECC

- The agency will maintain an active up to date Health Commerce System Account and identify sufficient coordinators to ensure ready access and information flow to and from the agency during an emergency situation.

- The agency will keep an up to date communications directory in both electronic and hard copy that lists all potential needed response partners, including but not limited to health care, local, state and federal government, emergency services and local resources.

- The agency will subscribe to local emergency notification services (specify).

- The agency will designate an emergency communications center (ECC) and/or point of contact through which all communications flow.

Public Information

Sample Language:

- The Public Information Officer (PIO) will confer with the Incident Command Officer and other members of the Disaster Response Team to reach a joint decision regarding the information, if any, to be released to the media. The PIO will also be in charge of determining alternate means of contacting staff.
After Receiving Notification of an Emergency: Direct Care Staff

Sample Language:

• Do not leave your home until you receive your assignment.

• Do not ask questions when you are called. This will only slow down the rate of calling and response time to the emergency.

• When you receive a call with your assignment, you will receive all of the necessary information about the emergency and those affected.

• Please wear your nametag and Agency shirt so you can be easily recognized by other cooperating agencies.

• Stay off of the phone so your second call can come through uninterrupted.

• If phone lines are down listen to radio stations (xxxx; xxxx) for instructions.

• If there is no power, or phone lines, open the emergency kit provided to you by the agency which includes a battery operated radio, and bus/subway tokens which will enable you to go to your prearranged meeting area if you do not have your own transportation.

If You are Away from Home When an Emergency Happens: Direct-care Staff

Sample Language

• Call the Agency office to let the Emergency Supervisors know that you are available to help. You will receive an assignment at that time.

• If there are no working telephones, either come to the triage site or to the Agency office (whichever is closest) for assignment. In the event that the telephones are not working, the Emergency Supervisors will be at the triage site and all assignments will be made from there.

If an Emergency Occurs During Working Hours: Direct Care Staff

Sample Language:

• When you report for assignment of emergency patients, give a list of those patients you have yet to see to the Emergency Supervisor. A decision will be made by one of the Emergency Supervisors as to whether you will be pulled to help with the emergency assessments, or be assigned to continue with your regular assignments or to assume some patients left from those nurses who are assigned to work on the emergency assessments. Those staff members who have had first aid training will be high priority to be assigned to emergency assessments.
Emergency Assessments

Sample Language:

- Each nurse or aide making home visits to patients must check in with the Agency office with an update ____________ (frequency). Any new assignments will be made at that time. When the nurse has completed the list of patients assigned to them, they will be assigned to a community assistance first aid site to help with triage if needed, or will be assigned to specific patients from the regular case load to complete that day’s schedule. At least one (1) Emergency Supervisor will be present at the designated check in site to further assign Agency employees as they arrive and coordinate the staff members. If a patient needs to be moved to another site, the following procedure will be followed:

1. If the patient is unharmed but the home is damaged or unsafe and the telephone system is working, contact family or friends that the patient may request and make arrangements for the patient’s transportation. Keep track of where the patient is going and all necessary telephone numbers, or contact the Emergency Supervisor for arrangements to be made through the county emergency planners for transportation to an alternate care facilities if other arrangements cannot be made.

2. If the patient is injured and needs transport, contact an Emergency Supervisor for arrangements to be made through the county emergency planners for transport to a hospital/emergency room/triage site, depending on the need as determined by the county emergency planners. Be sure to have a complete list of the patient’s needs when notifying the Emergency Supervisor.

Remember: The official personnel who are at the site (police, ambulance personnel, etc.) have had training in handling emergencies, as well as potentially hazardous situations. If they tell you not to go to a certain area, don’t go. In the event of damaged, blocked or impassable roads, staff members will take alternate routes or notify an Emergency Supervisor of inability to reach an area.

- Unsafe Home Situation

  - Before entering a patient’s home, determine if there is a safety issue (possible gas leak, exposed electric wire, etc.). Assess the situation and report to an Emergency Supervisor, who will report to the county emergency planners for proper emergency personnel to secure that site.

Emergency Supply Storage Area

Sample Language:

An emergency supplies storage area will be maintained at the Agency office for employees during the time period that they are working in the event of an emergency, and will be updated and maintained by the ________________ (assigned).
**Emergency Supervisor Tasks**

*Sample Language:*

Each month, all Emergency Supervisors will get an updated copy of the emergency list and keep it at home for reference if a emergency occurs after hours, or if the Agency office is damaged or destroyed. When Director gets a call asking for assistance with an emergency, she will call Assistant Director and Office Manager. Both will then go to the Agency office immediately. Immediate tasks for the Emergency Supervisors will be:

- Determine the area struck and those patients of the Agency’s affected by the emergency.
- The priority classification for each of these patients.
- An assignment list.
- While this is being determined, calls will be made to nursing homes and residential care facilities to determine the number of rooms which will be available for temporary placement of displaced patients and to local authorities to determine shelter options and locations. The Emergency Supervisors will also maintain a list of employees who have been notified and are available to assist in the emergency assessments. The patients who need assessments will be reassigned among the staff available and an Emergency Supervisor will then call each employee with assignments for who their team member is as well as the patient assignments.
- Calls will be made for prearranged transportation of patients in need of evacuation.

**Emergency During Working Hours**

*Sample Language:*

- When the Director gets a call asking for assistance with a disaster, she will notify Assistant Director, as well as the Office Manager and Secretary to begin the calling chain. Director and Assistant Director will determine the patient and staff assignments and keep a list of those staff members the callers have been able to contact, as well as a list of those patients each nurse has yet to see, so that any necessary redistribution of the patient assignments can be made.

- Office Staff will report to an Emergency Supervisor on those staff members that they have been able to contact, as well as which patients each of those nurses has yet to see. The Emergency Supervisors will in turn determine the assignments for those patients affected by the disaster. The teams will be notified of their assignments and the current patient caseload will also be assigned to the staff. Teams will need to meet their partner(s) at one of the three sites listed below:

1. If the phone system is working and the disaster is local meet at the Agency and receive your disaster supplies packet from one of the Emergency Supervisors.

2. If there is no phone system and the disaster is local, meet at the predesignated triage site and receive your disaster supplies packet from one of the Emergency Supervisors.
3. If the disaster is at another town, meet at the predesignated triage site and receive your disaster supplies packet from one of the Emergency Supervisors or at an assigned location.

- The emergency supply packet will consist of various supplies that may be needed, as well as emergency worksheets.

- An Emergency Supervisor will then go to the triage site to coordinate any patient needs that may exist, for problem solving and coordination of our efforts with the Emergency Response personnel and the county emergency planners. If the phone system is working, Director or Assistant Director will remain at the office to manage information and coordinate calls from staff, family members, etc. If the phone system is not working, Director will also go to the triage site and Assistant Director will remain at the office to sign out other emergency supply packets and assist any staff members who may arrive.

- Each emergency assessment team will fill out the emergency worksheet and turn them in to the Emergency Supervisors at least hourly with a report on the condition of patients that they have assessed during that time frame. This emergency worksheet will enable the Emergency Supervisors to maintain a tracking list for identification of those patients assessed, their status and what location they were moved to, if necessary.

- If assistance is requested by local authorities, those Emergency Supervisors who are at the triage site will coordinate Agency staff assignments for this. If our assistance is not requested, we will meet at the Agency office for a debriefing, allowing all involved to express their feelings, as well as ideas to improve for the next emergency plan implementation.

**Drills and Exercises**

*Sample Language:*

The agency will

- Review the emergency plan no less than annually (paper review);
- Conduct evaluation drills or exercises; and
- Update the plan based on results of those evaluations.

Agency staff members will participate in a minimum of one drill or exercise _____________ to determine the effectiveness and efficiency of the current policy and any forms developed for use in a disaster.

**Plan Deactivation: Call-Down Procedure**

*Sample Language:*

Once the emergency response plan is de-activated by the ________________, the Director will notify the Assistant Director and Office Manager to initiate the staff call down procedure and step down procedure to normal operations.

The _______________ will provide critical personnel an operational plan for the return to normal operations, including but not limited to:
• Staff notification
• Patient notification/possible location
• Patient Reassessment for services
• Documentation completion
• Damage reports
• Inventory
• Community Communication protocols
• Evaluation of agency performance