










Emergency Preparedness Resource Guide

*for **Home Care Providers***

(Insert
State Association
logo here)

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Introduction

(State Association) has designed this resource guide so that home care providers can educate and prepare themselves, their patients, and their agencies for a wide-range of disaster situations. It is the hope of **(State Association)** that home care providers will use this resource guide as a starting point for developing a specific disaster preparedness plan.

The definition of vulnerable is any individual or group that has a diminished ability or capacity to anticipate, cope, resist or recover from a natural or manmade hazard. Home care providers are entrusted with the care and protection of the most vulnerable residents of our state. As such, a lack of preparedness for a disaster could result in the home care provider itself being vulnerable. During a disaster, capacity – or the resources available to the community to help cope and respond to the disaster – may be diminished. **(State Association)** aims to help home care providers prepare for disasters so that together we can increase the capacity of home care providers to play a major role in emergency preparedness and recovery.

This resource guide is divided into eight sections:

1. Assessments
2. Incident Command System
3. Business Continuity Planning
4. Emergency Plan by Event
5. Exercises
6. HIPAA and Disasters
7. Succession Plans
8. Resource Contact Information

There are many resources available to assist you in increasing your knowledge of emergency preparedness. We used some of these sources in building this resource guide. Information was gathered from the MDH Office of Preparedness and Response, Occupational Safety Health Administration, Centers for Disease Control and Prevention, U. S. Department of Homeland Security, ASPR TRACIE, and the Federal Emergency Management Agency.

(State Association) wishes to thank Barbara Citarella, President of RBC Limited Healthcare & Management Consultants for her expertise in making significant updates and revisions and converting this Manual to a Resource Guide. (**State Association)** wishes to thank MDH for providing input and Diane Link of BlackTree Healthcare Consulting for her contribution to the development of the original content.

We would also like to thank Chroma Design and Communications for their assistance with design and production management.

We hope you will use this manual to be better prepared as a company – and to help your patients and their families become better prepared. As always, we encourage your feedback on this resource and your input into future initiatives.

Sincerely,

Main Contact
Title
State Association

Part 1:
Assessments

Conducting a Hazard Vulnerability Assessment

OVERVIEW

A Hazard Vulnerability Assessment (see Exhibit A) is a tool designed to help companies identify and evaluate their level of risk and preparedness for a variety of emergency or hazardous events. The assessment lists the most common weather-related events that may occur in our region based on research of prior weather events over the past ten years. The other events include potential hazards that agencies need to be prepared for. This template is designed with the ability to be customized based on your own assessment of your service area, your company, and your hazard vulnerabilities.

INSTRUCTIONS

Evaluate your company's probability, vulnerability and preparedness for each event listed based on a three-level scale.

Probability – Rated based on the frequency or likelihood of an event occurring.

3: Very likely event may occur (event every 1-3 years)
2: Likely event may occur (event every 3-10 years)
1: Unlikely event may occur (event was over 10 years)

Vulnerability – Rated based on the degree with which your company will be impacted. Consider items such as service disruption, infrastructure damage, health hazard, financial impact, and potential for life threatening incidents.

3: Total Disruption – Inability to provide services, utilize facilities, loss of life
2: Moderate Disruption – Inability to provide services, utilize facilities for short period of time
1: Low Disruption – little or no impact on ability to provide services, utilize facility

Preparedness – Rated based on your agency's experience in dealing with events of this nature or strength of emergency preparedness plan to address these events. *Note the scale is in the opposite order from prior scale.

1: Good – Plan is in place or agency has encountered event with successful outcome
2: Fair – Plan is in place but could be improved, event occurred but agency faced challenges
3: Poor – No plan in place or event occurred and agency was unable to overcome challenges

Once all areas are completed in the chart, multiply the ratings for each event area. The higher total scores for each event will identify the events that have the highest risk and may need immediate organizational planning. Agencies should determine the total score for an event that is an acceptable risk for their agency.

Exhibit A.1: Hazard Vulnerability Assessment Tool (SAMPLE)

EVENT	PROBABILITY LEVEL			VULNERABILITY LEVEL			PREPAREDNESS LEVEL			TOTAL SCORE *Multiply each column*
	3	2	1	3	2	1	1	2	3	
	Very Likely	Likely	Unlikely	Total Disruption	Moderate Disruption	Low Disruption	Good	Fair	Poor	
Natural Disasters										
Heat Emergency	X					X	X			3
Cold Emergency	X					X	X			3
Thunderstorm	X					X	X			3
Tornado		X			X			X		8
Hurricane		X			X			X		8
Flooding		X			X			X		8
Ice/Snow	X				X		X			6
Blizzard		X		X				X		12
Earthquake			X	X					X	9
Fire	X			X			X			9
Biological/Environmental										
Epidemic/Pandemic Flu			X		X		X			2
Epidemic/Pandemic Disease			X	X			X			3
Chemical Incident			X			X			X	3
Nuclear Incident			X	X					X	9
Air Pollution/Air Quality		X				X	X			2
Man Made Disasters										
Civil Disturbance			X		X				X	6
Bomb Threat			X		X		X			2
Terrorist Threat			X		X				X	6
Mass Casualty			X		X				X	6
Workplace Violence			X	X					X	9
Active Shooter			X	X					X	9
Operational										
Electrical Power Failure	X				X		X			6
Communication Failure	X				X		X			6
Water Failure			X			X	X			1
Transportation			X	X					X	9
Informational System Failure	X			X				X		18

Exhibit A.2: Hazard Vulnerability Assessment Tool

EVENT	PROBABILITY LEVEL			VULNERABILITY LEVEL			PREPAREDNESS LEVEL			TOTAL SCORE *Multiply each column*
	3	2	1	3	2	1	1	2	3	
	Very Likely	Likely	Unlikely	Total Disruption	Moderate Disruption	Low Disruption	Good	Fair	Poor	
Natural Disasters										
Heat Emergency										
Cold Emergency										
Thunderstorm										
Tornado										
Hurricane										
Flooding										
Ice/Snow										
Blizzard										
Earthquake										
Fire										
Biological/Environmental										
Epidemic/Pandemic Flu										
Epidemic/Pandemic Disease										
Chemical Incident										
Nuclear Incident										
Air Pollution/Air Quality										
Man Made Disasters										
Civil Disturbance										
Bomb Threat										
Terrorist Threat										
Mass Casualty										
Workplace Violence										
Active Shooter										
Operational										
Electrical Power Failure										
Communication Failure										
Water Failure										
Transportation										
Informational System Failure										

Conducting a Home Care Emergency Preparedness Assessment

Once you have assessed your hazard vulnerability, you must evaluate your company's preparedness status. You can use the tool provided in Exhibit B to complete this step.

This quick assessment will help you identify your company's preparedness in case of an emergency. This list is not inclusive of all items an agency may need to assess when preparing an emergency plan. An agency needs to consider their unique differences and specialties.

Exhibit B: Home Care Emergency Preparedness Assessment Tool

	Yes	No
Do you have access to updated patient census?		
Do you identify patients' acuity/risk levels?		
Do you update patients' acuity/risk levels?		
Do you have written emergency preparedness education for patients?		
Have you completed a hazard vulnerability assessment?		
Have you set up an incident command?		
Do you have an emergency preparedness plan and policy?		
Do you have a current list of employee contact information?		
Do you have your employees' emergency contact information?		
Have you provided education to all staff on the agency's emergency preparedness policy?		
Have you held an emergency preparedness drill?		
Have you identified your community emergency preparedness contacts? *(See list in back of this manual)*		
Have you communicated with your community emergency preparedness team?		
Do you have a plan for securing medical supplies during an extended emergency?		
Do you have a plan for transportation in case of emergency?		
Have you created a business continuity plan?		

If you answered no to any of these questions then **NOW** is the time to review, update or create a comprehensive emergency preparedness manual.

Patient Acuity Assessment

An important part of preparedness is knowing each patient's status, physical needs, and the availability of a caregiver to assist in an emergency. Upon admission, each patient should have an acuity assessment completed and kept on file for easy access. Using acuity levels, patients should then be categorized in an acuity risk level report. This list should be updated frequently and be easily accessible. The following Patient Acuity Assessment Template can be modified to fit the patient population that the organization serves.

Exhibit C: Patient Acuity/Risk Assessment Template

Patient Name / I.D.	Caregiver:
Address:	Phone Number:
Diagnosis:	
Case Manager/Assigned Staff:	

1. **High Priority** – Patient must have care. Patients in this priority level need uninterrupted services. In case of 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 patient is not seen. Examples include highly skilled wound care, unstable patients with no caregiver or informal support to provide care.
2. **Moderate Priority** – Services may be postponed with telephone contact. A caregiver can provide basic care until the emergency situation improves. Patient's condition is somewhat unstable, requires care but care can be postponed without jeopardy to the patient.
3. **Low Priority** – Patient may be stable and has access to informal resources to assist them. Patient can safely miss a scheduled visit safely with basic care provided by family or other support measures including the patient.

MEDICAL PROCEDURES / TREATMENTS	1-High Priority	2-Moderate Priority	3-Low Priority
Respiratory			
Ventilator			
BiPap			
Oxygen			
Suction			
Nebulizer			
Tracheostomy Care			
Nutrition			
Enteral Nutrition (Tube Feedings)			
Parental Nutrition (TPN)			
Meal Preparation			
Needs Assistance to be Fed			
Elimination			
Colostomy/Ileostomy			
Urinary Catheter (indwelling or intermittent)			
Dialysis in Home			
Dialysis at Center			
Toileting Assistance Needed			
Incontinent			

MEDICAL PROCEDURES / TREATMENTS *(cont.)*	1-High Priority	2-Moderate Priority	3-Low Priority
Medication			
Oral Medication Assistance			
Intravenous Medication Continuous			
Intravenous Medication Intermittent			
Wound Care			
Basic Wound Care			
Complicated Wound Care			
Wound Vac			
Infection - MRSA, VRE			

ADLS / SUPERVISION / COMMUNICATION	1-High Priority	2-Moderate Priority	3-Low Priority
Bedbound			
Requires Assistance with Transfer			
Wheelchair Dependent			
Dementia/Alzheimer's Supervision			
Behavioral Health Supervision			
Aphasia			
Deafness			
Non-English Language			
Other			
Disease Management Assessment			
Palliative Care			
Hospice Care			
Transport Car			
Transport Wheelchair			
Transport Ambulance			

DURABLE MEDICAL EQUIPMENT	In Home	Requires Electric	Portable
Oxygen			
Ventilator, Bipap, Cpap			
Suction			
Nebulizer			
Walker, Crutches, Canes			
Hospital Bed			
Specialty Air Mattress			
Hoyer Lift			
Wheelchair			

MEDICAL SUPPLIES	Amount needed per day/week		
Ostomy			
Catheter			
Glucometer			
Insulin Pumps			
Wound Supplies			
Other			

Part 2: ***Incident Command System***

Incident Command

OVERVIEW

The use of the Incident Command System (ICS) is a well-established emergency response protocol in military, public and private sectors. In 2004, the Homeland Security Presidential Directive-5 developed and implemented the National Incident Management System (NIMS). The goal of NIMS is to develop a national template for preparedness and response that incorporates government and nongovernment agencies to work together through collaboration of providers.

Home care providers are unique in the health care setting in that they are focused in the community versus in an institution. The ability for home care providers to support vulnerable patients and the community emergency management system requires an ICS that is designed so that all resources can integrate into the emergency operations structure with an established chain of command.

The ICS features include the following:

1. **Common Terminology/Clear Text**: The use of common terminology and the avoidance of using codes, slang or discipline-specific information allows for clear communication. Common terminology is used in the ICS instead of organizational titles or roles.

2. **Modular Organization**: The ICS structure starts at the top and expands downward as needed per event. The positions within the ICS that are needed are based on the extent or impact of the emergency event.

3. **Management by Objective**: Emergency events are not "business as usual," so clearly defined objectives will assist staff in focusing on their roles in an emergency response. Incident objectives are specific and state what is to be accomplished, are measurable with a timeframe, are attainable and reasonable, and are evaluated to determine effectiveness of strategies or tactics. The incident objectives should be based on a clear understanding of your organization's policies.

4. **Incident Action Planning**: The incident objectives are documented in the Incident Action Plan (IAP) and reflect the overall strategy for the incident management. The IAP is a written plan that enables staff to take action based on the incident objectives identified in the plan.

5. **Manageable Span of Control**: The incident management should be effective and efficient, thus the incident managers should have responsibility for no more than 3 to 7 subordinates.

6. **Pre-Designed Incident Locations/Facilities**: In the planning stage of ICS, a determination should be made on coordinating sites, command posts, staging areas for staff and supplies, and evacuation plans for office staff and patients.

7. **Resource Management**: Resources are defined as either tactical or support. Tactical resources include staff and equipment available for use in the response. Support resources are all other resources to support the event including food, equipment, supplies, vehicles, and communication tools. It is important to identify the location and availability of the resources not only within your agency but within your community or medical mutual aid system.

8. **Integrated Communication**: The integrated communication includes the hardware (telephones, cell phones, radios, and Internet), the advance planning of the communication policy and plan, and lastly the plan to share information internally and externally.

9. **Command Structure**: ICS provides a common command structure that identifies core principles and an efficient chain of command. Unity of command dictates that each person within the structure report to one supervisor. Single command exists when a single agency responds to the event; unified command structure is used when multiple agencies/disciplines are working together during the event. An example of unified command would be during a weather emergency when the emergency management incident commander and the agency incident commander work together to meet the incident objectives.

   Access information about how to receive formal ICS training at https://training.fema.gov/nims/.

Incident Management Team Roles and Responsibilities

OVERVIEW

The Incident Command System (ICS) is a management system, not an organizational chart. The incident command functions are developed based on a number of principles of emergency management including:

- Every event requires certain management functions be performed: the evaluation of the current incident, the development of incident objectives, the release of necessary resources and ongoing evaluation of the incident. Successful implementation of ICS requires defined incident command functions.
- ICS organization and titles frequently do not correlate to daily operation responsibilities or functions within your company. This is done purposefully to avoid role and title confusion. Those assigned positions in ICS come together during an event as the *Incident Management Team* (IMT) whose purpose is to respond to and recover from the event through a coordinated effort.
- Titles within the ICS should remain unchanged thus promoting interoperability between internal and external response partners.
- The IMT consists of command, general, branch, and unit staff with clearly defined roles and responsibilities. Depending on the size of the operations, some parts of the organizational structure may be eliminated such as branch or units.
- The IMT consists of the following:
    - **Incident Commander**: ALWAYS activated in an incident regardless of size or extent of incident. The Commander sets the objectives, devises strategies, prioritizes, and maintains overall responsibility for managing the incident. The Incident Commander is supported by four other management team members.
    - **Operations**: Responsible for tactical operations to carry out the incident objectives.
    - **Planning**: Collects and evaluates information and data for decision support, maintains resource status information, responsible for documentation of incident.
    - **Logistics**: Provides support, resources and other essential services to meet incident objectives.
    - **Finance**: Monitors costs related to incident, procurement of items, time recording, and cost analysis.
- Based on the incident size and company size, the Incident Commander may assume more than one role but **the Incident Commander is always one individual** and must always be activated in an emergency event.
- The Incident Management Team members also have other position titles that define roles and tasks assigned to the role including:
    - **Officers**: Part of the command section. Officer roles include Liaison Officer, Public Information Officer, Medical Director/Specialist, and Safety Officer. Each of these report directly to the Incident Commander.

- **Chiefs**: Oversight of the section (operations, planning, logistics, finance). Reports directly to the incident commander.
- **Directors**: Section branches may be activated. An example would be identifying a branch for infrastructure under the operations section. In order to maintain the chain of command and provide specific duties and roles to the branch a director is identified. The director reports to the corresponding section chief.
- **Leaders**: A unit under the branch may be activated. Example: infrastructure has an information system unit. The person assuming responsibility for the unit is the leader. The leader reports to the director.

ROLE DEFINITIONS

Command Section

The command section includes the incident commander and officers who support the incident commander.

- **Incident Commander**: The incident commander is the only role that is always initiated in an event. The incident commander directs the emergency response through development of incident objectives. A critical role of the commander is to determine the level of emergency response in relation to the impact on life, property and capability to maintain operations.
- **Public Information Officer**: The public information officer is responsible for developing and releasing information about the incident to the news media, to incident personnel, and to other appropriate agencies and organizations.
- **Safety Officer**: This position supports the command staff and is responsible for the overall safety of the response activities. The safety officer evaluates the data from multiple sources (weather alerts, emergency management updates) and communicates to the incident commander. The safety officer ensures that internal locations are hazard-free.
- **Liaison Officer**: The liaison officer serves as a link between external partners and the agency. This includes relay of information to the community, county or state emergency officials, public health authorities, and other agencies identified in the emergency plan.
- **Medical Director/Specialist**: This is a person that has specific expertise in clinical areas, such as infectious disease and trauma management, and is a resource for staff. The medical director/specialist reports directly to the incident commander, but works directly with operations as a resource.

Operations Section

The operations section, considered the "doers," consists of up to four positions.

- **Operations Section Chief**: The operations section chief oversees tactical operations. The chief activates additional positions based on the event needs as well as the availability of qualified staff to fill the positions. If there is no available qualified staff to fill the position, then the position is the responsibility of the highest position within the section.
- **Patient Care Branch Director**: The patient care branch director is responsible for continuation of patient care services and provision of care to injured volunteers/staff. The branch director is also responsible for patient census, triaging patients and patient location accountability.
- **Infrastructure Branch Director**: This position is responsible for assessment and functionality of agency facility structure.
    - Facility/Security Unit Leader: Under the infrastructure branch director, the facility/security unit leader is responsible for maintaining safety and security of the facility. This position integrates with local emergency or law enforcement officers.

Logistics Section

The logistics section, considered the "getters," provide the necessary services and support to sustain operations during the event. Included in this section are communication, information technology (IT), supply management, staffing, and scheduling and transportation. Responsibility in this section includes identification and inventories of current resources including supplies, equipment, personnel, and items to support operations.

- **Logistics Section Chief**: This position oversees the provision of services and support to sustain operations and operational response to event. The section is made up of two major branches: Service and Support. The logistics section works closely with operation section.
- **Service Branch Director**: The service branch director is responsible for ensuring the essential services of communication and information technology.
    - Communications and IT Unit Leaders: Under the service branch director, leaders assist in maintaining communication and IT solutions.
- **Support Branch Director**: This position organizes and maintains supplies, medical supplies, transportation and labor/volunteer pool. The branch director is accountable for resources used and requested for operations and ensure that resources are available.
    - Supply Management Unit Leader: This unit leader, who reports to the support branch director, ensures that medical and office supplies are inventoried, available and dispensed as needed.
    - Staffing/Scheduling Unit Leader: This unit leader ensures the current list of available staff is accurate and identifies staff that are assigned to other departments.
    - Transportation Unit Leader: This unit leader coordinates transportation assistance as needed for staff.

Planning Section

The planning section, considered the "thinkers," is activated when there are sufficient staff for operations and logistics. The role of planning is to gather, analyze and track event data from internal and external sources. This section is responsible for projecting the ability to sustain operations based on current information and future status.

- **Planning Section Chief**: This position oversees the planning section and determines the need for activation of situation and documentation units. The section chief collects and disseminates incident situation reports to the incident commander and is responsible for developing the Incident Action Plan.
- **Situation Unit Leader**: This unit leader is responsible for writing and maintaining incident updates based on internal and external resources.
- **Documentation Unit Leader**: This unit leader works with all members of the incident management team to ensure complete documentation of the incident and is responsible for archiving documents upon completion of event.

Finance/Administration Section

The finance/administration section oversees the costs, time allowance and expenditures related to the emergency event, including the purchasing of additional supplies, equipment, meals etc. This section is responsible for the screening of volunteers for assignments.

- **Finance/Administration Section Chief**: This section chief accounts for the expenditures and loss revenue associated with response and recovery and ensures that incident-related claims are investigated and submitted.
- **Time Unit Leader**: This unit leader ensures that all staff and volunteer hours utilized during the event are recorded. This position also assists with screening volunteers or staff prior to assignments.
- **Procurement/Claims/Costs Unit Leader**: This position works with the logistics section to obtain additional supplies, equipment, etc. This unit leader clearly documents cost of additional supplies and projects during the recovery phase and coordinates all claims and compensation related to response and recovery.

The Exhibit D Incident Command System (page 17) is a visual example of the ICS hierarchy which can be modified to reflect your company's size and/or incident. As appropriate, roles can be combined.

During activation of the Incident Command System, the planning section should document the various assignments. The assignment list in Exhibit E (page 18) is useful for each section leader and especially for the liaison officer.

Exhibit D: Incident Command System

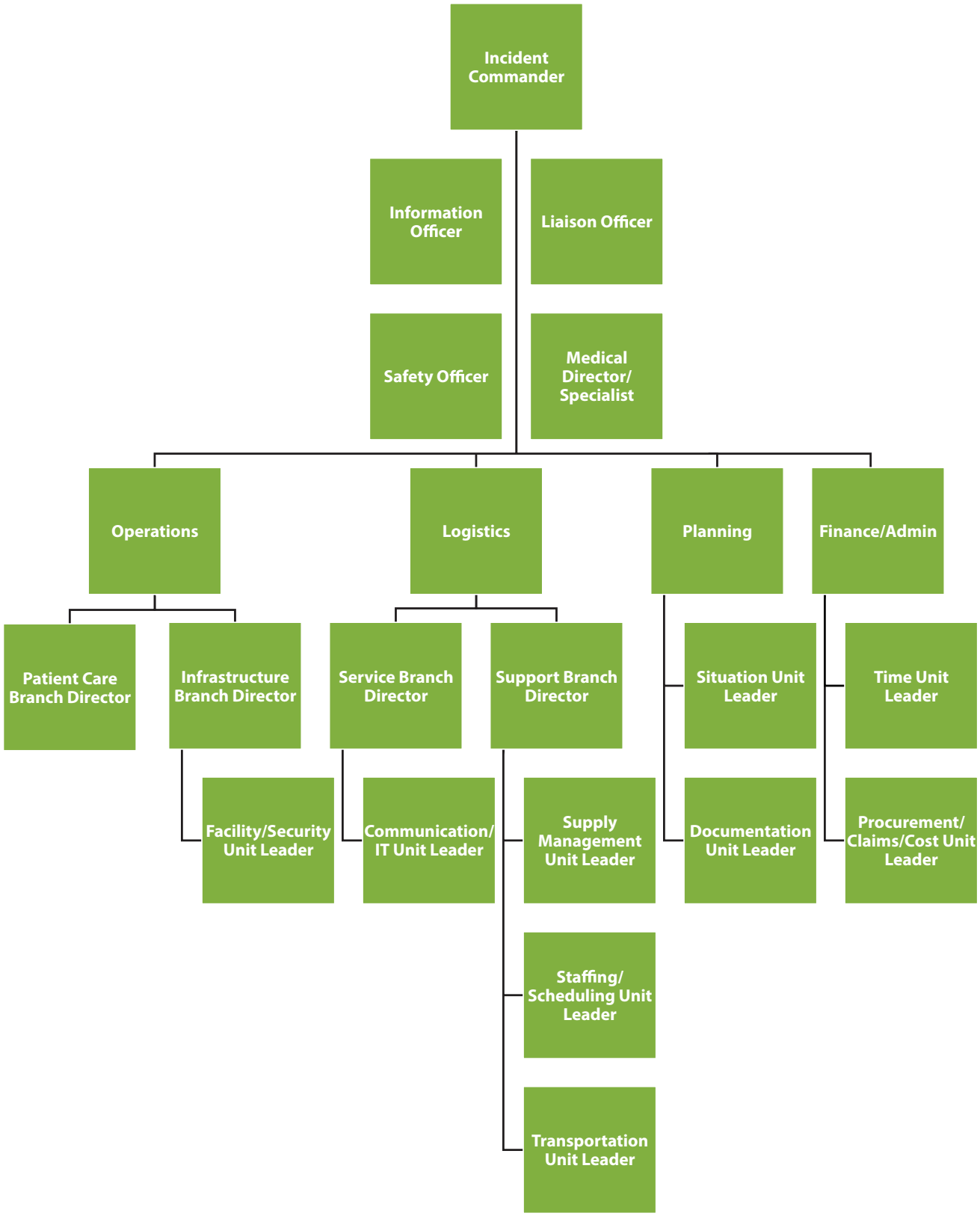

Exhibit E: Incident Command Assignment List

Incident Name:	
Date of Incident:	**Start/Stop Time of Incident**:

Position	Name/Department
COMMAND SECTION	
Incident Commander	
Public Information Officer	
Liaison Officer	
Safety Officer	
Medical Director/Specialist	
OPERATIONS SECTION	
Operations Chief	
Patient Care Branch Director	
Infrastructure Branch Director	
Facility/Security Unit Leader	
LOGISTICS SECTION	
Logistics Chief	
Service Branch Director	
Communication/IT Unit Leader	
Support Branch Director	
Supply Management Unit Leader	
Staffing/Scheduling Unit Leader	
Transportation Leader	
PLANNING SECTION	
Planning Chief	
Situation Unit Leader	
Documentation Unit Leader	
FINANCE/ADMINISTRATION SECTION	
Finance/Administration Chief	
Time Unit Leader	
Procurement/Claims/Cost Unit Leader	

Prepared by: _____

Date/Time: _____

Part 3: Business Continuity Planning

Home Care Continuity Planning Toolkit

OVERVIEW

A business continuity plan incorporates prevention, preparedness, response and recovery as part of a planning process to manage the risk in the event of an emergency. It is designed for use in emergencies where the agency is severely impacted. The business continuity plan should address the critical processes in each department that are essential to maintaining operations. The agency should involve a multidisciplinary team to address the critical processes and ensure that patient care is a priority along with the solvency of the agency.

The Home Care Continuity Planning Toolkit is being offered as a guide to home care providers to assist in developing continuity plans. There are multiple methods to developing a continuity plan, and the materials presented in this toolkit do not represent all methodologies or mandates for home care providers. The toolkit should be used to supplement the emergency preparedness plan that addresses the specific responses to each type of emergency event.

Home health care is unique in that the majority of services are performed outside of the facility. As a community provider, home care agencies care for the most vulnerable patients in the community. A continuity plan will assist the agency during the recovery period after an emergency event in returning to or maintaining operations.

There are several parts of a Continuity Plan, including:

- Home Care Business Continuity Checklist
- Business Impact Analysis
- Employee Contact Information Report
- Emergency Contact List – External Resources
- Business Record Location List
- Vendor List
- Information System Data Back-Up Plan
- Information Systems Report
- Information Systems Software List
- Forms and Supplies
- Insurance Contact List
- Event Log
- Financial Tracker
- Risk Management Plan

Home Care Business Continuity Checklist

This checklist provided in Exhibit F is intended to provide home care providers with guidance on Home Care Business Continuity Program components. Home care providers may elect to integrate their Continuity Plan with their Emergency Operations Plan (EOP), or create and maintain a separate document. However, during an event, it is assumed that both will be activated and, ultimately, managed through a similar structure and process. The order of the components listed here is suggested, not mandated. It is recommended that supporting documentation be kept in computer files or within separate binders and can be referenced in the "Reference/Location" column

This document is not intended to cover all aspects of your business or every continuity standard.

Exhibit F: Home Care Business Continuity Checklist

Program Component	Reference/Location	Status
1. Governance		
A. Policy and Purpose: Consider augmenting existing Emergency Management Program (EMP) policies with Home care Continuity Program components		
B. Scope and Applicability: Align with organizational priorities		
C. Planning Assumptions		
D. Authority and Responsibility		
■ Home care continuity program organization chart		
■ Home care continuity program responsibilities		
E. Program Evaluation (See also Execution section of this checklist tool, below)		
2. Data: Identifying Essential Services and Applications		
A. Business Impact Analysis (BIA) Identify essential services and applications (both IT and non-IT supported) that must be continued to maintain essential operations (e.g., supply chain, payroll, research) and health care delivery (patient care) following a disaster.		
■ Design questionnaire		
■ Conduct business impact analysis		
■ Perform analysis and summarize findings		
■ Complete report		
3. Integration: Developing Business Continuity Strategies		
A. Analytics and Strategy: Review BIA and Hazard Vulnerability Analysis (HVA) findings to understand what risks pose the greatest threat to essential functions. Use data to make decisions to reduce risks that will have the greatest adverse patient care and financial impacts.		

Program Component	Reference/Location	Status
B. Develop Business Continuity Strategies		
■ Clinical: Examine capabilities to provide care with a 96- hour disruption and identify and finalize strategies for ensuring continuity of essential clinical services. Identify essential personnel and duties.		
■ Research: Identify strategies for continuity during an interruption of essential services. Determine alternate locations for continuity of research operations in the event the primary location is unavailable		
■ Administrative: Identify strategies for continuity during an interruption of essential services. Determine alternate locations for continuity of business and finance operations in the event the primary location is unavailable		
C. Develop format and approach to align and/or integrate emergency operations and home care continuity plans		
4. Planning: Developing and Integrating Business Continuity Plans		
A. Align initiation and termination procedures associated with business continuity with existing procedures in the EOP		
B. Incorporate home care Incident Command System reference materials for the business continuity branch director and associated unit leaders, such as:		
■ Job action sheets		
■ Incident response guides		
■ Forms—Financial tracking and incident action plan documentation to ensure cost recovery and resumption of operations		
C. Management of Clinical and Support Activities		
■ Align plans for relocation and continuity of essential clinical services with home care surge/expansion plans. Include procedures for alternate site set up and operations.		
■ Departmental Plans ● Department Status Forms/Summary ● Identify/document infrastructure/other interdependencies ● Criteria and steps for closing and relocating a branch/unit ● Resumption of operations of essential clinical functions ● Downtime procedures for an extended IT outage		
D. Information Technology and Communications Systems		
■ Plans for downtime/workaround procedures for long-term disruptions		
■ Alignment with disaster recovery planning for IT & communications		
■ Document IT interdependencies		
E. Management of Resources and Assets		
■ Augment procedures for the Management of Resources and Assets in EOP with plans for continuity of essential services during supply chain interruptions		
■ Establish plans and agreements for alternative modes of transportation		
■ Coordinate Just in Time or immediately on-hand inventories and protocol to preserve critical care capacity. Define procedures (e.g., triaging visits) to expand and extend capacity to provide essential services as needed		
■ Document vital records		
■ Document vital equipment		

Program Component	Reference/Location	Status
F. Management of Workforce Roles and Responsibilities		
■ Process for assessment of staff availability and address up to 30% reduction in staff availability, with considerations of an ongoing surge of patients		
■ Process for post-event staff rotation		
■ Process for assigning staff to essential functions and the management of spontaneous volunteers		
■ Process for telecommuting to maintain continuity of business functions		
■ Identification of requirements (e.g., space, equipment, technology) and the process for relocation and resumption of responsibilities if at an alternate worksite		
G. Management of Utilities		
■ Review plans for provision, sustainability, and alternate means of providing utilities when primary source of essential utilities are unavailable		
■ Process for continuity of essential services during the loss of utilities		
H. Recovery and Resumption of Normal Operations		
■ Process for assessing and evaluating the agency for recovery and resumption of operations		
■ Process for testing functionality of equipment and identifying remaining needs for recovery		
■ Identification and establishment of agreements (MOUs/MOAs) with vendors and suppliers for recovery and resumption activities (e.g., debris removal, vital record recovery)		
■ Process for return of employees to normal workspace and resumption of normal operations		
5. Execution: Testing and Measuring Business Continuity Programs		
A. Testing and exercises		
■ Expand current exercises to include scenarios with operational impacts (e.g., supply chain operations, critical infrastructure, technology)		
■ Conduct department specific exercises (intake, scheduling, billing)		
B. Results monitoring: Data collection of gaps and results to drive future priorities		
■ Track and monitor number continuity metrics (e.g., number of BIAs completed, number of departmental continuity plans completed, number of exercises completed)		

Business Impact Analysis

OVERVIEW

A business impact analysis (BIA) is performed within each department to identify and prioritize essential processes. An essential process is defined as a process that if not performed will disrupt operations, interfere with patient care, prevent meeting of mandatory regulations/requirements, or inhibit the meeting of the agency's mission.

Each department should complete the business impact analysis and identify the specific essential functions needed to perform patient care services or maintain operations. The departments should also identify a return to operation or "RTO." RTO is the amount of time and service level within the department in which the process must be restored after an emergency event in order to avoid severe consequences. Once the department has a list of essential functions, each function should be prioritized as to its impact on restoring to normal operations. The agency then shall take each department BIA and prioritize the essential functions based on the agencies operational needs to restore operations and to guide resource allocations.

A Business Impact Analysis Template is provided in Exhibit G.

Exhibit G: Business Impact Analysis Template

Critical Business Activity	**Description**	**Priority**	**Impact of loss** *(Describe losses in terms of financial, staffing, loss of reputation, etc.)*	**RTO** *(Critical period before business losses occur)*
SAMPLE: OASIS Submission	*Submit OASIS data via Internet 3x week*	*Mod*	■ *Loss revenue until OASIS submit* ■ *Regulation state*	*1 month*
SAMPLE: Physician Orders	*Print Physician Orders* *Mail Orders* *Receive Orders* *Post Orders EMR*	*Mod*	■ *Regulation state must be signed within 28 days* ■ *Unable to bill until order received*	*28 days*

Completed by: _____ Date: _____

Exhibit H: Employee Contact Information Report

An employee contact information report is used to track the communication with employees in the event of emergency. This tool is an ongoing list of employees that includes name, title and contact numbers. At the initiation of an emergency plan this tool can be updated with the time of notification and response.

Employee	Title/Function	Office Phone #	Cellular/ Pager #	Home Phone #	EMAIL	Time Called	Response Time	Comment

Exhibit I: Emergency Contact List – External Resources

Along with employee contact information the agency needs to keep an updated list of key community contacts including local emergency management offices and utility providers.

Key contacts	Contact number/s
Local Health Department	
Police	
Emergency Services	
Ambulance	
Medical	
Security	
Insurance company	
Suppliers	
Water and Sewage	
Gas	
Electricity	
Telephone	

Exhibit J: Business Record Location List

Most companies have numerous locations of business records including contracts, employment records and patient related information. A business record location tool is utilized as a record of where these records are located throughout the agency.

Description	Primary Location of Records	Alternate (Backup) Location of Records	Other Sources to Obtain Records
SAMPLE: Payer Contracts	*Administration Office*	*Manager Files*	*Scanned into private drive and Biller has copy*
SAMPLE: Service Contracts	*Administration Office*	*CEO office*	*Scanned into private drive*

Exhibit K: Vendor List

Most companies have numerous vendors from patient related care to operational vendors. A vendor list can be used as a tool to list all vendors and contact information in a central location. The vendor list includes the contact information without having to locate the vendor contract.

Vendor Name	Goods/Service Provided	Contact Name	Address	Phone #
SAMPLE: Medical Supplies 2 You	*Patient supplies*	*Mary Jo Goods*	*Anywhere USA*	*555-555-5555*
SAMPLE: Interpret This	*Foreign Language Interpreters*	*Sue Coordinate*	*Maryland St.*	*555-555-5432*

Exhibit L: Information System Data Back-Up Plan

All computerized information should be backed up to a location that is accessible during an emergency. This tool will assist the agency in identification of who will back up the information and where that information is stored.

Data for backup	Frequency of backup	Backup media/service	Person responsible	Backup procedure steps
SAMPLE: Customer database	*Weekly*	*External hard drive*	*A Person*	■ *Remove external drive from fire safe* ■ *Copy data from Customer database* ■ *Return external drive to fire safe*

Exhibit M: Information Systems Report

Most companies use many reports as part of their daily operation. As part of the business continuity planning, a list should be prepared of reports, their function, and how to retrieve them.

Report Name	Report Description	System Produced From	Alternate Sources of Report or Information
SAMPLE: Daily Census	*Active patients on census with address*	*Yes*	*Paper Medical Record*

Exhibit N: Information Systems Software List

Most companies use many software products as part of their operations. These software products may be in addition to their electronic medical record. A listing of all software products should be compiled along with the priority rating needed for business recovery impact on operations.

Software Application	Publisher or Vendor	Platform	Recovery Criticality
SAMPLE: Bill Maker	*Payer National Software*	*Windows*	*VH*

Exhibit O: Forms and Supplies

Along with computerized items, prepare a list of all paper forms and supplies needed for operations. In case of destruction of office materials, a list of alternate storage location and vendor contact should be included.

Form/Supply Name/Description	Primary Locations Where Stored	Alternate Sources to Obtain Form/Supply	Vendor's Name/ Phone
Sample: Patient Consents/Admission Book	*Copy Room 2nd shelf*	*Storage Company*	*ABC Forms 333-333-3333*

Exhibit P: Insurance Contact List

Compile a list of all insurance carriers and review the contract for inclusions/exclusions of coverage in an emergency. Keep this list handy as a contact tool during emergencies.

Insurance type	Policy coverage	Policy exclusions	Insurance company and contact	Last review date	Payments due
Sample: Business Interruption	*Business interruption due to:* ■ *Fire* ■ *Flood* ■ *Theft*	■ *Terrorism* ■ *Tsunami* ■ *Landslide*	*XYZ Insurance, A Person Ph: XXX-XXX-XXXX*	*4/1/2014 copy of business license sent*	*Yearly January 1*
Sample: Workers Compensation	*Employees during work hours*	*Driving to and from work*	*ABC 12 Memorial Drive Maryland 21212*	*1/1/2014 Current copy of employees sent along with mileage logs*	*Yearly January 1*

Exhibit Q: Event Log

Upon initiating of incident command system an event log needs to be started and maintained through the emergency event. This log will be used during the event as a report of actions and is an important part of the post evaluation of the incident.

Date	Time	Information / Decisions / Actions	Initials
Sample: 12/12/12	*0900 hrs*	*Activate Business Continuity Plan extended snow storm*	*TL*
Sample: 12/12/12	*1100 hrs*	*Received triage patient list Scheduling Priority 1*	*DL*

Exhibit R: Financial Tracker

Upon initiation of the incident command system, a financial tracking log should be implemented. The financial tracker is used to record all expenses related to an incident and may be used for reporting and reimbursement.

Incident Name/Date

Date	Payee/Payor	Description	Medical Supplies	Office Supplies	Equipment	Personnel	Food and Essentials	Mileage	PO # / Invoice # / Expense Report #	Other	Subtotal
6/12/15	*ABC Grocers*	*Water Bottles/ice*					*15.00*				*15.00*
6/12/15	*123 Supply*	*first aid kits*	*125.00*								*125.00*
6/12/15	*Office Supply C0*	*laptop/printer/paper*		*25.00*	*2,450.00*						*2,475.00*
6/12/15	*XYZ Hospital*	*aide to hospital 8 hrs*				*80.00*		*5.25*			*85.25*
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		Expense Total	*125.00*	*25.00*	*2,450.00*	*80.00*	*15.00*	*5.25*		—	*2,700.25*

Note: It is also recommened that you create a scanned file of any expenses as a computerized record.

Exhibit S: Risk Management Plan

A part of the development of business continuity plan is to identify potential risks (hazard assessment) and identify actions that can be done to minimize impact. The next step would be identify the contingency plan that can be used to reduce impact to patient care and operations.

Risk Description:	Likelihood	Impact	Priority	Preventative Action	Contingency Plans
SAMPLE: Severe Weather limiting travel	*VH*	*VH*	*VH*	■ *Ensure staff have completed triage list of patients* ■ *Have up to date 4 wheel driver list* ■ *Key members arrive to facility prior to severe weather*	■ *Make visits prior to storm* ■ *Triage over phone* ■ *Utilize alternative transportation, i.e., 4 wheel drive volunteers/National Guard*

Part 4: ***Emergency Plan by Event***

Hazard Vulnerabilities

OVERVIEW

A crucial part of emergency preparedness is identifying the hazard vulnerabilities in your area. The development of a response plan enables an agency to educate their providers, patients and caregivers in the event of an emergency. The following emergency plans can be used as a starting point in preparing emergency preparedness policies for your agency. This is not intended to be a complete list of all potential emergency incidents or a complete emergency response plan.

Bioterrorism

OVERVIEW

Biological agents are organisms or toxins that can kill or incapacitate people, livestock and crops. A biological attack is the deliberate release of germs or other biological substances that can make you sick.

There are three basic groups of biological agents that could likely be used as weapons: bacteria, viruses and toxins. Biological agents can be dispersed by spraying them into the air, person-to-person contact, infecting animals that carry the disease to humans and by contaminating food and water.

BEFORE A BIOLOGICAL THREAT

A biological attack may or may not be immediately obvious. In most cases local health care workers will report a pattern of unusual illness or there will be a wave of sick people seeking emergency medical attention. The public would be alerted through an emergency radio or TV broadcast, or some other signal used in your community, such as a telephone call or a home visit from an emergency response worker.

The following are things a patient can do to protect self, family and property from the effects of a biological threat:

- Build an **Emergency Supply Kit** (https://www.ready.gov/build-a-kit)
- Make a **Family Emergency Plan** (https://www.ready.gov/make-a-plan)
- Check with patient's doctor to ensure all required or suggested immunizations are up to date for self, children and elderly family members.
- Consider installing a High-Efficiency Particulate Air (HEPA) filter in furnace return duct, which will filter out most biological agents that may enter the house

DURING A BIOLOGICAL THREAT

The first evidence of an attack may be when symptoms of the disease caused by exposure to an agent are noticed. In the event of a biological attack, public health officials may not immediately be able to provide information on what should be done. It will take time to determine exactly what the illness is, how it should be treated, and who is in danger.

Patients should follow these guidelines during a biological threat:

- Watch TV, listen to the radio, or check the Internet for official news and information including signs and symptoms of the disease, areas in danger, if medications or vaccinations are being distributed and where to seek medical attention if the patient becomes ill.
- If you become aware of an unusual and suspicious substance, quickly get away.
- Cover mouth and nose with layers of fabric that can filter the air but still allow breathing. Examples include two to three layers of cotton such as a t-shirt, handkerchief or towel.
- Depending on the situation, wear a face mask to reduce inhaling or spreading germs.
- If exposed to a biological agent, remove and bag clothes and personal items. Follow official instructions for disposal of contaminated items.

- Wash with soap and water and put on clean clothes.
- Contact authorities and seek medical assistance. You may be advised to stay away from others or even quarantined.
- If symptoms match those described and you are in the group considered at risk, immediately seek emergency medical attention.
- If the disease is contagious expect to receive medical evaluation and treatment.
- For non-contagious diseases, expect to receive medical evaluation and treatment.
- In a declared biological emergency or developing epidemic avoid crowds
- Wash hands with soap and water frequently.
- Do not share food or utensils.

AFTER A BIOLOGICAL THREAT

Pay close attention to all official warnings and instructions on how to proceed. The delivery of medical services for a biological event may be handled differently to respond to increased demand.

The basic public health procedures and medical protocols for handling exposure to biological agents are the same as for any infectious disease. It is important to pay attention to official instructions via radio, television, and emergency alert systems.

Visit the **Centers for Disease Control and Prevention** (http://emergency.cdc.gov/agent/agentlist.asp) for a complete list of potential agents/diseases and appropriate treatments.

Source: Ready.gov

CDC Bioterrorism Agents

DISEASES/AGENTS – CATEGORY A

Anthrax (*Bacillus anthracis*)

Botulism (*Clostridium botulinum toxin*)

Plague (*Yersinia pestis*)

Smallpox (*variola major*)

Tularemia (*Francisella tularensis*)

Viral hemorrhagic fevers (filoviruses [e.g., Ebola, Marburg] and arenaviruses [e.g., Lassa, Machupo])

The U.S. public health system and primary healthcare providers must be prepared to address various biological agents, including pathogens that are rarely seen in the United States. High-priority agents include organisms that pose a risk to national security because they:

- can be easily disseminated or transmitted from person to person;
- result in high mortality rates and have the potential for major public health impact;
- might cause public panic and social disruption; and
- require special action for public health preparedness.

DISEASES/AGENTS – CATEGORY B

Brucellosis (*Brucella species*)

Epsilon toxin of Clostridium perfringens

Food safety threats (e.g., Salmonella species, *Escherichia coli O157:H7*, *Shigella*)

Glanders (*Burkholderia mallei*)

Melioidosis (*Burkholderia pseudomallei*)

Psittacosis (*Chlamydia psittaci*)

Q fever (*Coxiella burnetii*)

Ricin toxin from Ricinus communis (castor beans)

Staphylococcal enterotoxin B

Typhus fever (*Rickettsia prowazekii*)

Viral encephalitis (alphaviruses [e.g., Venezuelan equine encephalitis, eastern equine encephalitis, western equine encephalitis])

Water safety threats (e.g., *Vibrio cholerae, Cryptosporidium parvum*)Category A Diseases/Agents

Second highest priority agents include those that:

- are moderately easy to disseminate;
- result in moderate morbidity rates and low mortality rates; and
- require specific enhancements of CDC's diagnostic capacity and enhanced disease surveillance.

DISEASES/AGENTS – CATEGORY C

Emerging infectious diseases such as Nipah virus and Hantavirus

Third highest priority agents include emerging pathogens that could be engineered for mass dissemination in the future because of:

- availability;
- ease of production and dissemination; and
- potential for high morbidity and mortality rates and major health impact.

From CDC | Bioterrorism Agents/Diseases (by Category) | Emergency Preparedness & Response (http://www.bt.cdc.gov/agent/agentlist-category.asp)

Chemical Emergencies

OVERVIEW

Chemical agents are poisonous vapors, aerosols, liquids and solids that have toxic effects on people, animals or plants. While potentially lethal, chemical agents are difficult to deliver in lethal concentrations because they dissipate rapidly outdoors and are difficult to produce.

BEFORE A CHEMICAL EMERGENCY

A chemical attack could come without warning. Signs of a chemical release include people having difficulty breathing, eye irritation, loss of coordination, nausea, or burning in the nose, throat and lungs. The presence of many dead insects or birds may indicate a chemical agent release.

What should be done to prepare for a chemical threat:

- Build an **Emergency Supply Kit** (https://www.ready.gov/build-a-kit) and include:
  - Duct tape
  - Scissors
  - Plastic to cover doors, windows and vents
- Make a **Family Emergency Plan** (https://www.ready.gov/make-a-plan)

DURING A CHEMICAL EMERGENCY

What should be done in a chemical attack:

- Quickly try to define the impacted area or where the chemical is coming from, if possible. Take immediate action to get away.
- If the chemical is inside the building, get out of the building without passing through the contaminated area, if possible.
- If unable to get out of the building or find clean air without passing through the affected area, move as far away as possible and shelter-in-place (https://www.ready.gov/shelter).

If instructed to remain in the home or office building:

- Close doors and windows and turn off all ventilation, including furnaces, air conditioners, vents, and fans.
- Seek shelter in an internal room with the disaster supplies kit.
- Seal the room with duct tape and plastic sheeting.
- Listen to the radio or television for instructions from authorities.

If caught in or near a contaminated area outdoors:

- Quickly decide what is the fastest way to find clean air:
- Move away immediately, in a direction upwind of the source.
- Find the closest building to shelter-in-place (https://www.ready.gov/shelter).

AFTER A CHEMICAL EMERGENCY

Do not leave the safety of a shelter to go outdoors to help others until authorities announce it is safe to do so.

A person affected by a chemical agent requires immediate medical attention from a professional. If medical help is not immediately available, decontaminate yourself and assist in decontaminating others.

Decontamination guidelines are as follows:

- Use extreme caution when helping others who have been exposed to chemical agents.
- Remove all clothing and other items in contact with the body.
  - Cut off clothing normally removed over the head to avoid contact with the eyes, nose and mouth.
  - Put contaminated clothing and items into a plastic bag and seal it. Remove eyeglasses or contact lenses.
  - Put glasses in a pan of household bleach to decontaminate them and then rinse and dry.
- Wash hands with soap and water.
- Flush eyes with water.
- Gently wash face and hair with soap and water before thoroughly rinsing with water.
- Proceed to a medical facility for screening and professional treatment.

Source: Ready.gov

Civil Disturbance and Workplace Violence

Civil disturbance and workplace violence are rare, but are issues that can interfere with the patient care and operations of a home care provider. Health care professionals are faced with increased risk of workplace violence due to several factors, including prevalence of handguns in patients' homes and neighborhoods, number of mentally ill patients living independently in communities without follow-up care, abuse of drugs and alcohol, increased presence of gang membership, dealing with distraught families and the solo work associated with home care. Agencies should have training in place on ways to mitigate and respond to potential or actual violent threats in the home care setting.

TERMINOLOGY

Civil disturbance: An act of disorder or violence to the public law and order. Some examples of civil disturbances include riots, acts of violence, insurrections, and unlawful obstructions or assemblies.

Workplace violence: Any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the worksite, including patient homes.

EMERGENCY PLAN FOR CIVIL DISTURBANCE

- As soon as you are aware of a civil disturbance occurring in your area, implement your communication plan to alert staff.
- Staff should remain calm, and leave and avoid areas of civil disturbance, if possible.
- Triage patient visits as appropriate.
- If visits need to be made to the area, then they should be made in pairs or with an escort.
- Transfer of patients from the area to a safe location should be considered and arrangements made.
- If civil disturbance is occurring and visible at the office or a patient's home, notify 911 immediately and seek a secure location.
- All doors should be locked with entrance only by verification of credentials.
- If need be, evacuation of the building or relocation of personnel will be decided by the incident commander.

PRE-EMERGENCY PLAN FOR WORKPLACE VIOLENCE

- Identification and mitigation of potential workplace violence should occur continuously.
- Upon admission, staff should screen each patient's environment for potential threats and follow policy for refusal of admission due to an unsafe environment.
- Communication to all visiting staff should be made, identifying any potential issues or disruptive situations in a patient's home.
- Staff members are encouraged to report any incident or questionable behavior to a supervisor immediately, and a zero tolerance for workplace violence should be in place. Staff members are encouraged to report incidents of violence to local police.

There are several things that a health care provider can do to prevent or respond to workplace violence, including:

- Ensure that there is always an unobstructed exit from room/building during patient visits.
- Immediately recognize and respond to escalating behaviors and warning signs.
- If feeling threatened at any time, conclude the visit, vacate the location, and immediately contact a supervisor.
- Utilize a "buddy system" if there is a potential for violence by combining nursing, therapy, or aide visits at the same time. An agency may consider security escorts in cases of high risk locations or if there is a potential for escalation of behaviors due to crucial conversations that could lead to violence. Communicate with office upon arrival and departure of patient home with a planned check-in time set.
- Avoid visiting a patient during high-risk times, such as after hours or evenings.

ACTIVE WORKPLACE VIOLENCE

- If violent behavior is exhibited, immediately leave the area.
- If there is an active shooter occurrence in either the office or a patient home:
  - **Evacuate**: Leave belongings behind and seek a safe area. Assist patient or others in leaving if possible. Prevent others from entering areas where the active shooter may be. When safe to do so, call 911.
- If evacuation is not possible:
  - **Hide Out**: Find a place to hide where the active shooter is less likely to find you. The hiding place should be out of the view of the active shooter in an area with protection from shots fired directly at you (such as in a locked room or under desk/furniture). If possible, avoid locations that would keep you from exiting. Turn off or silence cell phones. Do not talk and turn off any source of noise. Remain calm and hide behind large items. Dial 911 and alert police to the active shooter's location. If unable to speak, leave the line open and allow the dispatcher to listen.
  - **Take Action**: As a last resort, and only when in imminent danger, attempt to disrupt or incapacitate the active shooter. Take aggressive action toward the person, such as throwing items, improvising a weapon, and yelling. Be committed and prepared to act.
  - **After Police Arrive**: Once police arrive, their first purpose is to stop the active shooter. Officers will proceed directly to the area where the last shots or communication occurred. Remain calm and follow officers' instructions. Put down anything in your hands. Raise your hands and keep them visible at all times. If given orders to evacuate, immediately leave the area with hands visible.
- Following a workplace violence incident, emotional and psychological support to all employees should be provided.

Communication Interruption

Communication systems in the home care industry are a vital link to staff and patients. A communication system failure can include telephone and information systems failures. Home care providers need to have a plan in place to ensure operations continue uninterrupted.

TELEPHONE INTERRUPTION

- Transfer or forward all calls to a working number or answering service, if possible.
- Utilize cell phones to communicate with patients and staff. Give patients the cell phone number of a designated contact person if necessary.
- Contact the telephone provider to alert them of the outage.
- Initiate incident command for extended outages.
- Communication with the office should be kept open for emergency use only.

INFORMATION SYSTEM INTERRUPTION

- In the event of a planned interruption in computerized medical records, a hard copy should be printed for use by visiting staff. This should include, at minimum, a medication list, demographics, and plan of care.
- If interruption will last longer than 24 hours, an alternative documentation plan should be activated.
- Administrative staff will ensure that paper forms for documentation are available for staff to utilize.
- If interruption is less than 24 hours, then staff should plan on completing data entry within 48 hours.
- Initiate incident command for extended outages.

Extreme Heat and Cold

Extreme heat and cold can cause illness and death in the vulnerable population that home care providers serve. Extreme heat and high humidity make it harder for the body to maintain normal temperature through skin evaporation. Atmospheric conditions and poor air quality can also cause respiratory emergencies. Conditions such as heat exhaustion and heat stroke along with asthma and respiratory distress can occur during heat emergencies. Extreme cold weather can also cause emergency health conditions and death. Conditions such as frostbite and hypothermia can occur quickly in the very young and elderly.

EXTREME HEAT

- Communicate with patients and ensure they have air conditioning. Fans will not prevent heat-related illnesses.
- Ensure that patients and staff have sufficient water available.
- Encourage patients to stay indoors in air conditioning.
- Avoid activities during the midday time frame and try to stay in shaded areas. If they must be active outdoors, they should take regular breaks in an air conditioned environment and rehydrate. Know the signs and symptoms of a heart attack.
- Know the signs and treatments of heat exhaustion.
    - Symptoms of heat exhaustion include extreme thirst, fatigue, weakness, clammy skin, nausea or vomiting, and rapid breathing.
    - To treat heat exhaustion, have the victim drink cool water, rest, take a cool shower or bath.
    - Go to an air-conditioned environment.
- Know the signs and treatments of heat stroke. The most serious heat-related illness, heat stroke occurs when body temperature rises too rapidly, to as much as 106 degrees F or higher within 10 to 15 minutes. Heat stroke can cause death or permanent disability if emergency treatment is not provided. Symptoms of heat stroke include red, hot and dry skin, no sweating, and rapid, weak pulse.
    - Get the victim to a shady or cool area and call 911 immediately.
    - Until they arrive, cool the victim as quickly as possible with a cool bath or shower, a spray of cool water from a garden hose, or by wrapping the victim in a cool, wet sheet.
    - Check body temperature often and continue cooling efforts until temperature drops to 101-102 F.

EXTREME COLD

- Communicate with patients and ensure that they have a safe heat source available in their home.
- Encourage patients to stay indoors. Patients should avoid strenuous activities and dress in warm layers when outside. Make sure they know the signs and symptoms of a heart attack.
- Encourage staff to have vehicles prepared for cold weather, including assessing antifreeze/windshield fluids, heater in operating condition, and a car emergency kit including items such as blankets, food and water, flares, and jumper cables.

- Instruct staff to wear appropriate clothing covering vulnerable skin areas such as fingers, toes, ears, and head.
- Know the signs and treatment for frostbite. Frostbite is an injury to the body caused by freezing of the skin and underlying tissues. Symptoms include reddened skin with gray/white patches, numbness in affected part, extremity feels firm or hard, and blisters may occur in severe cases.
    - Immediately move patient to warm dry area cover the body with blankets.
    - Do not rub affected area or use hot water to warm it.
    - Seek immediate medical attention.
- Know the signs and treatment for hypothermia. Hypothermia occurs when body heat is lost faster than it can be replaced and body temperature falls below 95 degrees F. Symptoms may include uncontrollable shivering, cold, pale skin, numbness, fatigue, poor circulation, disorientation, slurred speech, and bluish or puffy skin. This is a medical emergency.
    - Call 911 and move patient to warm and dry area.
    - Remove any wet clothing and replace with warm, dry clothes and blankets.
    - Warm the center of the body first — chest, neck, head and groin — using an electric blanket, if available.
    - Do not warm the hands and feet first, as warming extremities first can cause shock.
    - Do not immerse the person in warm water. Rapid warming can cause heart arrhythmia.
    - Give the person a warm drink, only if conscious. Avoid caffeine or alcohol.

Fire Emergency

FIRE EMERGENCY AT OFFICE LOCATION

Each department or office location should have assigned an incident commander, area monitor and assistant for persons with special needs.

In the event of a fire at the office location:

R = Rescue: Anyone in immediate danger if it does not endanger your life.
A = Alarm: Activate nearest fire alarm and call 911.
C = Confine: Close all doors and windows.
E = Extinguish: Use a fire extinguisher ONLY if it is a small fire.
Evacuate: Evacuate the area if fire is large or there is no fire extinguisher available.

When fire is discovered:

- Activate the nearest fire alarm.
- Assign an individual to notify the local fire department by calling 911.
- If the fire alarm is not available, notify the site personnel about the fire emergency by the following means:
  - Voice Communication
  - Overhead Paging
  - Phone Paging

Upon being notified about the fire emergency, occupants must:

- Turn off lights and shut office doors if safe to do so.
- Leave the building using the designated escape routes.
- Assemble in the designated area (specify location_____).
- Remain outside until the incident commander announces that it is safe to reenter.

Incident commander and supervisors must:

- Coordinate an orderly evacuation of personnel.
- Perform an accurate head count of personnel reported to the designated area.
- Determine a method to locate missing personnel that does not include reentering building.
- Provide the fire department personnel with the necessary information about the facility and missing personnel.
- Perform assessment and initiate emergency preparedness plan.

Area monitors must:

- Ensure that all employees have evacuated the assigned area or floor.
- Report any problems to the incident commander at the assembly area.

***Assistants to* persons with special needs:**

- Assist all persons with special needs in emergency evacuation.

Only return to the building once the "all clear" message is communicated by the emergency responders or incident commander.

FIRE EMERGENCY AT PATIENT HOMES

All homes should have a safety evaluation completed on admission. Include a check for working smoke detectors. All patients and caregivers should be instructed on the emergency plan and evacuation plan.

In the event of a fire during a patient visit:

R = Rescue: Anyone in immediate danger if it does not endanger your life.
A = Alarm: Activate nearest fire alarm or call 911.
C = Confine: Close all doors and windows.
E = Extinguish: Use fire extinguisher ONLY if it is a small fire.
Evacuate: Evacuate the area if fire is large or there is no fire extinguisher available.

If unable to evacuate the patient from the home:

- Move the patient to an area that has access to outside.
- Close all doors.
- Turn off oxygen equipment unless harm will come to patient.
- If able, open a window in your location a few inches from top and bottom.
  DO NOT BREAK WINDOW.
- Notify 911 of your location and the need for rescue.

Floods

Floods can be internal (e.g., broken water pipes) or external caused by weather or destruction of water containment walls or equipment (e.g., broken water main or damage to dam).

Floods can occur in a few minutes to a few days.

KNOW THE TERMINOLOGY FOR FLOOD ALERTS

Flood Watch: Flooding is possible in your area.

Flash Flood Watch: Flash flooding (rapidly rising water) is possible. Be prepared to move to higher ground.

Flood Warning: Flooding is occurring or will occur soon. If advised to evacuate. Do so immediately.

Flash Flood Warning: A flash flood is occurring; seek higher ground immediately. Never attempt to drive through flooded roads.

INTERNAL FLOODS

Upon identification of flooding in a building, initiate emergency preparedness plan and assess area for structural damage.

- If able, move items that are in danger of damage to a secure location.
- Turn off all electrical appliances if able.
- Activate emergency communication with staff alerting them not to report to the office until clear.

EXTERNAL FLOODING

If any flood watch or warning is announced for your area, the following should be initiated:

- Evaluate patients' demographics and access to homes in case of flooding.
- Triage patient visits prior to flooding, if possible.
- Assess all patients' ability to respond to floods and potential evacuation.
- Assess all patients' level of supplies (medicine, medical supplies, oxygen, food, water).
- Ensure patients have communication available for emergency updates via television, radio or telephone.
- Encourage patients to have a "grab and go" kit including medication, medication list, health information, contact information, charged batteries, cell phone, flashlight, durable medical equipment/medical supplies, change of clothing, cash, food and water.
- Ensure patient knows evacuation locations and plan.

INSTRUCTIONS FOR PATIENTS AND CAREGIVERS FOR EACH FLOOD ALERT

Flood Watch is Issued

- If able, move to a higher floor of home.
- Arrange transportation in case an evacuation is ordered.

Flood Warning is Issued

- Follow the above actions and stay alert to news stations for evacuation alerts.
- If EVACUATION alert is given, gather "grab and go" kit and evacuate immediately.
- Once you are safely at the evacuation area, notify the home care office.

Flash Flood Watch is Issued

- Be alert to signs of flash flooding (rapidly rising water).
- Be prepared to move to higher ground.
- Never drive onto roads that are covered with water.

Flash Flood Warning is Issued

- **EVACUATE IMMEDIATELY** (you may only have seconds to escape).
- Move to an area away from streams, creeks, rivers, and storm drains.
- Do not drive around barricades.
- Do not drive onto roads that are covered with water.
- If car stalls in rapidly rising water, abandon car and climb to higher ground immediately.

After the Flood

- Listen to reports to learn when it is safe to return.
- Listen to reports to learn if the water supply is safe to drink.
- Avoid floodwaters. Floodwaters are often contaminated and may be electrically charged.
- Inspect property and building for structural damage, sewer system damage, and well water contamination. Do not enter a building if the framing or foundation are damaged.
- Clean and disinfect everything that got wet. Discard all food that came in contact with floodwaters, including canned goods.
- Notify your supervisor that you have returned to your home.

Hurricane

A hurricane is a tropical storm with winds that have reached a speed of 74 mph or more. There are sustained winds, possible tornadoes, and flooding. The Atlantic Ocean hurricane season is June 1 to November 30.

TERMINOLOGY

Tropical Depression: A rotary circulation of clouds with winds up to 38 mph.

Tropical Storm: A rotary circulation of clouds with winds between 39 and 73 mph.

Hurricane Watch: Issued when there is a threat of hurricane conditions within 36 hours or less.

Hurricane Warning: Issued when hurricane conditions are expected in 24 hours or less.

Storm Surge: A huge dome of water pushed onshore by a hurricane. When coupled with high tide, the storm surge will be the tide and surge combined causing flooding.

EMERGENCY PREPARATION FOR HURRICANE WATCH

- Initiate communication with patients.
- Evaluate patient demographics and assess whether they live in an evacuation area. If so identify where and how they would evacuate. Remind patients of the importance of communicating with the home care provider if and when they evacuate.
- Instruct patient on preparing a "grab and go" kit (including medications, identification, cell phone, money, food, and water).
- Evaluate each patient's level of supplies (medicine, medical supplies, oxygen, food and water) to last at least three days per person in the home.
- Identify patient needs for back-up oxygen source in case of power outage. Assist patient in notification of oxygen company.
- Update patent acuity triage information.
- Secure outside environment by tying down or removing items that could become airborne.
- Prepare vehicle with a full tank gas.

EMERGENCY PREPARATION FOR HURRICANE WARNING

- As the storm approaches, the Hurricane Watch may change to a Hurricane Warning, meaning that the storm arrival is within 24 hours.
- Communicate with patients on evacuation plans and reinforce that they need to call the agency when and where evacuation occurs.
- Initiate agency incident command.
- Notify local emergency management incident command of any patients that are in need of assistance with evacuation.
- Triage visits for the next 24-48 hours.
- Continue to monitor emergency broadcasts for changes in weather conditions and potential for tornadoes and flooding.

Influenza

Many patients with illnesses such as influenza will be able to remain in their homes during the course of the illness. The role of the emergency preparedness plan is to take measures to protect home care staff members and prevent further spread of the illness. Influenza is transmitted mostly through airborne droplets (sneezing or coughing), but indirect contact through hand transfer from contaminated surfaces to mucosal surfaces (such as the nose or mouth) can occur.

Home health agencies are likely to be called upon to support the care of these patients. Patients may be diverted from hospital facilities to the home health setting in order to free up beds for more acute patients. The agencies may become overburdened and a shortage of personnel and supplies may occur, thus preplanning and coordination with local health departments and health systems is a must.

In the event of pandemic influenza, your local health department will implement an incident command structure and give guidance to health care providers.

TERMINOLOGY

Seasonal flu: Strain or type of flu viruses that circulate each year typically from October to as late as May.

Pandemic flu: A new strain of flu with little or no immunity for people. Although rare, this type of pandemic illness can cause severe consequences, including high rates of worker absenteeism, overcrowding at health care systems and death among residents. At the pandemic level, the virus is spread over multiple continents.

PREPARATION FOR SEASONAL INFLUENZA

- Encourage annual influenza vaccination for all employees and patients.
- Identify essential staff and review business continuity plans.
- Identify contact at local health department.
- Develop and educate staff on management of ill staff members (fever and respiratory symptoms).
- Educate staff on standard precautions and screening of patients with potential influenza symptoms.
- Educate staff on individual response planning including backup for family or child care arrangements.
- Monitor MDH's influenza surveillance reporting at https://phpa.health.maryland.gov/influenza/fluwatch/Pages/Home.aspx.

SUPPLY PREPARATION

- Two to three weeks of medical supplies including personal protection equipment should be available in the office and in clinicians' trunk supplies.
- Gloves
- Gowns
- Antimicrobial soap
- Alcohol-based hand sanitizers
- N95 face mask/respirator

IDENTIFICATION/SCREENING OF PATIENTS

- Before and during influenza season (October to May) assess patient for influenza vaccination status and assist patients in acquiring vaccinations, if appropriate.
- The symptoms of influenza include fever or feeling feverish/chills, cough, sore throat, runny or stuffy nose, muscle aches, headache, and fatigue.

INFECTION CONTROL FOR PATIENTS WITH SUSPECTED OF CONFIRMED INFLUENZA ILLNESS

Schedule patients with influenza symptoms or illness with the same caregivers to reduce the risk of spread.

Staff should follow **standard precautions** including:

- Hand hygiene: Wash hands before and after patient contact, after contact with any potentially infectious material, and before and after donning protective equipment, including gloves.
- Gloves: Wear gloves for any contact with potentially infectious material (e.g., secretions, tissues, dirty linens).
- Gowns: Gowns should be worn with patient care activity when contact with body fluids is likely, including respiratory excretions.
- Instruct patient on respiratory hygiene and hand hygiene. Cover mouth and nose when coughing or sneezing. Throw tissues away after each use. Wash hands often, especially after coughing, sneezing, and wiping or blowing the nose.
- Staff should follow **droplet precautions** for patients with suspected or confirmed influenza for seven days after illness onset or until 24 hours after resolution of fever and respiratory symptoms. Droplet precautions include:
    - All of the standard precautions, plus:
    - Placing patient in separate room away from other residents, if possible.
- Instruct on using tissue when coughing or sneezing and to place used tissues immediately in plastic bag for disposal in regular trash.
- Instruct patient/caregivers on frequent hand-washing after contact with patient or patient articles.
- Wear mask (preferably N95) prior to entering room.
- Hand hygiene before and after removing mask.
- Instruct patient to wear mask, if possible, when leaving the home for appointments and to limit visitors to home.

Pandemic Influenza

OVERVIEW

An influenza pandemic is a global outbreak of a new influenza A virus. Pandemics happen when new (novel) influenza A viruses emerge which are able to infect people easily and spread from person to person in an efficient and sustained way. The United States is NOT currently experiencing an influenza pandemic. CDC influenza programs protect the United States from seasonal influenza and an influenza pandemic, which occurs when a new flu virus emerges that can infect people and spread globally.

Source: Centers for Disease Control and Prevention (CDC)

BEFORE A PANDEMIC

- Store a two week supply of water and food.
- Periodically check regular prescription drugs to ensure a continuous supply in your home.
- Have any nonprescription drugs and other health supplies on hand, including pain relievers, stomach remedies, cough and cold medicines, fluids with electrolytes, and vitamins.
- Get copies and maintain electronic versions of health records from doctors, hospitals, pharmacies and other sources and store them, for personal reference. Get help (http://healthit.gov/bluebutton) accessing electronic help records.
- Talk with family members and loved ones about how they would be cared for if they got sick, or what will be needed to care for them at home.

DURING A PANDEMIC

Limit the Spread of Germs and Prevent Infection:

- **Avoid close contact** with people who are sick.
- When sick, **keep your distance** from others to protect them from getting sick too.
- **Cover mouth and nose** with a tissue when coughing or sneezing. It may prevent those around you from getting sick.
- **Washing hands** often will help protect from germs.
- **Avoid touching eyes, nose or mouth**.
- **Practice other good health habits**. Get plenty of sleep, be physically active, manage stress, drink plenty of fluids, and eat nutritious food.

Source: Ready.gov

HOW IS PANDEMIC FLU DIFFERENT FROM SEASONAL FLU?

Seasonal Flu vs. Pandemic Flu

	Seasonal Flu	Pandemic Flu
How often does it happen?	Happens annually and usually peaks between December and February	Rarely happens (three times in 20th century)
Will most people be immune?	Usually some immunity from previous exposures and influenza vaccination	Most people have little or no immunity because they have no previous exposure to the virus or similar viruses
Who is at risk for complications	Certain people are at high-risk for serious complications (infants, elderly, pregnant women, extreme obesity and persons with certain chronic medical conditions)	Healthy people also may be at high risk for serious complications
Where can I get medical care?	Health care providers and hospitals can usually meet public and patient needs	Health care providers and hospitals may be overwhelmed Alternate care sites may be available to meet public and patient needs
Will a vaccine be available?	Vaccine available for annual flu season Usually, one dose of vaccine is needed for most people	Although the US government maintains a limited stockpile of pandemic vaccine, vaccine may not be available in the early stages of a pandemic Two doses of vaccine may be needed
Will antivirals be available?	Adequate supplies of antivirals are usually available	Antiviral supply may not be adequate to meet demand
How many people could get sick and suffer complications?	Rates of medical visits, complications, hospitalizations and death can vary from low to high CDC estimates that flu-related hospitalizations since 2010 ranged from 140,000 to 710,000, while flu-related deaths are estimated to have ranged from 12,000 to 56,000.	Rates of medical visits, complications, hospitalizations and death can range from moderate to high. Number of deaths could be much higher than seasonal flu (e.g. The estimated U.S. death toll during the 1918 pandemic was approximately 675,000)
What impact will it have on schools and workplaces?	Usually causes minor impact on the general public, some schools may close and sick people are encouraged to stay home Manageable impact on domestic and world economies	May cause major impact on the general public, such as travel restrictions and school or business closings Potential for severe impact on domestic and world economies

RELATED LINKS:

How Influenza Pandemics Occurs (NIAID Video)
(https://www.youtube.com/watch?v=DdFCx8jbesQ&list=PL9rasaw-kjnzq6gz7bkMg8TQPMVKv7BjI)

Source: Centers for Disease Control and Prevention (CDC)

Exhibit T: Home Health Care Services Pandemic Influenza Planning Checklist

Home Health Care Services Pandemic Influenza Planning Checklist

Planning for pandemic influenza is critical. The Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention have developed the following checklist to help public and private organizations that provide home health care services assess and improve their preparedness for responding to pandemic influenza. Home health agencies will likely be called upon to provide care for patients who do not require hospitalization for pandemic influenza, or for whom hospitalization is not an option because hospitals have reached their capacity to admit patients. These agencies may become overburdened very quickly and shortages of personnel and supplies for providing home health care may occur. This checklist is modeled after the one included in the HHS Pandemic Influenza Plan (www.hhs.gov/pandemicflu/plan/sup3.html#app2). The list is comprehensive but not complete; each home care agency will have unique and unanticipated issues that will need to be addressed as part of a pandemic planning exercise. Also, some items on the checklist may not be applicable to a given agency. Collaboration with hospitals, local pandemic planning committees and public health agencies will be essential to ensure that the affected population receives needed health care services. Further information can be found at www.pandemicflu.gov.

This checklist identifies key areas for pandemic influenza planning. Home health care organizations can use this tool to identify the strengths and weaknesses of current planning efforts. Links to websites with information are provided throughout the document. However, actively seeking information that is available locally or at the state level will be necessary to complete the development of the plan. Also, for some elements of the plan (e.g., education and training programs), information may not be immediately available and it will be necessary to monitor selected websites for new and updated information.

1. Structure for planning and decision making.

Completed	In Progress	Not Started	
☐	☐	☐	Pandemic influenza has been incorporated into emergency management planning for the organization.
☐	☐	☐	A planning committee has been created to specifically address pandemic influenza preparedness.
☐	☐	☐	A person has been assigned responsibility for coordinating preparedness planning (hereafter referred to as the pandemic response coordinator) for the practice or organization. (Insert name, title and contact information) _____ _____
☐	☐	☐	Members of the planning committee1 include the following: (Insert name, title and contact information for each) Administration: _____ Nursing: _____ Clerical: _____ Other: _____
☐	☐	☐	A point of contact has been identified for questions/consultation on infection control (e.g., hospital- or state health department-based infection control professional, healthcare epidemiologist). (Insert name, title, and contact information) _____ _____

2. Development of a written pandemic influenza plan.

Completed	In Progress	Not Started	
☐	☐	☐	Copies of relevant sections of the Department of Health and Human Services Pandemic Influenza Plan have been obtained. (www.hhs.gov/pandemicflu/plan/)
☐	☐	☐	Copies of available state and/or local pandemic influenza plans have been obtained.
☐	☐	☐	A written plan has been completed or is in progress that includes the elements listed in #3 below.
☐	☐	☐	The plan describes the organizational structure (i.e., lines of authority, function and assignment of responsibility) that will be used to operationalize the plan.
☐	☐	☐	The plan complements2 local response plans in communities served by the home health care agency.

1. The committee could be very small (e.g., two or three staff members) or very large, depending on the size and needs of the organization. Members of the "group of professional personnel" required by CMS as one of the Home Health Agency Conditions of Participation should be included on the planning committee.
2. As communities develop their pandemic response plans, the provision of home health care will be a pivotal concern. Home health care agencies should have input into these plans to ensure there are no conflicts between what the agency can provide and what the community expects.

3. Elements of an influenza pandemic plan.

Completed	In Progress	Not Started	
❑	❑	❑	**A plan is in place for monitoring for pandemic influenza in the population served.**
			❑ Responsibility has been assigned for monitoring national and state public health advisories (e.g., www.cdc.gov/flu/weekly/fluactivity.htm) and updating members of the pandemic influenza planning committee when cases of pandemic influenza have been reported in United States and in the geographic area. (Insert name, title, and contact information) _____
			❑ A system has been created to monitor influenza-like illness in patients cared for in the home (i.e., weekly or daily number of patients with influenza-like illness). www.cdc.gov/flu/professionals/diagnosis/ (Having a system for tracking illness trends during seasonal influenza will ensure that organizations can detect stressors that may affect operating capacity, including staffing and supply needs, during a pandemic.)
			❑ A system is in place to report unusual cases of influenza-like illness and influenza-related deaths to local health authorities.
❑	❑	❑	**A communication plan has been developed and includes the following information:**
			❑ Key public health points of contact for pandemic influenza have been identified. (Insert name, title, and contact information for each)
			❑ Local health department _____
			❑ State health department _____
			❑ Local emergency management _____
			❑ The organization's point person for external communication (e.g., with hospitals, nursing homes, health departments, social services agencies) has been assigned. (Insert name, title and contact information)
			❑ A list has been created of healthcare entities and their points of contact (e.g., other home care services providers, local hospitals, residential care facilities, social service agencies, emergency medical services providers, health centers and rural health facilities, relevant community organizations [including those involved with disaster preparedness]) with whom the home care agency anticipates that it will be necessary to maintain communication and coordination of care during a pandemic. (Insert location of contact list): _____
			❑ The pandemic response coordinator has contacted local or regional pandemic influenza planning groups to obtain information on communication and coordination of plans.
			❑ The pandemic response coordinator has contacted other home care services providers in the area regarding their pandemic influenza planning efforts. (Whenever possible, home care agencies should consider joint planning and coordination opportunities.)
❑	❑	❑	**An education and training program has been developed to ensure that all personnel understand the implications of, and control measures for, pandemic influenza and the current community response plan. (For more information on the scope of recommended education and training, see www.hhs.gov/pandemicflu/plan/sup3.html#edutrain)**
			❑ A person has been designated to coordinate education and training (e.g., identify and facilitate access to education and training programs, ensure that home care personnel attend, and maintain a record of attendance). (Insert name, title, and contact information): _____
			❑ Current and potential sites have been identified for long-distance (e.g., web-based programs offered by professional associations or federal agencies) and local (e.g., health department or hospital sponsored programs) education of home care personnel. (www.cdc.gov/flu/professionals/training/)
			❑ Language and reading-level appropriate materials have been identified on pandemic influenza (e.g., available through state and federal public health agencies and professional organizations) and a plan is in place for obtaining these materials.
			❑ The education and training program includes information on infection control measures to prevent the spread of pandemic influenza, including information on measures home health care personnel should apply during home care of patients. (For further information on infection control recommendations for home care, see www.hhs.gov/pandemicflu/plan/sup4.html#care)

3. Most home health agencies will already have a list of healthcare organizations and points of contact that can be used for this purpose.

3. Elements of an influenza pandemic plan. *(continued)*

Completed	In Progress	Not Started	
❑	❑	❑	**Informational materials on pandemic influenza for patients and their families have been identified that are language and reading-level appropriate for the population being served and a plan is in place to obtain and disseminate these materials.**
			❑ Materials have been identified or developed to guide family members on infection control and care of patients with pandemic influenza in the home. **www.pandemicflu.gov/plan/tab3.html**
			❑ Patients and families are encouraged to maintain a 30-day supply of medications and medical supplies as well as a two-week supply of non-perishable food and water.
❑	❑	❑	**A plan has been developed for the management of patients during a pandemic, which covers the following issues:**
			❑ Plans have been developed to manage patient care during the height of a pandemic to accommodate the increased number of patients who will need home care services.
			❑ The scope of services that the agency will provide and those that will be denied or referred to other providers has been clearly defined.
			❑ The role and responsibility of the agency regarding distribution of infection control supplies (e.g., masks, hand hygiene materials), food, medications, and other necessities in the home to patients and their families has been discussed with a local or regional pandemic influenza planning group.
			❑ Plans include decision tools for determining which patients can have altered service schedules based on their health conditions, needs, and available resources.
			❑ Local plans and criteria for the disposition of patients have been discussed with area hospitals and other home care agencies. (Hospitals may discharge patients to home and home health care agencies early to free-up bed space for critically ill patients.)
			❑ The plan considers how social service agencies (e.g., Red Cross, Salvation Army) will help meet the needs of families in the community (e.g., by providing child- or elder-care meals, shopping services) in homes where there are patients with pandemic influenza, particularly where the primary adult support person living in the home is ill.
			❑ The plan considers how the agency will maintain a database of clients who require electrically-dependent technology-driven care (e.g., ventilators, breathing treatments, suction, pumps, turning devices), oxygen, special nutrition requirements, dialysis, etc.
❑	❑	❑	**An infection control plan is in place and includes the following:**
			❑ An infection control policy for the care of pandemic influenza patients in the home. (**www.hhs.gov/pandemicflu/plan/sup4.html and www.cdc.gov/flu/professionals/infectioncontrol/**)
			❑ The policy requires healthcare personnel to use Standard (**www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html** and Droplet Precautions (i.e., mask for close contact) (**www.cdc.gov/ncidod/dhqp/gl_isolation_droplet.html**) with symptomatic patients.
			❑ A list has been developed of supplies (e.g., surgical masks, gloves, alcohol-based hand hygiene products) that will be used during home care of patients with pandemic influenza.
❑	❑	❑	**An occupational health plan has been developed that includes the following:**
			❑ A liberal/non-punitive sick leave policy for managing home care personnel who have symptoms of, or documented illness with, pandemic influenza. The policy considers: • The handling of staff who become ill at work • When personnel may return to work after recovering from pandemic influenza • When personnel who are symptomatic, but well enough to work, will be permitted to continue working
			❑ A system for evaluating symptomatic personnel before they report for duty has been developed and tested during a non-pandemic (e.g., seasonal) influenza period.
			❑ Mental health and faith-based resources have been identified that are available to provide counseling to personnel during a pandemic.
			❑ The management of personnel who are at increased risk for influenza complications (e.g., pregnant women, immunocompromised healthcare workers) has been addressed by placing them on administrative leave or altering their work location
			❑ Staff have been encouraged to develop their own family care plans for the care of dependent minors and seniors in the event community containment measures (e.g., "snow days," school closures) are implemented and for possible illness in adult family members.
			❑ The agency has the ability to monitor influenza vaccination of healthcare personnel.
			❑ Influenza vaccine is offered or made available on an annual basis to healthcare personnel.

3. Elements of an influenza pandemic plan. *(continued)*

Completed	In Progress	Not Started	
❑	❑	❑	**A vaccine and antiviral use plan has been developed.**
			❑ Websites containing current federal and state health department recommendations for the use and availability of vaccines and antiviral medications have been identified. (**www.cdc.gov/flu/professionals/vaccination/**)
			❑ An estimate has been developed of the number of personnel who would be targeted as first and second priority for receipt of pandemic influenza vaccine and antiviral prophylaxis, based on HHS guidance for use. (**www.hhs.gov/pandemicflu/plan/appendixd.html**)
			❑ The potential role of the home health care organization in the distribution of vaccine and antivirals in the community has been discussed with the local health department and/or regional pandemic planning committee.
❑	❑	❑	**Issues related to surge capacity during a pandemic have been addressed.**
			❑ A plan is in place for managing a staffing shortage within the organization due to illness in personnel or their family members.
			❑ The minimum number and categories of nursing staff and other professional personnel necessary to sustain home care services for a given number of patients or on a day-to-day basis have been determined. Cross-training (where applicable) has been implemented.
			❑ Priorities for providing care have been established.
			❑ Contingency staffing plans have been developed for either limiting home care access or recruiting temporary personnel during a staffing crisis.
			❑ Hospitals and other appropriate healthcare service providers have been consulted regarding contingency staffing resources.
			❑ Anticipated consumable resource needs (e.g., masks, gloves, hand hygiene products) have been estimated.
			❑ A primary plan and contingency plan to address supply shortages have been developed, including detailed procedures for acquisition of supplies through normal channels as well as requesting resources for replenishing supplies when normal channels have been exhausted.
			❑ Plans include stockpiling at least a week's supply of resources when there is evidence that the potential for pandemic influenza has reached the United States.
			❑ There is an understanding of the process for requesting and obtaining assets (e.g., personal protective equipment, medical supplies) made available through the community's response plan.
			❑ Information has been obtained on local and regional plans and resources for dealing with mass fatalities including removal of the deceased from the home.

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Version 5

Power Outage

Power outages can occur any time of year and cause emergency situations for patients in home health and interrupt home care operations.

AGENCY POWER OUTAGE

Initiate incident command for extended power outages.

- If an emergency generator is available, it should be checked regularly.
- Essential electric equipment should be connected to generator.
- Emergency lighting should be available and additional battery operated flashlights can be used.
- Determine if alternative work location is available.

PATIENT HOME POWER OUTAGE

- Patients should notify their electric power company when there is a power outage, especially if the patient is on oxygen or any power-dependent durable medical equipment.
- Patients should discuss back-up devices and battery-operated devices in case of power outage with their home equipment supplier.
- Patients that are on medication that requires refrigeration should keep back-up cold packs available for storage during power outages.
- Prolonged power outages may result in food spoilage. Encourage patients to be aware of proper food handling.
- Be aware of the danger of carbon monoxide poisoning. Never run a generator inside a home, basement or garage, even if the windows are open. Never use a gas range or oven to heat a home. Never use a charcoal grill, hibachi, lantern, or portable camping stove inside a home.

Radiological Emergencies

OVERVIEW

Although rare, radiation emergencies are possible. It is important for the public to prepare in advance, which can help alleviate fear and panic.

DIRTY BOMB OR RADIOLOGICAL DISPERSAL DEVICE

Radiological Dispersal Device (RDD): a device that spreads radioactive contamination.

Dirty Bomb: when explosives are used to spread radioactive powder or pellets.

A dirty bomb is not the same as a nuclear weapon and does not have the force and destruction of a nuclear blast. The main danger from a dirty bomb is from the explosion, which may cause serious injuries and property damage.

Immediate serious illness from radiation exposure is very unlikely unless people are extremely close to the blast. Contamination, inhalation, or ingestion of radioactive dust may create an increased risk of illness.

IMPROVISED NUCLEAR DEVICE OR NUCLEAR WEAPON

Improvised Nuclear Device (IND): an explosive nuclear weapon.

While not as powerful as Cold War-era nuclear weapons, improvised nuclear devices can cause significant injury and damage.

A nuclear explosion involves a large blast that produces an intense wave of heat, light, air, and radiation. Anything immediately near the explosion, including buildings, roads, and cars, will be destroyed.

The resulting radioactive dust and debris cloud, known as **fallout**, can be carried long distances before falling to the ground. This can expose many individuals to high levels of radiation.

INDUSTRIAL ACCIDENT

Industrial incidents involving radiological materials may be accidental or intentional. Radioactive material used for commercial, industrial or medical purposes could be released from its protective container. The radiation risk to individuals who are not immediately close to the accident is low.

NUCLEAR POWER PLANT ACCIDENT OR INCIDENT

Nuclear power plants have protections in place to prevent the release of radiation. However, a serious incident could allow some radiation to escape, most likely as a plume of steam carried by the wind.

The risk to residents would depend on plume size, direction, and wind speed. Parts of Maryland lie within a 10-mile radius of two nuclear power plants: the Calvert Cliffs Nuclear Power Plant in Calvert County and the Peach Bottom Atomic Power Station in southern Pennsylvania. These areas are known as **plume exposure zones** and could be affected if a plume of radiation were released during an accident or attack.

Additionally, parts of the state are less than 50 miles from four other plants in Pennsylvania, New Jersey, and Virginia. These areas, known as **ingestion pathway zones,** could be affected by contaminated food or water in a radiation emergency.

RADIOLOGICAL EXPOSURE DEVICE

Radiological Exposure Device (RED): a terrorist threat intended to expose people to significant radiation without their knowledge. Also called a hidden sealed source.

A Radiological Exposure Device is constructed from an unprotected radioactive material. It could be hidden in a public place, exposing those who sit or pass close by to potentially harmful levels of radiation.

If the radioactive contents are released from the container, the device could be capable of causing radiological contamination.

WHAT ARE THE HEALTH EFFECTS OF RADIATION?

The health impact of radiation exposure depends upon the type of radiation, length of exposure time, and protection provided by surrounding materials.

Short-term effects: could impact the brain, skin, intestines, and blood system.

Long-term effects: could include an increased risk of cancer.

Any emergency, including those involving radiation, can cause emotional and psychological distress. Many more people will experience the mental health effects than the physical effects during a radiation emergency.

WHAT PROTECTIVE ACTION CAN BE TAKEN?

- **Follow the directions of local and state authorities.**
- **Stay together if you are with family, friends, or pets.** Notify authorities of your location, names of yourself and those you are with, and serious injuries or medical problems.
- **Reduce the amount of time you are exposed to or contaminated by radioactive dust.**
- **Seek safe shelter to protect yourself from radiation exposure.**
  - ***In a building:* stay there as long as it is not damaged**. Seek an interior room and close all windows and doors. Turn off fan systems (heating, air conditioning).
  - ***Outside:* Seek a safe building for shelter**.
  - ***Do not leave safe shelter until advised by first responders and authorities.***
- **Reduce radioactive contamination.**
  - *Cover your nose and mouth with cloth* to avoid inhaling radioactive dust. Only remove the face cover once you are in a safe place and have thrown away contaminated clothes.
  - *Throw out clothing which may be contaminated.* Place the clothing in a plastic bag and store away from others.
  - *Seek a safe internal room* in a building after discarding your outer clothing.
  - *Avoid eating and drinking food or fluids which could have been contaminated.* Eating or drinking from sealed containers is okay if the outer surfaces have been cleaned of contamination.
  - *Wash exposed skin* or shower to reduce external contamination of your body.

Source: Maryland Department of Health; Office of Preparedness and Response

Tornado

A tornado is a violent windstorm characterized by a rotating, funnel-shaped cloud that can spawn thunderstorms. Tornados can occur without advance warning.

TERMINOLOGY

Tornado Watch: Issued when conditions are favorable for formation of tornadoes.

Tornado Warning: Issued when a tornado has been sighted or indicated by weather radar.

AT THE OFFICE

Tornado Watch: Stay alert to emergency broadcast for changes in condition.

Tornado Warning: Complete the following:

- Overhead announcement/message to staff that tornado warning is in effect.
- Close all curtains/blinds for all windows.
- Staff/visitors should move to secure location within the building, in the lowest level away from windows, doors and outside walls. Locations such as small interior rooms or hallways on the lowest level are desirable.
- In your secure location (if able) get under sturdy furniture and use arms to protect your head and neck.
- Stay in the location until the all clear is announced.

VISITING STAFF/PATIENTS

Tornado Watch: Communicate with staff. Be alert and monitor emergency broadcasts for changes in condition.

Tornado Warning:

- **If in the patient home**: Assist patient/caregivers to assess safe area in home. Safe location should be in lowest level of home or cellar away from windows, doors and outside walls. If unable to relocate patient to another floor, then move the patient as far away as possible from windows, hanging objects on the walls, and tall furniture.
  - Move to an interior hallway or small interior room if possible.
  - Close all windows and curtains.
  - Pad patient with extra blankets/pillows.
  - Remain in safe location, monitoring emergency broadcasts, until the all clear is announced.
  - NOTE: If patient lives in a manufactured home (e.g., mobile homes, trailer park), immediately leave location and go to nearest building or storm shelter.

- **In vehicle**: If you are traveling in a car during a Tornado Warning, immediately drive to a secure location or storm shelter.
    - Never try to outrun a storm.
    - Take cover immediately. If debris is flying in air and hitting the car, pull over and park. Avoid parking under an overpass or bridge.
    - If you are able, get out of your car, lie in a ditch or low-lying area away from the vehicle.
    - If unable to exit the car, then take cover with seat belt on covering head/neck with arms and any padded material, such as coats, cushions, etc.

AFTER A TORNADO

- After a tornado has passed, assess everyone for injuries and provide first aid.
- Be alert for downed power lines and flash flooding.
- Do not reenter buildings until you are told it is safe to enter.
- Initiate the incident command, if appropriate.
- Communicate with staff/supervisors on conditions.

Winter Weather

Winter weather can range from accumulating snow to ice conditions. Winter weather can make driving hazardous and cause barriers to entry into patients' homes. Prior to performing visits, assess if the patient has been able to clear sidewalks and driveways of ice and snow.

TERMINOLOGY

Severe Winter Storm: A severe winter storm is a storm that produces four or more inches of snow in a 12-hour period or six or more inches during a 24-hour period.

Winter Storm Watch: Indicates that severe winter weather may affect your area.

Winter Storm Warning: Indicates that a winter storm is occurring, or will occur, in your area.

Freezing Rain: Rain that freezes when it hits the ground, creating a coating of ice on roads, walkways, trees, and power lines.

Sleet: Rain that turns to ice pellets before reaching the ground. Sleet causes moisture on roads to freeze and become slippery.

Blizzard Warning: Sustained winds or frequent gusts to 35 mph or greater and considerable amounts of falling or blowing snow are expected to prevail for a period of three hours or longer.

Ice Storms: Occur when freezing rain falls from clouds and freezes immediately when it touches the ground.

PLANNING FOR WINTER WEATHER

During winter season **all staff** should prepare and assess vehicles for winter weather conditions:

- Vehicle: Make sure to use windshield fluid with a freeze factor below 32 degrees F and antifreeze. Always have a full tank of gas. Assess tire tread for wear and replace if needed.
- Equipment: Include an emergency kit with jumper cables, flares, windshield ice scraper, shovel/broom, ice melt or kitty litter, flashlight, blankets, change of clothing, food and water, charged cell phone, and first aid kit.

Before storm season arrives, identify individuals with four-wheel drive vehicles and the ability to use alternative means of transportation.

DURING WINTER WEATHER WATCH/WARNING

Initiate communication with patients including:

- Evaluate patients' demographics and assess main roads/snow removal plan.
- Evaluate patients' level of supplies (medicine, medical supplies, oxygen, food and water).
- Update patient acuity and assess visit schedule needs for next 1-2 days.

DURING WINTER WEATHER EVENT

- Initiate incident command.
- Triage patient visits based on needs assessments.
- Monitor emergency weather and road condition reports.
- Prior to patient visit, inquire if there is safe access to home (e.g., ice/snow accumulation prohibiting entry).

Part 5: ***Exercises***

Types of Emergency Preparedness Exercises

OVERVIEW

On September 16, 2016, the final rule on Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers was published (Federal Register Vol. 81, No. 180 at §418.113). The Condition of Participation (CoP) Final Rule establishes national emergency preparedness requirements for participating providers to plan adequately for both natural and man-made disasters, and coordinate with Federal, state, tribal, regional and local emergency preparedness systems. The CoP at §418.113(d)(2) requires providers to test their Emergency Disaster Plan (EDP). (Source: CMS Memorandum June 2, 2017)

The experience gained during testing or exercises is the best way to prepare teams to respond effectively to an emergency. Testing and exercises assist in the evaluation of the EDP, identify procedural deficits, test or validate changes to the plan, and clarify roles and responsibilities. There are different types of exercises that can be used to evaluate emergency plans, procedures and plan capabilities. (Source: Ready.gov)

Exhibit U: Discussion-based Exercises

Type of Exercise	Utility/Purpose	Type of Player Action	Duration	Real-Time Play?	Scope
Discussion-Based	**To familiarize players with current plans, policies, agreements, and procedures; develop new plans, policies, agreements, and procedures**	**Notional; player actions are imaginary or hypothetical**	**Rarely exceeds 8 hours**	**No**	**Varies**
Seminar	Provide an overview of new or current plans, resources, strategies, concepts, or ideas	N/A	2-5 hours	No	Multi- or single agency
Workshop	Achieve a specific goal or build a product (e.g., exercise objectives, SOPs, policies, or plans)	N/A	3-8 hours	No	Multiagency or multiple functions
Tabletop Exercise	Assist senior officials in the ability to understand and assess plans, policies, procedures, and concepts	Notional	4-8 hours	No	Multiagency or multiple functions
Game	Explore decision making processes and examine the consequences of those decisions	Notional	2-5 hours	No (some simulations provide real- or near-real-time play)	Multiagency or multiple functions

Exhibit V: Operations-based Exercises

Type of Exercise	Utility/Purpose	Type of Player Action	Duration	Real-Time Play?	Scope
Operations-Based	**Test and validate plans, policies, agreements, and procedures; clarify roles and responsibilities; identify resource gaps**	**Actual; player action mimics reaction, response, mobilization, and commitment of personnel and resources**	**May be hours, days, or weeks depending on purpose, type, and scope**	**Yes**	**Varies**
Drill	Test a single operation or function	Actual	2-4 hours	Yes	Single agency or function
Functional Exercise	Test and evaluate capabilities, functions, plans, and staffs of Incident Command, Unified Command, Intel centers, or other command/operations centers	Command staff actions are actual; movement of other personnel, equipment, or adversaries is simulated	4-8 hours or several days or weeks	Yes	Multiple functional areas/ Multiple functions
Full-Scale Exercise	Implement and analyze plans, policies, procedures, and cooperative agreements developed in previous exercises	Actual	1 full day or longer	Yes	Multiple agencies or multiple functions

Part 6: ***HIPAA and Disasters***

What Emergency Professionals Need to Know

OVERVIEW

Disasters and emergencies can strike at anytime with little or no warning and the local healthcare system in the midst of an emergency response can be rapidly inundated with patients, worried family and friends looking for their loved ones, and media organizations requesting patient information. Knowing what information can be released, to whom, and under what circumstances, is critical for healthcare facilities in disaster response. This guide is designed to answer frequently asked questions regarding the release of information about patients following an incident.

NOTE: This guide does NOT replace the advice of your facility Privacy Officer and/or legal counsel who should be involved in planning for information release prior to an event, developing policy before a disaster that guides staff actions during a disaster, and during an emergency when contemplating disclosures.

This guide does address what information can be disclosed and under what circumstances. Covered entities can disclose needed patients' protected health information (PHI) without individual authorization:

- If necessary to treat the patient or a different patient or if the information would help treat a different patient
- To a public health authority, as outlined below
- At the direction of a public health authority, to a foreign agency acting in collaboration with the public health authority
- To persons at risk of contracting or spreading a disease or condition (if authorized by other law)
- With certain people involved with patient's care/ responsible for the patient
- When there is imminent threat to public health/ safety

WHAT IS HIPAA AND THE PRIVACY RULE?

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations, the HIPAA Privacy, Security, and Breach Notification Rules, protect the privacy and security of patients' PHI, but is balanced to ensure that appropriate uses and disclosures of the information may still be made when necessary to treat a patient, to protect the nation's public health, and for other critical purposes.

DOES HIPAA APPLY TO ME OR MY ORGANIZATION?

The HIPAA Privacy Rule applies to disclosures made by employees, volunteers, and other members of a covered entity's or business associate's workforce. Covered entities are health plans, healthcare clearinghouses, and those healthcare providers that conduct one or more covered healthcare transactions electronically, such as transmitting healthcare claims to a health plan.

Business associates generally include persons or entities (other than members of the workforce of a covered entity) that perform functions or activities on behalf of, or provide certain services to, a covered entity that involve creating, receiving, maintaining, or transmitting PHI. Business associates also include subcontractors that create, receive, maintain, or transmit PHI on behalf of another business associate.

HIPAA does not apply to disclosures made by those who are not covered entities or business associates (although such persons or entities are free to follow the standards on a voluntary basis if desired).

WHEN CAN PHI BE SHARED?

Patient health information, or PHI, can be shared under the following circumstances:

Treatment: Under the HIPAA Privacy Rule, covered entities may disclose, without a patient's authorization, PHI about the individual as necessary to treat the patient or to treat a different patient. Treatment includes the coordination or management of healthcare and related services by one or more healthcare providers and others, consultation between providers, providing follow-up information to an initial provider, and the referral of patients for treatment.

Public Health Activities: The HIPAA Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to PHI that is necessary to carry out their public health mission. Therefore, the HIPAA Privacy Rule permits covered entities to disclose needed PHI without individual authorization:

- **To a public health authority that is authorized by law** to collect or receive such information for the purpose of preventing or controlling disease, injury or disability, or to a person or entity acting under a grant of authority from or under contract with such public health agency,. This could include, for example: the reporting of disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions.
- **At the direction of a public health authority to a foreign government agency** that is acting in collaboration with the public health authority.
- **To persons at risk of contracting or spreading a disease or condition** if other law, such as state law, authorizes the covered entity to notify such persons as necessary to prevent or control the spread of the disease or otherwise to carry out public health interventions or investigations.

Disclosures to Family, Friends, and Others Involved in an Individual's Care and for Notification:
A covered entity may share PHI with a patient's family members, relatives, friends, or other persons identified by the patient as involved in the patient's care. A covered entity may also share information about a patient as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the patient's care, of the patient's location, general condition, or death. This may include—if necessary to notify family members and others—the police, the press, or the public at large.

- The covered entity should get verbal permission from individuals or otherwise be able to reasonably infer that the patient does not object, when possible; if the individual is incapacitated or not available, covered entities may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest.
- In addition, a covered entity may share PHI with disaster relief organizations such as the American Red Cross, which are authorized by law or by their charters to assist in disaster relief efforts, for the purpose of coordinating the notification of family members or other persons involved in the patient's care, of the patient's location, general condition, or death. It is unnecessary to obtain a patient's permission to share the information in this situation if doing so would interfere with the organization's ability to respond to the emergency.

Imminent Danger: Healthcare providers may share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public – consistent with applicable law (such as state statutes, regulations, or case law) and the provider's standards of ethical conduct.

Disclosures to the Media or Others Not Involved in the Care of the Patient/Notification: Upon request for information about a particular patient by name, a hospital or other healthcare facility **may release limited facility directory information** to acknowledge an individual is a patient at the facility and provide basic information about the patient's condition in general terms (e.g., critical or stable, deceased, or treated and released) if the patient has not objected to or restricted the release of such information or, if the patient is incapacitated, if the disclosure is believed to be in the best interest of the patient and is consistent with any prior expressed preferences of the patient. Reference 45 CFR 164.510(a). In general, except in the limited circumstances described elsewhere, affirmative reporting to the public or media of specific information about treatment of an identifiable patient, such as specific tests, test results or details of a patient's illness, **may not be done** without the patient's written authorization (or the written authorization of a personal representative who is legally authorized to make healthcare decisions for the patient).

General or aggregate information in mass casualty events that does not identify an individual or meets the requirements of the HIPAA Privacy Rule's de-identification provisions is **not considered PHI** (e.g., X number of casualties were received by the hospital with the following types of injuries).

Minimum Necessary: For most disclosures, a covered entity must make reasonable efforts to limit the information disclosed to that which is the "minimum necessary" to accomplish the purpose. (Minimum necessary requirements do not apply to disclosures to health care providers for treatment purposes.) Covered entities may rely on representations from a public health authority or other public official that the requested information is the minimum necessary for the purpose.

Note: The disclosures listed above are at the discretion of the covered entity and are **not required** disclosures under the Rule. Some of these disclosures may be required by other federal, state or local laws (for example, mandatory reporting of positive infectious disease test results).

DOES THE HIPAA PRIVACY RULE PERMIT DISCLOSURE TO PUBLIC OFFICIALS RESPONDING TO A BIOTERRORISM THREAT OR OTHER PUBLIC HEALTH EMERGENCY?

Yes. The HIPAA Privacy Rule recognizes that various agencies and public officials will need PHI to deal effectively with a bioterrorism threat or emergency. The public health threat does not have to reach a declared emergency status. If information is needed by a government agency to protect the health of the public (e.g., a food-borne outbreak), the agency may request and receive appropriate clinical and other information about the patient's disease, care, and response to treatment. To facilitate the communications that are essential to a quick and effective response to such events, the HIPAA Privacy Rule permits covered entities to disclose needed information to public officials in a variety of ways. Further, if the covered entity has obligations to report test results and other information to public health agencies by statute, rule, or ordinance, the HIPAA Privacy Rule generally permits these disclosures.

Covered entities may disclose PHI, without the individual's authorization, to a public health authority acting as authorized by law in response to a bioterrorism threat or public health emergency (reference 45 CFR 164.512(b)), public health activities). The HIPAA Privacy Rule also permits a covered entity to disclose PHI to public officials who are reasonably able to prevent or lessen a serious and imminent threat to public health or safety related to bioterrorism (reference 45 CFR 164.512(j)), to avert a serious threat to health or safety). In addition, disclosure of PHI, without the individual's authorization, is permitted where the circumstances of the emergency implicates law enforcement activities (reference 45 CFR 164.512(f)); national security and intelligence activities (reference 45 CFR 164.512(k)(2)); or judicial and administrative proceedings (reference 45 CFR 164.512(e)).

IS THE HIPAA PRIVACY RULE "WAIVED" OR "SUSPENDED" DURING AN EMERGENCY?

The HIPAA Privacy Rule is not suspended during a public health or other emergency; however, under certain conditions the Secretary of the U.S. Department of Health and Human Services may waive certain provisions of the HIPAA Privacy Rule section 1135(b)(7) of the Social Security Act, if such a waiver is deemed necessary for the particular incident when the Secretary declares a public health emergency and the President declares an emergency or disaster under the Stafford Act or National Emergencies Act. For more information, access "Is the HIPAA Privacy Rule suspended during a national or public health emergency?" Access Hurricane Irma and HIPPA Bulletin: Limited Waiver of HIPAA Sanctions and Penalties During a Declared Emergency for an example of how sanctions and penalties could be waived in a declared emergency.

DOES THE HIPAA PRIVACY RULE PERMIT DISCLOSURE TO LAW ENFORCEMENT?

A HIPAA-covered entity may disclose PHI to law enforcement with the individual's signed HIPAA authorization. A covered entity may disclose directory information as mentioned above to law enforcement upon request. Further disclosures to law enforcement for purposes of reunification and family notification are permitted as discussed above.

A HIPAA-covered entity also may disclose PHI to law enforcement without the individual's signed HIPAA authorization in certain incidents, including:

- To report to a law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public.
- To report PHI that the covered entity in good faith believes to be evidence of a crime that occurred on the premises of the covered entity.
- To alert law enforcement to the death of the individual, when there is a suspicion that death resulted from criminal conduct.
- When responding to an off-site medical emergency, as necessary to alert law enforcement about criminal activity.
- To report PHI to law enforcement when required by law to do so (such as reporting gunshots or stab wounds).
- To comply with a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, or an administrative request from a law enforcement official (the administrative request must include a written statement that the information requested is relevant and material, specific and limited in scope, and de-identified information cannot be used).
- To respond to a request for PHI for purposes of identifying or locating a suspect, fugitive, material witness or missing person, but the information disclosed must be limited to certain basic demographic and health information about the person.
- To respond to a request for PHI about an adult victim of a crime when the victim agrees (or in limited circumstances if the individual is unable to agree). Child abuse or neglect may be reported, without a parent's agreement, to any law enforcement official authorized by law to receive such reports.

HOW DOES THE HIPAA PRIVACY RULE APPLY TO DISCLOSURES INVOLVING FOREIGN NATIONALS?

Covered entities may disclose PHI for all persons, regardless of nationality, according to the disclosures listed in the Privacy Rule and discussed above. Disclosure of PHI to embassies, consulates or other third parties, such as the American or International Red Cross acting in a capacity to facilitate notifications or repatriation following an emergency, is permitted under the existing disclosures of the HIPAA Privacy Rule, as referenced above.

FOR MORE INFORMATION

- Bulletin: HIPAA Privacy in Emergency Situations
- Can healthcare information be shared in a severe disaster?
- Health Information Privacy – Is HIPAA Privacy Rule Suspended during a National or Public Health Emergency?
- Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule: A Guide for Law Enforcement
- HIPAA Privacy Rule: Disclosures for Emergency Preparedness – A Decision Tool
- Hurricane Katrina Bulletin: HIPAA Privacy and Disclosures in Emergency Situations
- Incorporating Active Shooter Incident Planning into Health Care Facility Emergency Operations Plans. Appendix A: Information Sharing. (Page 29 of 33)
- When does the Privacy Rule allow covered entities to disclose PHI to law enforcement officials?
- HIPAA Policy Brief

For more information on HIPAA and Public Health:

http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/publichealth/index.html For more information on HIPAA and Emergency Preparedness and Response: http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/index.html General information on understanding the HIPAA Privacy Rule may be found at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

Source: Aspr-Tracie – Healthcare Emergency Preparedness Information Gateway

Part 7: ***Succession Plans***

Delegation and Communication

OVERVIEW

Succession Planning is defined as "Delegation of authorities during an emergent situation is critical. It establishes the order in which the organization's leadership team, at different levels, will assume responsibilities and control of the operations in the absence of the primary leadership. The succession plan ensures continuous coverage of leadership duties critical to ongoing operations of the organization thus providing continuity of patient care. It is expected to ensure continuity in not only functioning of the agency but also in external relationships and partnerships."

The following forms will assist you developing a structure for communication and delegation.

Exhibit W: Lines of Succession / Delegation of Authority

The emergency plan must also identify which staff would assume specific roles in another's absence through succession planning and delegations of authority. Succession planning is defined as a process for identifying and developing staff with the potential to fill key business leadership positions in the company.

LINES OF SUCCESSION				
Planning Requirement	**Answer/Response**	**Person Responsible**	**Due Date**	**Complete?**
What are the orders of succession for your agency by the title (not name) of the official?				☐
Who is the designated successor of each listed official?				☐
What are the conditions under which designated successors would assume authority and responsibility (e.g., in the absence of the director or inability to contact an official) and how would they assume it?				☐

DELEGATION OF AUTHORITY				
Planning Requirement	**Answer/Response**	**Person Responsible**	**Due Date**	**Complete?**
What are your facility or agency's predelegated authorities for making policy determinations and decisions at headquarters, field, and other organizational levels or locations?				☐
What types of authority are to be delegated (e.g., authority to issue isolation or quarantine orders) during a public health emergency?				☐
What is the position title associated with each type of authority listed above?				☐
What are the triggers for activating each of the listed authorities?				☐

Exhibit W: Communication Succession Plan

COMMUNICATION				
Planning Requirement	**Answer/Response**	**Person Responsible**	**Due Date**	**Complete?**
To whom will you communicate changes in your agency's operations as a result of a public health emergency?				☐
When will you communicate with them?				☐
How will you communicate with them?				☐
Who will speak to the press or outside agencies in a public health emergency?				☐

Part 8: **Resource Contact Information**

NOTE: The next several pages include resource contact information specific to Maryland, but please insert your own state resources.

Emergency Management Agencies

MARYLAND

Maryland Emergency Management Agency (MEMA)
http://mema.maryland.gov/

5401 Rue Saint Lo Drive
Reisterstown, MD 21136
410-517-3600

DISTRICT OF COLUMBIA

District of Columbia Homeland Security and Emergency Management Agency (HSEMA)
http://hsema.dc.gov/

2720 Martin Luther King Jr. Avenue, SE,
Washington, DC 20032
Phone: 202-727-6161
Fax: 202-715-7288
TTY: 202-730-0488

COUNTY EMERGENCY PREPAREDNESS OFFICES/DEPARTMENTS

Allegany County Emergency Preparedness
http://www.alleganyhealthdept.com/bioterrupdate.html

Anne Arundel County Emergency Preparedness
http://www.aahealth.org/emergency

Baltimore City Emergency Preparedness
http://emergency.baltimorecity.gov/

Baltimore County Emergency Preparedness
http://www.baltimorecountymd.gov/Agencies/health/resources/PHEP.html

Calvert County Emergency Preparedness
http://www.calverthealth.org/healththreats/emergency/index.htm

Caroline County Emergency Preparedness
http://www.carolinecounty.org/309/Emergency-Preparedness

Carroll County Emergency Preparedness
http://cchd.maryland.gov/community-services-emergency-preparedness-2/

Cecil County Emergency Preparedness
http://cecilcountyhealth.org/emergency-preparedness/

Charles County Emergency Preparedness
http://www.charlescountyhealth.org/emergency-preparedness/

Dorchester County Emergency Preparedness
http://www.dorchesterhealth.org/index.php?page=emergency-preparedness-bioterrorism

Frederick County Emergency Preparedness
http://health.frederickcountymd.gov/176/Public-Health-Preparedness

Garrett County Emergency Preparedness
https://garretthealth.org/emergency-preparedness/

Harford County Emergency Preparedness
https://harfordcountyhealth.com/community-health/emergency-preparedness-services/

Howard County Emergency Preparedness
https://www.howardcountymd.gov/Departments/Health/Emergency-Preparedness

Kent County Emergency Preparedness
http://www.kenthd.org/emergency_prep.php

Montgomery County Emergency Preparedness
http://www.montgomerycountymd.gov/HHS/ProgramIndex/HealthServicesindex.html

Prince Georges County Emergency Preparedness
https://www.princegeorgescountymd.gov/1875/Preparedness

Queen Anne's County Emergency Preparedness
http://www.qahealth.org/

Saint Mary's County Emergency Preparedness
http://www.smchd.org/emergency-preparedness/

Somerset County Emergency Preparedness
https://somersethealth.org/emergency-preparedness/

Talbot County Emergency Preparedness
http://talbotdes.org/ems.asp?AspxAutoDetectCookieSupport=1

Washington County Emergency Preparedness
https://washcohealth.org/public-health-emergency-preparedness/

Wicomico County Emergency Preparedness
http://www.wicomicohealth.org/index.aspx?pageid=52

Worcester County Emergency Preparedness
http://www.worcesterhealth.org/nursing-sidebar/emergency-preparedness-sidebar

For updated information about local health department preparedness offices, go to:
https://health.maryland.gov/Pages/Emergency-Preparedness.aspx

For additional information about Emergency Management Agencies in Maryland, go to:
http://mema.maryland.gov/Pages/emmgrs.aspx

HEALTH DEPARTMENTS

Maryland Department of Health
201 W. Preston Street, Baltimore, Maryland 21201
Toll Free: 1-877-463-3464
MDH After Hours/Emergency: 410-795-7365

Government of the District of Columbia Department of Health
899 North Capitol Street, NE, Washington, DC 20002
Phone: 202-442-5955
TTY: 711
E-mail: doh@dc.gov

COUNTY HEALTH DEPARTMENTS

Allegany County: 301-759-5000

Anne Arundel County: 410-222-7095

Baltimore City: 410-396-4398

Baltimore County: 410-887-2243

Calvert County: 410-535-5400

Caroline County: 410-479-8000

Carroll County: 410-876-2152

Cecil County: 410-996-5550

Charles County: 301-609-6900

Dorchester County: 410-228-3223

Frederick County: 301-600-1029

Garrett County: 301-334-7777

Harford County: 410-838-1500

Howard County: 410-313-6300

Kent County: 410-778-1350

Montgomery County: 240-777-1245

Prince Georges County: 301-883-7879

Queen Anne's County: 410-758-0720

St. Mary's County: 301-475-4330

Somerset County: 443-523-1700

Talbot County: 410-819-5600

Washington County: 240-313-3200

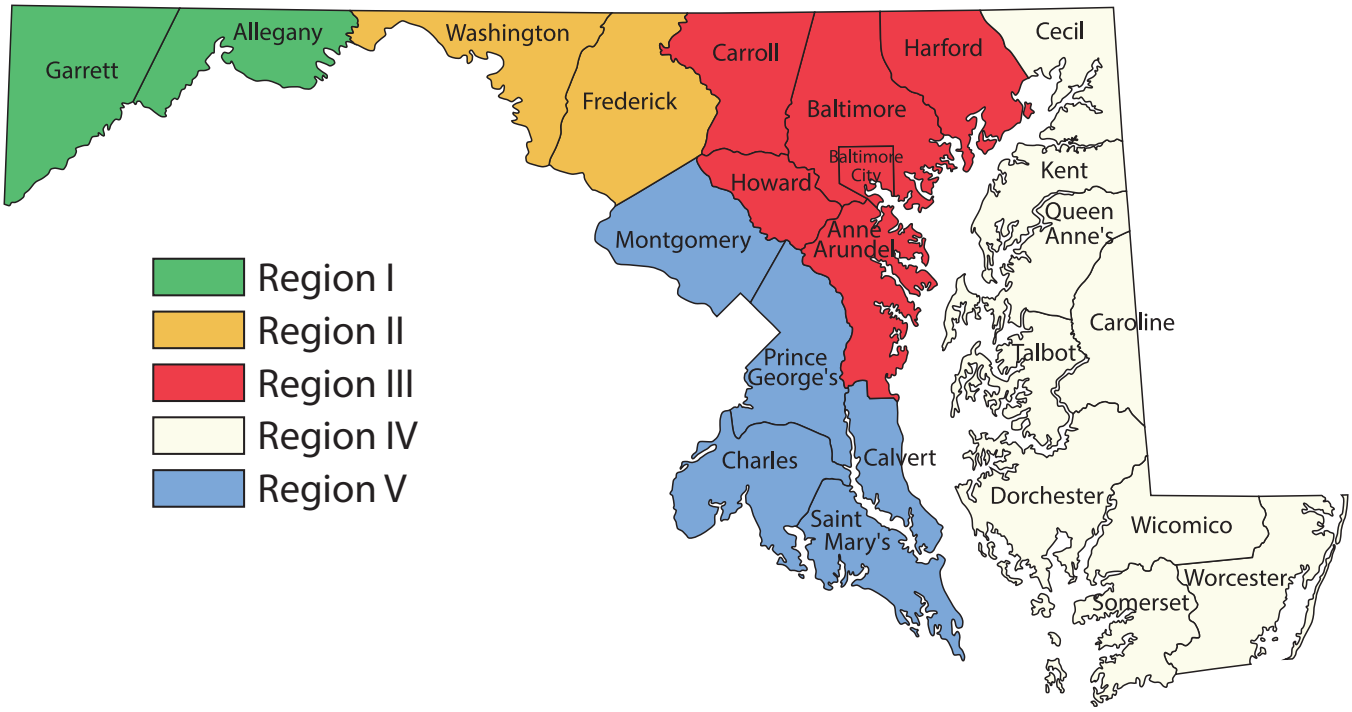
Wicomico County: 410-749-1244

Worcester County: 410-632-1100

REGIONAL HEALTH & MEDICAL COALITIONS

Health & Medical Coalitions are separated into regions in Maryland. These coalitions of health care providers and public health professionals collaborate on emergency planning for each region. Each of the regional coalitions has an assigned home care representative. You may visit www.mdemergencyprepnetwork.org for more information.

Maryland Health and Medical Regions



FEDERAL GOVERNMENT RESOURCES

Priority Telecommunications Services (GETS)
https://www.dhs.gov/government-emergency-telecommunications-service-gets

1135 WAIVER

When the President declares a major disaster or an emergency under the Stafford Act or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency, the Secretary is authorized to take certain actions in addition to his regular authorities under section 1135 of the Social Security Act. He may waive or modify certain Medicare, Medicaid, Children's Health Insurance Program (CHIP) and Health Insurance Portability and Accountability Act (HIPAA) requirements as necessary to ensure to the maximum extent feasible that, in an emergency area during an emergency period, sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act (SSA) programs and that providers of such services in good faith who are unable to comply with certain statutory requirements are reimbursed and exempted from sanctions for noncompliance other than fraud or abuse.

https://www.phe.gov/Preparedness/legal/Pages/1135-waivers.aspx

HIPAA - DISCLOSURES FOR EMERGENCY PREPAREDNESS

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/decision-tool/index.html

HIPAA DECISION MAKING TOOL

https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/emergencyprepdisclose.pdf

HHS ASPR (Assistant Secretary for Preparedness and Response) and TRACIE (Technical Resources, Assistance Center, and Information Exchange)

https://asprtracie.hhs.gov/

https://asprtracie.s3.amazonaws.com/documents/aspr-tracie-fact-sheet.pdf

RESOURCES USED TO PREPARE THIS MANUAL

A Guide for Home Care Patients Using Power-Dependent Equipment (2014).
http://www.mncha.org/Resources/EP%20Resources%202014/2014-0703%20EP%20Guide%202.pdf

Active Shooter How to Respond (2008) U.S. Department of Homeland Security.
Retrieved from www.dhs.gov/xlibrary/assets/active_shooter_booklet.pdf

Cold Stress Guide, United States Department of Labor Occupational Safety & Health Administration.
Retrieved from www.osha.gov

Disaster Preparedness (2010) Maryland Department of Health and Mental Hygiene Office of Preparedness and Response

Emergency Disasters in Homecare (2011) Occupational Safety Health Administration.
Retrieved from www.osha.gov/dte/grant_materials/fy10/sh-20861-10/emergencydisasters.pdf

Emergency Preparedness and Response (2014) Centers for Disease Control and Prevention.
Retrieved from www.bt.cdc.gov/disasters/hurricanes/preparedness.asp

Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers (2004)
United States Department of Labor: Occupational Safety and Health Administration.
Retrieved from www.osha.gov/Publications/OSHA3148/osha3148.html

Heat Wave: A Major Summer Killer National Weather Service Office of Climate, Water and Weather Services.
Retrieved from www.nws.noaa.gov

Kain, Stan (nd) Safe Winter Travel.
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(Insert State Association logo and contact information)