EMERGENCY PREPAREDNESS PACKET FOR HOME HEALTH AGENCIES

Prepared by
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I.

The National Association for Home Care &Hospice (NAHC) Emergency Preparedness Workgroup was established to develop an all hazards emergency preparedness plan to be used by home care and hospice providers.

Members of the workgroup are representatives from several State home care and hospice associations and represent all segments of the country. In addition to the workgroup, an expert review panel was convened to review the final materials developed.

The materials developed consist of templates of tools to assist in emergency preparedness for agencies, patients and their families, and agency staff. In addition, the incident command system has been outlined and included to instruct homecare and hospice providers of state and local emergency response structures.

A common element the members of the work group share is the difficulties they have experienced when promoting the role of home care to local and state emergency planners. Both state association representatives and home care providers have had to be very proactive to ensure home care and hospice is represented at planning meetings. Furthermore, there is no consensus from community and state planners on how home care and hospice providers should function during an emergency. We have heard home care agencies will be expected to do such things as deliver medications or provide transportation for patients to shelters and to staff inpatient facilities. These expectations are not only an inefficient use of valuable resources, they do not take into consideration how home care and hospice providers will continue to care for their existing patients and the possible surge of new patients.

In light of the confusion surrounding the role of home care in emergency planning, the task force has included in the emergency preparedness materials a position paper defining the role home care will play in emergency planning and response.

In May 2007, NAHC requested the Centers for Medicare and Medicaid Services (CMS) to grant regulatory waivers for home care and hospice providers in order to facilitate effective and efficient planning and response. The CMS' initial response to our request did not provide regulatory relief as a proactive measure. However, in October 2007 the CMS Survey & Certification Group issued a letter to State survey agencies that included a Frequently Asked Question (FAQ) document that uses an all hazards approach to address allowable deviations from provider survey and certification requirements during a declared public health emergency.

http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=ascending&itemID=CMS1204638&intNumPerPage=2000
NAHC continues to pursue additional regulatory relief provisions.

Following is a list of tools and materials the work group has developed:

1. Position Paper on the Role of Home Health in Emergency Planning
2. Hazard Vulnerability Assessment
3. HHA Emergency Preparedness Assessment
4. Incident Command System
5. HHA Preparedness Plan
6. Items to Consider for Admission
7. Abbreviated Assessment
8. Abbreviated OASIS Assessment
9. Memorandum of Understanding
10. Patient emergency Preparedness Plan
11. Family Emergency Preparedness Plan
12. Staff Emergency Preparedness Plan
13. Business Continuity Plan

APPENDICIES

First Aid Kit –Appendix A
Emergency Supply Kits – Appendix B
Supply List – Appendix C

The National Association for Home Care and Hospice would like to thank the members of the Emergency Preparedness Workgroup and the Expert Review Committee for contributing their time and expertise to this project.

Note: The term “home care” used through out this packet includes home health, hospice and private duty agencies.

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IV. THE ROLE OF HOME HEALTH AND HOPICE IN EMERGENCY, DISASTER, AND EVACUATION PLANNING

The terrorist attacks on New York City and Washington, DC, on September 11, 2001, the hurricanes that struck the Gulf States in 2005, along with preparations for an impending influenza pandemic have dramatically underscored the vital role of all aspects of the health care delivery system, including home care, in addressing emergency situations.

On November 25, 2002, President Bush signed into law the "Homeland Security Act of 2002" (Public Law 107-296). The Department of Homeland Security's primary mission is to help prevent, protect against, and respond to acts of terrorism within our nation's communities. Title V of the law -- Emergency Preparedness and Response, directs the Secretary of Homeland Security (Secretary) to carry out and fund public health-related activities to establish preparedness and response programs. The Secretary is directed to assist state and local government personnel, agencies, or authorities, non-federal public and private health care facilities and providers, and public and non-profit health and educational facilities, to plan, prepare for, prevent, identify, and respond to biological, chemical, radiological, nuclear event and public health emergencies.

Since the enactment of the "Homeland Security Act of 2002, tens of billions of dollars have been provided for first responders, including terrorism prevention and preparedness, general law enforcement, firefighter assistance, airport security, seaport security and public health preparedness. After many proactive initiatives on the part of home care providers, home care and hospice are just beginning to be included in emergency planning on both the national and local level. Unfortunately, plans for home care and hospice providers during an emergency are often based on misconceptions of the role they should play.

The institutional bias towards health care planning and delivery in our nation, both in emergencies and non-emergencies, has left home care poorly defined for many. This has been evident by some State and local emergency plans that expect home care providers to fill-in resource gaps such as augmenting hospital staffs or provide transportation for patients and non-patients to community shelters.

Home care and hospice agencies can be a fundamental foundation that can support the traditional hospital health care system during a time of disaster. However, they should be able to function utilizing their inherent strengths and existing care delivery structure.

Home care and hospice agencies already perform activities necessary for effective emergency planning, such as, assisting hospitals when at surge capacity; providing community wide vaccination, participate in community out reach programs to disseminate public health information, and educating patients on disease management. In addition, their ability to deliver health services to individuals in non-structured environments without additional training makes them ideal as key responders in times of crisis. For example,

during hurricanes Katrina and Rita home care and hospice professionals were instrumental in caring for patients housed in shelters and non-traditional health care facilities.

With respect to preparedness and response to disasters affecting the public health, it is critical that home care and hospice agencies' infrastructure be strengthened, and that the special qualities and abilities of these health care providers be utilized. As a service performed primarily in individual homes and the community, home care and hospice are essential to disaster preparedness and response efforts.

Today, home care is the only "system" that is oriented to the community in a broad enough way to provide a massive infrastructure. Through the home care and hospice agencies in this country, it is possible to put a nurse in every zip code. In fact, in many counties in this nation, the public home care agency is the sole community provider. The home care clinicians are well acquainted with their communities to the point that they can be quickly deployed.

The home care clinicians of today are trained in community health service. They are able to assess the patient's symptoms as well as the environment in which they reside. They conduct patient and safety assessments, skilled care and treatment, educate patient and family, monitor and instruct on infection control practices in the home, and assist with medical and social supports that are critical to the process of healing the sick and protecting the well. Today, these skills are essential to serve and protect our communities' health.

Home care providers need to be classified as essential heath care workers and be provided such considerations as gas vouchers, official identification cards or papers, access to restricted areas, and access to alternate communication systems.

As such, home care providers should be included in emergency and preparedness response programs and be allowed greater self- determination regarding their contribution to emergency planning and response initiatives. To utilize home health and hospice providers as only support systems for other health care providers during emergencies would not be an efficient use of a valuable resource.

Types of Home Care Agencies

Emergency planners must understand the various structures that home care is delivered within to recognize the full scope of assistance home care agencies can provide during disaster planning and response efforts . Home care services are usually provided by home care organizations that include home health agencies; hospices, homemaker and home health agencies; staffing and private duty agencies.

Home Health Agencies

The term “home health agency” often indicates that a home care provider is Medicare certified. A Medicare-certified agency has met federal minimum requirements for patient care and management and therefore can provide Medicare and Medicaid home health services. Individuals requiring skilled home care services usually receive their care from a home health agency.

Hospices

Hospice care involves a core interdisciplinary team of skilled professionals and volunteers who provide comprehensive medical, psychological, and spiritual care for the terminally ill and support for patients' families. Hospice care also includes the provision of related medications, medical supplies, and equipment. Most hospices are Medicare certified and licensed according to state requirements.

Homemaker and Home Care Aide Agencies

Homemaker and HCA agencies employ homemakers or chore workers, HCAs, and companions who support individuals through meal preparation, bathing, dressing, and housekeeping. Personnel are assigned according to the needs and wishes of each client. Some states require these agencies to be licensed and meet minimum standards established by the state.

Staffing and Private-duty Agencies

Staffing and private-duty agencies generally are nursing agencies that provide individuals with nursing, homemaker, HCA, and companion services. States vary on whether they require these agencies to be licensed or meet regulatory requirements. Some staffing and private-duty agencies assign nurses to assess their clients' needs to ensure that personnel are properly assigned and provide ongoing supervision.

Medicare certified home health and hospice agencies are more likely to accept patients that are rapidly discharged from hospitals and skilled nursing facilities during an emergency. Medicare certified agencies are usually structured as either: hospital based and fall under the direction of the hospital; free-standing and self directed; or public health or government based agencies and are directed by local and State governments.

Non- Medicare certified agencies such as homemaker and home care aide agencies and staffing and private duty agencies will also have a role in emergency planning, however may not be able to provide skilled services to the degree of a Medicare certified agency.

NAHC wishes to thank Barbara Citarella of RBC Ltd. for her contribution to this document

V. Hazard Vulnerability Analysis

The Hazard Vulnerability Analysis tool is designed to so agencies can evaluate their level of risk and preparedness for a variety of hazardous events. A hazard vulnerability assessment is usually the first step in emergency planning for an organization. The tool lists events that might be encountered by an agency, and can be individually tailored. Included are the instructions on how to use the tool along with a list of possible hazards that would require disaster planning.

Hazard Vulnerability Assessment

Event	Probability			Level of vulnerability /Degree of disruption			Preparedness			Score
	High (3)	Moderate (2)	Low (1)	High (3)	Moderate (2)	Low (1)	Low (3)	Moderate (2)	High (1)	
Ice Snow										
Flooding										
Earthquake										
Hurricane										
Hazardous Material Accident										
Fire										
Tornado										
Volcano										
Civil Disturbance										
Mass Causality Event										
Terrorist Attacks										
Pandemic/Infectious Disease										
Electrical failure										
Communications Failure										
Information System Failure										
Water failure										
Transportation Interruption										
Environmental/ Altered Air Quality Pollution										

HAZARD VULNERABILITY ANALYSIS
Instructions

- List potential hazardous events for your organization.

- Evaluate each event for probability, vulnerability and preparedness.

- Probability, Vulnerability, and Preparedness are rated on a three level scale from high to low. Probability and Vulnerability are ranked with a score of "3" for high, "2" for moderate and "1" for low. Conversely, for the Preparedness category, a score of "3" represents a low ranking for preparedness while a score of "1" represents a high level of preparedness. A score of "2" represents a moderate ranking for preparedness.

- When evaluating probability, consider the frequency and likelihood an event may occur.

- When evaluating vulnerability, consider the degree with which the organization will be impacted, such as, infrastructure damage, loss of life, service disruption etc.

- When evaluating preparedness, consider elements, such as, the strength of your preparedness plans and the organization's previous experience with the hazardous event.

- Multiply the ratings for each event in the area of probability, vulnerability and preparedness. The total values with the higher scores will represent the events most in need of organization planning for emergency preparedness.
  Using this method, 1 is the lowest possible score, while 27 is the highest possible score.

  NOTE: The scale for preparedness is in reverse order from probability and vulnerability where by "low" =3 and "high"=1.

- The organization should determine which values represent an acceptable risk level and which values require additional planning and preparation.

Potential Hazards

Natural Disasters

- Hurricanes
- Tornadoes
- Heavy thunder storms
- Flash flooding
- Flooding
- Mud/rock slides
- High winds
- Hail
- Severe winter weather
- Avalanche
- Extreme high heat
- Drought
- Wildfire
- Earthquake
- Volcano eruption
- Tidal wave/Tsunami

Man-made Disasters

- War (conventional, biological, chemical or nuclear)
- Toxic material emission/spill (from a train or nearby plant)
- Riot or other civil disorder
- Nuclear plant melt down or other nuclear disaster
- Terrorism
- Fire

Technological Failures

- Electrical
- Communications
- IT system
- Heating /cooling

Other

- Disease outbreak
- Community infrastructure breakdown (bridges collapse, Dam breaks, etc.)
- Utility failure
- Transportation failure

VI. The Home Health Agency Preparedness Assessment

The Home Health Agency Emergency Preparedness Assessment can be broken down by assessing the agency's preparedness according to general categories for consideration. The agency identifies specific tasks to be completed under each category in order to mitigate the affects of any adverse event that might interfere with normal operations. Below are several categories for consideration when determining what tasks are to be employed and by whom.

- Administrative considerations:
- Supplies consideration:
- Utility considerations:
- Record protection
- Financial
- Communication
- Surge capacity
- Staff
- Patient education
- Transportation

Following are two examples of a home health agency emergency preparedness plan. Example "1" is a detailed checklist for agencies that are ready to implement a comprehensive emergency preparedness plan. Example "2" is a less detailed checklist and contains fewer, but important, activities under each category. This checklist will assist agencies that are in the beginning stages of developing plans for disaster preparedness.

HOME CARE EMERGENCY PREPAREDNESS AESSESSMENT (Example 1)			
	Date Completed	**Date Reviewed**	**Name or Title of Individual (s) Responsible for Completion**
Administrative			
Incident Command Structure - Chain of command and lines of authority established			
Liaison established with State and local Emergency Management Coordinator (EMC) and emergency preparedness plans. Confirmed contacts on a regular schedule (i.e. quarterly)			
Alternate command center established			
Identify a meeting place for all personnel if agency is not accessible			
Compact agreement with other health care facilities			
Established Memorandum of Understanding with other stakeholders			
Mock drill schedule and performance assessment			
Supplies			
Vendor alternatives examined			
Office supply inventory -- 3-5 days of supplies on hand needed to continue operations			
Utilities			
Plan developed for loss of water and power: - bottled water - generator			
Record Protection			
Plan developed to protect medical records			

HOME CARE EMERGENCY PREPAREDNESS AESSESSMENT (cont)			
	Date Completed	**Date Reviewed**	**Name or Title of Individual (s) Responsible for Completion**
Backup plan in place for electronic records			
Off-site/distance storage			
Financial			
Mechanism to track agency costs during emergency or adverse situations			
Business continuity plan developed			
Communication			
Alternate communication system in place (cell phones, pagers, satellite phones)			
Coordination with local/State EMS policy on communicating with other health facilities			
Telephone tree established and communicated to staff			
Coordinate with local and State EMC information dissemination in the community (media releases, general info etc.)			
Surge Capacity			
Define surge capacity for your agency: - maximum caseload - scope of services			
Identify actions to increase surge capacity			
Patient classification/ prioritization list developed			
Identify which staff will be available to the agency during an emergency			
Communicate plans with local health care facilities regarding scope service and agency surge			

HOME CARE EMERGENCY PREPAREDNESS AESSESSMENT (cont)			
	Date Completed	**Date Reviewed**	**Name or Title of Individual (s) Responsible for Completion**
Current list of staff addresses on file to assign patients accordingly			
Condensed admission packet developed			
Patient tracking system developed and maintained			
Staff			
EP orientation program developed for all staff			
Establish a continuing EP education schedule			
Compile and maintain a current list of staff emergency contact numbers			
Protocols for communication of field staff with office/ supervisors established			
Altered job descriptions/duties identified for each discipline			
Instruct and assist staff to develop personal/family emergency plans			
Plan for mental health services for employees			
Patient education			
Patient educations materials are provided to assist patients prepare for emergencies and to provide self-care if agency personnel are not available			
Patients are informed of local/state evacuation plan			
Patients are instructed on the agency's triage system.			
Patients are instructed on the agency notification protocols for patients that relocate			

HOME CARE EMERGENCY PREPAREDNESS AESSESSMENT (cont)			
	Date Completed	**Date Reviewed**	**Name or Title of Individual (s) Responsible for Completion**
Patients are informed of the potential for care to be deferred in an emergency			
Transportation			
Plans for transportation interruptions			
Alternate transportation arranged			
Gasoline allocation plan			
Mechanism developed to identify staff as emergency personnel			
Identify gas stations that can operate during power outages			

HOME CARE EMERGENCY PREPAREDNESS ASSESSMENT (Example 2)			
	Date Completed	**Date Reviewed**	**Name or Title of Individual (s) Responsible for Completion**
Administration			
Establish a command center			
Establishing liaisons with community planners			
Setting up memorandums of understanding with other providers			
Supplies			
Policy for supply allocation during emergencies			
Vendor contracts			
Stockpiling supplies			
Utilities			
Plans for water and electrical failures			
Record Protections			
Back up procedure			
Off-site storage			
Financial			
Identify funding sources if normal payment structure are interrupted			
Communication			
Alternate communication devices in place			
Establish a telephone tree			

	Date Completed	**Date Reviewed**	**Name or Title of Individual (s) Responsible for Completion**
Surge Capacity			
Define surge capacity for the agency			
Identify actions to increase surge capacity • available staff • patient triage procedure			
Staff			
Instruct staff on agency EP plan at orientation and establish a training schedule			
Current list of staff emergency contact phone numbers			
Stress importance of developing a family EP plan			
Patient Education			
Patient education materials are developed to assist patients prepare for emergencies.			
Patients are informed of local/state evacuation plan			
Patients are instructed on the agencies EP plan			
Transportation			
Develop plans for transportation interruptions (road closures, mass transit disruption, etc.)			

VII. The Incident Command System

The Incident Command System (ICS) document introduces the ICS and provides a description of the federal ICS structure and purpose. ICS is part of the broader incident management system outlined in the Department of Homeland Security's National Incident Management System (NIMS).

Understanding the Incident Command System

Federal, state and local governments have created universal emergency and disaster planning standards for health care organizations. Government units such as Homeland Security, the Federal Emergency Management Agency, and the Centers for Disease Control, in concert with State and County public health or health and human service units have developed these standards. Government expects health care organizations to adopt and implement a standard planning protocol so that in the event of a disaster or emergency resources are maximized to best respond to a specific incident. This can only be accomplished when we plan similarly and then integrate agency specific plans into the broader planning responses by officials.

National Incident Management System (NIMS)

In response to attacks on September 11, 2001 President George W. Bush issued Homeland Security Presidential Directive 5 (HSPD-5) in February 2003.

HSPD-5 called for a National Incident Management System (NIMS) and identified steps for improved coordination of Federal, State, local, and private industry response to incidents and described the way these agencies will prepare for such a response.

The Secretary of the Department of Homeland Security announced the establishment of NIMS in March 2004. One of the key features of NIMS is the Incident Command System (ICS):

- A comprehensive, national approach to incident management.
- Applicable across all jurisdictions and all types of emergency incidents (and non-emergency scenarios) regardless of size or complexity.
- Used to improve coordination and cooperation between public and private entities.
- Uses the Incident Command System to manage incidents.

Examples of incidents when standardized planning might be employed include:

- Fire, both structural and wild-land.
- Natural disasters, such as tornadoes, floods, ice storms or earthquakes.
- Human and animal disease outbreaks.
- Search and rescue missions.
- Hazardous materials incidents.
- Criminal acts and crime scene investigations.
- Terrorist incidents, including the use of weapons of mass destruction.
- National Special Security Events, such as Presidential visits or the Super Bowl.
- Other planned events, such as parades or demonstrations.

ICS may be used for small or large events. It can grow or shrink to meet the changing needs of an incident or event.

Management of these incidents requires partnerships that often require local, State, Tribal, and Federal agencies. These partners must work together in a smooth, coordinated effort under the same management system.

ICS is Built on Best Practices

ICS is:

- A proven management system based on successful business practices.
- The result of decades of lessons learned in the organization and management of emergency incidents.

ICS has been tested in more than 30 years of emergency and non-emergency applications, by all levels of government and in the private sector. It represents organizational "best practices," and as a component of NIMS has become the standard for emergency management across the country.

NIMS requires that all levels of government, including Territories and Tribal Organizations, adopt ICS as a condition of receiving Federal preparedness funding.

What ICS Is Designed To Do

Designers of the system recognized early that ICS must be interdisciplinary and organizationally flexible to meet the following management challenges:

- Meet the needs of incidents of any kind or size.
- Allow personnel from a variety of agencies to meld rapidly into a common management structure.
- Provide logistical and administrative support to operational staff.
- Be cost effective by avoiding duplication of efforts.

ICS consists of procedures for controlling personnel, facilities, equipment, and communications. It is a system designed to be used or applied from the time an incident occurs until the requirement for management and operations no longer exists.

The Incident Command System, or ICS, is a standardized, on-scene, all-hazard incident management concept. ICS allows its users to adopt an integrated organizational structure to match the complexities and demands of single or multiple incidents without being hindered by jurisdictional boundaries.

ICS has considerable internal flexibility making it a cost effective and efficient management approach for both small and large situations.

Lessons Learned: Weaknesses in Incident Management are often due to:

- Lack of accountability, including unclear chains of command and supervision.

- Poor communication due to both inefficient uses of available communications systems and conflicting codes and terminology.
- Lack of an orderly, systematic planning process.
- No common, flexible, pre-designed management structure that enables commanders to delegate responsibilities and manage workloads efficiently.
- No predefined methods to integrate interagency requirements into the management structure and planning process effectively.

A poorly managed incident response can be devastating to our economy and our health and safety. With so much at stake, we must effectively manage our response efforts. The Incident Command System allows us to do so. ICS is a proven management system based on successful business practices.

Emergency Management Limitations:

- Government cannot do everything for everyone.
- Assistance is not guaranteed.
- Prioritized response and recovery.
- Individuals must be prepared for self preservation for the system to work.

Conclusion: In every emergency or disaster these statements will always apply:

- Local governments are the first to arrive and the last to leave.
- Local governments are responsible for the community.
- Local governments are in charge.
- Local governments have resource limitations.
- Individuals and families must make emergency and disaster plans and review them periodically.
- Institutional and community based health care agencies must plan for emergencies and disasters in a uniform manner and then take steps to integrate them into the local government planning effort (s).

Emergency management, personal and family preparedness, and agency planning is a system of local, county, state and federal and private resources organized to mitigate, plan for, respond to and recover from emergencies and disasters.

This home health organization will network with state and county emergency management officials on an ongoing basis to integrate our agency-specific plan into the broader, formal community and municipal response to disasters and emergencies.

Additional Resources

FEMA - National Integration Center (NIC) Incident Management Systems Integration Division http://www.fema.gov/emergency/nims/index.shtm
The Yale New Haven Center for Emergency Preparedness and Disaster Response Online Education and Training: http://ynhhs.emergencyeducation.org/
NIMS online: http://www.nimsonline.com/
Basic Incident Command for Medical and Public Health Professionals: http://www.mcph.org/BT/BT%202.19.03/ICS%20for%20Maine%20PH.ppt#1

VIII. The Home Health Agency Emergency Preparedness Plan Agency XYZ

The home health agency preparedness plan is detailed, all hazard, plan designed to guide for agencies when developing their emergency preparedness policies and procedures. Providers will need to tailor the plan to meet their agency's individual needs.

All-Hazard Emergency Preparedness Policy

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

Examples of incidents include:

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

Plan Activation/Deactivation

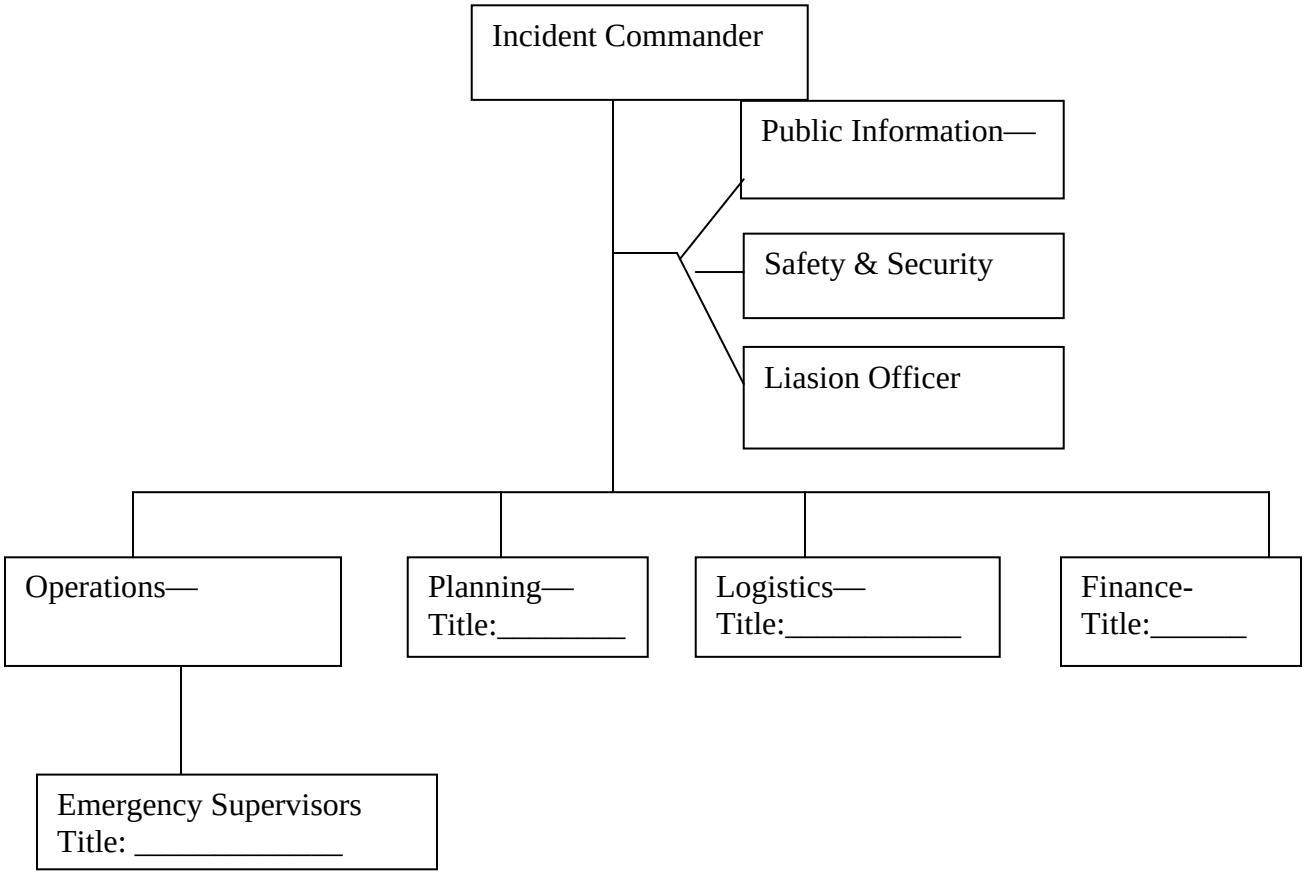
The Director, who serves as the Incident Commander, has the authority to activate and deactivate this Emergency Preparedness Plan based on information known to her/him at the time which indicates such need. If the Director is not available, the Assistant Director, and then the Chief Clinical Officer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

Goal: Allow smooth transition of patient services and ensure continuity of care for all patients served by this agency.

Objectives

- To identify the chain of command /Incident Command System
- To identify primary and alternative command centers
- To allow for the timely identification of the patients who are affected in the case of an emergency.
- To provide those patients with the care and assistance that they need in the event of an emergency.
- To be readily available to assist emergency responder personnel in first aid care for those in the community.
- To assess patient's home environment for safety and assist them to a safe environment if needed.
- To coordinate Agency staff members in patient care and evaluation, as well as any Agency personnel assistance with care of those in the community who are affected by the emergency.
- To identify staff roles and responsibilities

Sample Organizational Chart for Disaster Response Team



ASSIGNMENT SHEET

You can assign roles by person or by organizational role.

Position	**Examples of Organizational Role**	**Responsibilities**	**Assigned to**
Incident Commander (IC)	Administrator	Establish/maintain command	

Support Staff 1. Information Officer 2. Liaison Officer **3.** Safety and Security	 1. 2. 3.	1. Central Point for Information dissemination 2. Point of Contact for other agencies 3. Anticipates, detects, and corrects unsafe situations	
Operations	VP Operations	Directs all incident tactical operations	
Planning & Intelligence	Deputy Administrator	Collects, analyzes key information Formulates Incident Action Plan; Maintains documents, prepares for demobilization	
Logistics	Human Resources, facilities department	Responsible for acquisition and maintenance of facilities, staff, equipment, materials	
Finance/Administration	Comptroller	Monitors costs, contracts, financial and time reporting	

XYZ Home Care Agency
Emergency Preparedness Plan

Incident Command Center

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

Both offices will maintain data backup through e-vaulting, hard-wired phones, emergency generators.

Planning

Administration

1. Each office will keep and maintain a current list of contact information for staff, staff family members, vendors, emergency services, hospitals and other appropriate community resources.

2. The Director will ensure the existence of an incident command system and team to respond to an emergency situation.

3. All staff shall receive emergency preparedness training appropriate for their position on a yearly basis.

Patient Care & Planning

- On admission, the admitting nurse will assign each patient a priority code, dictating that patient's emergency rating. The admitting nurse will obtain a list of contact numbers, and discuss emergency planning options with the patient and family. All information will be kept in the patient's chart and shall be kept in paper as well as electronic format.

  At that time, each patient will be given a list of items to have prepared and available for use in the event of an emergency.
- Any patients requiring power for life support equipment will be registered with the local utility companies and with local emergency offices. Each patient and family will receive education that will assist them in managing emergencies.
- A list of vendors who supply each patient's medical supplies will be obtained and kept in the patient's chart.

Plan Activation--Emergency Call Down Procedure (refer to Calling List)

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

XYZ Home Care Agency
Emergency Preparedness Plan

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

If phones are not available, the information officer will contact two (2) prearranged radio stations (xxxx;xxxx) with an announcement for staff and patients.

After Receiving Notification of an Emergency - Direct Care Staff

- Do not leave your home until you receive your assignment.
- Do not ask questions when you are called. This will only slow down the rate of calling and response time to the emergency.
- When you receive a call with your assignment, you will receive all of the necessary information about the emergency and those affected.
- Please wear your nametag and Agency shirt so you can be easily recognized by other cooperating agencies.
- Stay off the phone so your second call can come through uninterrupted.
- If phone lines are down listen to radio stations (xxxx; xxxx) for instructions.
- If there is no power, or phone lines, open the emergency kit provided to you by the agency which includes a battery operated radio, and bus/subway tokens which will enable you to go to your prearranged meeting area if you do not have your own transportation.

If You Are Away From Home When an Emergency Happens - Direct Care Staff

- Call the Agency office to let the Emergency Supervisors know that you are available to help. You will receive an assignment at that time.
- If there are no working telephones, either come to the triage site or to the Agency office (whichever is closest) for assignment. In the event that the telephones are not working, the Emergency Supervisors will be at the triage site and all assignments will be made from there.

If an Emergency Occurs During Working Hours - Direct Care Staff

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

Assignments

- The Chief Clinical Officer will have power to assign staff to specific tasks, and with the coordinator will work with appointed Team Leaders to assist in pinpointing patients affected by the emergency and assigning clinical staff members to check on those patients by utilizing the pre-arranged priority classification system (see last page).

- After Office Manager and Secretary have called and put a staff member on alert, that staff member will wait for an Emergency Supervisor to call back with their assignment and where to meet their partner or security escort, if assigned.

Security

- The Security Officer will make assessments regarding the security of the command center, the safety and travel conditions for staff and make arrangements for relocation of the command center, transportation and/or safety escorts as needed.
- The Security Officer will also ensure all staff have needed identifying badges and/or uniforms which will allow them access to their agency.

Public Information

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

Regional Resource Center

- The Director will obtain and maintain a list of contacts for the local Regional Resource Center as well as a list of possible resources and supplies available through that center.

Emergency Assessments

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

    1. If the patient is unharmed but the home is damaged or unsafe and the telephone system is working, contact family or friends that the patient may request and make arrangements for the patient's transportation. Keep track of where the patient is going and all necessary telephone numbers, or contact the Emergency Supervisor for arrangements to be made through the county emergency planners for transportation to an alternate care facility if other arrangements cannot be made.
    2. If the patient is injured and needs transport, contact an Emergency Supervisor for arrangements to be made through the county emergency planners for transport to a hospital/emergency room/triage site, depending on the need as determined by the county emergency planners. Be sure to have a complete list of the patient's needs when notifying the Emergency Supervisor.

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

Unsafe Home Situation

- Before entering a patient's home, determine if there is a safety issue possible

gas leak, exposed electric wire, etc.). Assess the situation and report to an Emergency Supervisor, who will report to the county emergency planners for proper emergency personnel to secure that site.

Emergency Supply Storage Area

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

Emergency Supervisor Tasks

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

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

Emergency During Working Hours

- When the Director gets a call asking for assistance with a disaster, she will notify Assistant Director, as well as the Office Manager and Secretary to begin the calling chain. Director and Assistant Director will determine the patient and staff assignments and keep a list of those staff members the callers

have been able to contact, as well as a list of those patients each nurse has yet to see, so that any necessary redistribution of the patient assignments can be made.

- Office Staff will report to an Emergency Supervisor on those staff members that they have been able to contact, as well as which patients each of those nurses has yet to see. The Emergency Supervisors will in turn determine the assignments for those patients affected by the disaster. The teams will be notified of their assignments and the current patient caseload will also be assigned to the staff. Teams will need to meet their partner(s) at one of the three sites listed below:
    1. If the phone system is working and the disaster is local meet at the Agency and receive your disaster supplies packet from one of the Emergency Supervisors.
    2. If there is no phone system and the disaster is local, meet at the triage site and receive your disaster supplies packet from one of the Emergency Supervisors.
    3. If the disaster is at another town, meet at the triage site and receive your disaster supplies packet from one of the Emergency Supervisors or at an assigned location.
- The emergency supply packet will consist of various supplies that may be needed, as well as emergency worksheets.

- An Emergency Supervisor will then go to the triage site to coordinate any patient needs that may exist, for problem solving and coordination of our efforts with the Emergency Response personnel and the county emergency planners. If the phone system is working, Director or Assistant Director will remain at the office to manage information and coordinate calls from staff, family members, etc. If the phone system is not working, Director will also go to the triage site and Assistant Director will remain at the office to sign out other emergency supply packets and assist any staff members who may arrive.
- Each emergency assessment team will fill out the emergency worksheet and turn them in to the Emergency Supervisors at least hourly with a report on the condition of patients that they have assessed during that time frame. This emergency worksheet will enable the Emergency Supervisors to maintain a tracking list for identification of those patients assessed, their status and what location they were moved to, if necessary.
- If assistance is requested by the County Defense Director, those Emergency Supervisors who are at the triage site will coordinate Agency staff assignments for this. If our assistance is not requested, we will meet at the Agency office for a debriefing, allowing all involved to express their feelings, as well as ideas to improve for the next emergency plan implementation.

Agency staff members will participate in an annual desktop drill to determine the effectiveness and efficiency of the current policy and any forms developed for use in a disaster.

Staff Phone Tree:

Role/Title	Name	Home	Cell	Email	Other Numbers

Emergency Contacts:

Organization Type	Name	Phone	Cell	Email
Fire				
EMS				
Emergency Office				
Hazmat				
Department of Health				
Terrorism Tip Line				
Hospital:				
RRC:				
County Highway Dept				

Vendors

Priority Classification

***LEVEL 1 - <u>High Priority</u>.** Patients in this priority level need uninterrupted services. The patient must have care. In case of a disaster or emergency, every possible effort must be made to see this patient. The patient's condition is highly unstable and deterioration or inpatient admission is highly probable if the patient is not seen. Examples include patients requiring life sustaining equipment or medication, those needing highly skilled wound care, and unstable patients with no caregiver or informal support to provide care

***LEVEL 2 - <u>Moderate Priority</u>** Services for patients at this priority level may be postponed with telephone contact. A caregiver can provide basic care until the emergency situation improves. The patient's condition is somewhat unstable and requires care that should be provided that day but could be postponed without harm to the patient.

***LEVEL 3 - <u>Low Priority</u>** The patient may be stable and has access to informal resources to help them. The patient can safely miss a scheduled visit with basic care provided safely by family or other informal support or by the patient personally.

****LEVEL 4 - <u>Lowest Priority</u>** Visits may be postponed 72 hours or more with little or no adverse effects. Willing and able caregiver available or patient is independent in most ADLs.

*Source: State of New York Department of Health: Letter to Home Care Service and Hospice Administrators from Antonia Novello, MD, May10, 2005

** Contributed by the National Association for Home Care and Hospice Emergency Preparedness Expert Review Committee.

Abbreviated Assessment Tools

The following tools: Items to Consider for Admission, the Abbreviated Clinical Assessment, and the Abbreviated Outcome and Assessment Information Set (OASIS) were developed to assist providers compile a patient admission packet to be used during a declared public health emergency.

The Items to Consider for Admission document contains a list of elements necessary to complete an admission that will minimally be required.

The abbreviated Clinical Assessment and Abbreviated OASIS assessment reflect allowable deviations from the comprehensive assessment and OASIS assessment requirements during a declared public health emergency as outlined in the Centers for Medicare and Medicaid Services (CMS) memo to State Medicare Survey agencies.

CMS clarified in the memo, that during a public health emergency modifications to the comprehensive assessment regulation at 42 CFR § 484.55 may be made. An abbreviated assessment can be completed to assure the patient is receiving proper treatment and to facilitate appropriate payment. The OASIS assessment is abbreviated to include only the patient tracking items and items required for payment. The requirement to complete the OASIS in 5 days is also waived. In addition, the OASIS transmission requirement is suspended during a public health emergency. CMS will require providers to maintain adequate documentation to support provision of care and payment.

Agencies should consider working with their software vendors to develop software that will allow data entry of alternate assessment forms.

The following link is the Survey and Certification memo to the State Survey Directors.
http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=ascending&itemID=CMS1204638&intNumPerPage=2000

Items to Consider in Creating a Rapid Patient Assessment

1. **Conditions of Participation**

   a. Patient Rights- Consents/Advance Directives/Payment for care/Complaints

   b. Comprehensive assessment- Utilize abbreviated systems review
   - Demographics/patient identifiers
   - Verify eligibility for home care/homebound status
   - Determine immediate care needs
   - Determine support care needs
   - Drug regimen review

   c. Plan of Care/orders for care
   - physician/hospital info diagnoses
   - mental status
   - services
   - equipment/supplies
   - visit frequency/duration
   - prognosis
   - rehab potential
   - functional limitations
   - activities permitted
   - nutritional requirements
   - meds and treatments/allergies
   - safety
   - treatment/modality orders

   d. OASIS- patient tracking sheet items and the "M00" items required for payment

   e. Coordination of care-document contacts/referrals

   2. Accepted Standards of Care/ State Licensing Regulations
   a. Vital Signs-assessment
   b. system review
   c. care plan
   d. treatment
   e. pain
   f. meds administered
   g. transfer info/referral as needed
   h. infection control considerations- including appropriate measures when dealing with "high risk bodies"(i.e. communicable diseases)

Source: The Home Care Association of New Jersey

AGENCY NAME

Abbreviated Assessment

(M0040) Patient Name: _____
Date:_____

(M0064) SS# _____

Address: _____

(M0066) D.O.B: _____ **(M0069) Gender: _____**

Primary Physician:_____

Primary Problem/Reason for Admission: _____
_____

Significant Medical History: _____
_____
_____

Assessment:
Temp: _____ HR: _____ Rhythm _____ BP_____ Resp: _____

Lung Sounds:_____ SOB_____ Edema_____ Pain:_____

Location: _____

Infection control precautions: MRSA____ C-dif_____ VRE _____ Other _____

Type of precautions:
Standard _____ Airborne_____ Contact _____

Other Pertinent Finding:
_____
_____
_____

Mental Status:_____ **Functional Status/Activities**: _____
_____

Clinician Signature/Title/Date: _____

Diet/Nutritional Status/Hydration: _____

Support System/Assistance: _____

Home Environment: _____

Safety Concerns: _____

Equipment: _____ **Homebound Status: _____**

Emergency contact name /phone: _____

Treatments and Visit Frequency: _____

_____

Goals: _____

Advanced Directives: _____

Allergies: _____

Drug	Dosage	Frequency	Route

Clinician Signature/Title/Date: _____

Home Health Patient Tracking Sheet

(M0010) C M S Certification Number: __ __ __ __ __ __

(M0014) Branch State: __ __

(M0016) Branch I D Number: __ __ __ __ __ __ __ __ __ __

(M0018) National Provider Identifier (N P I) for the attending physician who has signed the plan of care**:**

__ __ __ __ __ __ __ __ __ __ ☐ **UK – Unknown or Not Available**

(M0020) Patient I D Number: __

(M0030) Start of Care Date: __ __ /__ __ /__ __ __ __
month / day / year

(M0032) Resumption of Care Date: __ __ /__ __ /__ __ __ __ ☐ **NA - Not Applicable**
month / day / year

(M0040) Patient Name:

__ __
(First) (M I) (Last) (Suffix)

(M0050) Patient State of Residence: __ __

(M0060) Patient Zip Code: __ __ __ __ __ __ __ __ __

(M0063) Medicare Number: __ __ __ __ __ __ __ __ __ __ __ __ ☐ **NA – No Medicare**
(including suffix)

(**M0064) Social Security Number: __ __ __ - __ __ - __ __ __ __** ☐ **UK – Unknown or Not Available**

(M0065) Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ ☐ **NA – No Medicaid**

(M0066) Birth Date: __ __ /__ __ /__ __ __ __
month / day / year

(M0069) Gender:

☐ 1 - Male

☐ 2 - Female

(M0140) Race/Ethnicity: (Mark all that apply.)

☐ 1 - American Indian or Alaska Native

☐ 2 - Asian

☐ 3 - Black or African-American

☐ 4 - Hispanic or Latino

☐ 5 - Native Hawaiian or Pacific Islander

☐ 6 - White

Clinicianꞌs Signature/Date ____

(M0150) Current Payment Sources for Home Care: (Mark all that apply.)

- ☐ 0 - None; no charge for current services
- ☐ 1 - Medicare (traditional fee-for-service)
- ☐ 2 - Medicare (HMO/managed care/Advantage plan)
- ☐ 3 - Medicaid (traditional fee-for-service)
- ☐ 4 - Medicaid (HMO/managed care)
- ☐ 5 - Workers' compensation
- ☐ 6 - Title programs (e.g., Title III, V, or XX)
- ☐ 7 - Other government (e.g., TriCare, VA, etc.)
- ☐ 8 - Private insurance
- ☐ 9 - Private HMO/managed care
- ☐ 10 - Self-pay
- ☐ 11 - Other (specify)
- ☐ UK - Unknown

Clinician's Signature/Date _____

OASIS-C Assessment Items Required for Payment

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?

□ 1 - Early
□ 2 - Later
□ UK - Unknown
□ NA - Not Applicable: No Medicare case mix group to be defined by this assessment.

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		**(M1024) Payment Diagnoses (OPTIONAL)**	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete **only if** the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-CM	Description/ ICD-9-C M
(M1020) Primary Diagnosis a.	**(V-codes are allowed)** a. (__ __ __ . __ __) □0 □1 □2 □3 □4	**(V- or E-codes NOT allowed)** a. (__ __ __ . __ __)	**(V- or E-codes NOT allowed)** a. (__ __ __ . __ __)
(M1022) Other Diagnoses b.	**(V- or E-codes are allowed)** b. (__ __ __ __ . __ __) □0 □1 □2 □3 □4	**(V- or E-codes NOT allowed)** b. (__ __ __ . __ __)	**(V- or E-codes NOT allowed)** b. (__ __ __ . __ __)
c.	c. (__ __ __ __ . __ __) □0 □1 □2 □3 □4	c. (__ __ __ . __ __)	c. (__ __ __ . __ __)
d.	d. (__ __ __ __ . __ __) □0 □1 □2 □3 □4	d. (__ __ __ . __ __)	d. (__ __ __ . __ __)
e.	e. (__ __ __ __ . __ __) □0 □1 □2 □3 □4	e. (__ __ __ . __ __)	e. (__ __ __ . __ __)
f.	f. (__ __ __ __ . __ __) □0 □1 □2 □3 □4	f. (__ __ __ . __ __)	f. (__ __ __ . __ __)

(M1030) Therapies the patient receives at home: **(Mark all that apply.)**

□ 1 - Intravenous or infusion therapy (excludes TPN)
□ 2 - Parenteral nutrition (TPN or lipids)
□ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
□ 4 - None of the above

Clinician's Signature/Date _____

(M1200) Vision (with corrective lenses if the patient usually wears them):

- □ 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.
- □ 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- □ 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

(M1242) Frequency of Pain Interfering with patient's activity or movement:

- □ 0 - Patient has no pain
- □ 1 - Patient has pain that does not interfere with activity or movement
- □ 2 - Less often than daily
- □ 3 - Daily, but not constantly
- □ 4 - All of the time

(M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage: (Enter "0" if none; excludes Stage I pressure ulcers) Column 1 Complete at SOC/ROC/FU & D/C		Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	___	___
Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	___	___
Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	___	___
Unstageable: Known or likely but unstageable due to non-removable dressing or device	___	___
Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	___	___
Unstageable: Suspected deep tissue injury in evolution.	___	___

(M1322) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

□ 0 □ 1 □ 2 □ 3 □ 4 or more

(M1324) Stage of Most Problematic Unhealed (Observable) Pressure Ulcer:

- □ 1 - Stage I
- □ 2 - Stage II
- □ 3 - Stage III
- □ 4 - Stage IV
- □ NA - No observable pressure ulcer or unhealed pressure ulcer

Clinician's Signature/Date _____

(M1330) Does this patient have a **Stasis Ulcer**?

- 0 - No [***Go to M1340***]
- 1 - Yes, patient has BOTH observable and unobservable stasis ulcers
- 2 - Yes, patient has observable stasis ulcers ONLY
- 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing) ***[Go to M1340***]

(M1332) Current Number of (Observable) Stasis Ulcer(s):

- 1 - One
- 2 - Two
- 3 - Three
- 4 - Four or more

(M1334) Status of Most Problematic (Observable) Stasis Ulcer:

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing

(M1342) Status of Most Problematic (Observable) Surgical Wound:

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing

(M1400) When is the patient dyspneic or noticeably Short of Breath?

- 0 - Patient is not short of breath
- 1 - When walking more than 20 feet, climbing stairs
- 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- 4 - At rest (during day or night)

Clinician's Signature/Date _____

(M1610) Urinary Incontinence or Urinary Catheter Presence:

- 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage)
- 1 - Patient is incontinent
- 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic)

(M1620) Bowel Incontinence Frequency:

- 0 - Very rarely or never has bowel incontinence
- 1 - Less than once weekly
- 2 - One to three times weekly
- 3 - Four to six times weekly
- 4 - On a daily basis
- 5 - More often than once daily
- NA - Patient has ostomy for bowel elimination
- UK - Unknown **[Omit "UK" option on FU, DC]**

(M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?

- 0 - Patient does not have an ostomy for bowel elimination.
- 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
- 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

- 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- 2 - Someone must help the patient put on upper body clothing.
- 3 - Patient depends entirely upon another person to dress the upper body.

(M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

- 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
- 3 - Patient depends entirely upon another person to dress lower body.

(M1830) Bathing: Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

- 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 1 - With the use of devices, is able to bathe self in shower or tub independently,
- 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
  - (a) for intermittent supervision or encouragement or reminders, OR
  - (b) to get in and out of the shower or tub, OR
  - (c) for washing difficult to reach areas.
- 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.
- 6 - Unable to participate effectively in bathing and is bathed totally by another person.

Clinician's signature/Date _____

(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

- 0 - Able to get to and from the toilet and transfer independently with or without a device.
- 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
- 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
- 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
- 4 - Is totally dependent in toileting.

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

Clinician's signature/Date _____

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

□ 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
□ 1 - Able to take injectable medication(s) at the correct times if:
(a) individual syringes are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.
□ 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
□ 3 - Unable to take injectable medication unless administered by another person.
□ NA - No injectable medications prescribed.

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

(__ __ __) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).
□ NA - Not Applicable: No case mix group defined by this assessment.

Clinician's signature/Date _____

X. Memorandum of Understanding

A memorandum of understanding (MOU) is a document describing an agreement between two or more parties, indicating an intended common line of action. It most often is used in cases where parties do not intend to imply a legal commitment. It is a more formal alternative to a gentlemen's agreement.

Source: Wikipedia the free encyclopedia, retrieved June 4, 2008.

Memorandum of Understanding
Between
Your Organization
And
Partnering Organization

This Memorandum of Understanding (MOU) establishes a *type of partnership* between *your organization* and *partner organization*.

I. Mission

Brief description of your organization's mission. You might want to also include a sentence about the specific program if applicable.

Brief description of the partnering organization's mission.

Together, The Parties enter into this Memorandum of Understanding to mutually promote *describe efforts that this partnership will promote*. Accordingly, *your organization and the partnering organization.* operating under this MOU agree as follows:

II. Purpose and Scope

Your organization and *partnering organization* – describe the intended results or effects that the organizations hope to achieve, and the area(s) that the specific activities will cover.

1. Why are the organizations forming a collaboration? Benefits for the organization.
2. Who is the target population?
3. How does the target population benefit

Include issues of funding if necessary. For example, "Each organization of this MOU is responsible for its own expenses related to this MOU. There will/will not be an exchange of funds between the parties for tasks associated with this MOU".

III. Responsibilities

Each party will appoint a person to serve as the official contact and coordinate the activities of each organization in carrying out this MOU.
The initial appointees of each organization are:

List contact persons with address and telephone information
The organizations agree to the following task for this MOU:
Your organization will:

List tasks of your organization as bullet points

Your Partnering organization will:

List tasks of your organization as bullet points

Your organization and partnering organization will:

List tasks of your organization as bullet points

IV. Terms of Understanding

The term of this MOU is for the period of *insert length of MOU* , from the effective date of this agreement and may be extended upon written mutual agreement. It shall be reviewed at least *insert how often* to ensure that it is fulfilling its purpose and to make any necessary revisions.

Either organization may terminate this MOU upon 30 days written notice without penalty or liabilities.

Authorization

The signing of this MOU is not a formal undertaking. It implies that the signatures will strive to reach, to the best of their ability, the objectives stated in the MOU.

On behalf of the organization I represent, I wish to sign this MOU and contribute to its future development.

Your Organization:
Name:
Title :
Signature: *Date:*

Partnering Organization:
Name:
Title:
Signature: *Date:*

Source: United States Department of Housing and Urban Development, Neighborhood Networks, Regional Technical Assistance Project (RTAP)

Resources

The U.S. Department of Housing and Urban Development, Neighbor Networks
http://www.hud.gov/offices/hsg/mfh/nnw/partnerships/partnershipsresources/nnwpartnermou.pdf

The Department of Homeland Security, SAFECOM, Writing Guide for a Memorandum of Understanding.
http://www.safecomprogram.gov/SAFECOM/library/interoperabilitybasics/1288_writingguide.htm

XI. Patient, Family, and Staff Emergency Preparedness Plans

Home care providers must include educating patients and staff on disaster preparedness in their emergency preparedness plans. Critical to patient and staff preparedness is the need to have a well-developed family emergency preparedness plan as well. The Patient, Family, and Staff Emergency Preparedness Plans are sample plans home care agencies can distribute and review with patients, families and staff. The tools may be used as constructed in this packet or altered to meet individual patient, family, or agency needs.

The Patient Emergency Preparedness Plan was designed to address patients with varying care needs. The plan is divided into two sections; the first section includes general instructions for emergency preparedness and is applicable to all patients, while the second section addresses considerations for individuals with special needs.

The Family Emergency Preparedness Plan is a comprehensive plan that can be distributed to the families of both patients and agency staff members.

The Staff Emergency Preparedness Plan specifically addresses considerations for emergency planning that are unique to home care personnel.

Patient Emergency Preparedness Plan

Emergency Contact Information	
Phone	**Address**
• Police	
• .Fire	
• EMS	
• Local Red Cross	
• Local Emergency Management Office	
• Physician	
• Pharmacy	
• Neighbor	
• Relatives	
•	
• Radio or TV stations: Know which station will have emergency broadcast announcements and set a TV or radio to that station	

Make a list

- Medications
- Medical information
- Allergies and sensitivities
- Copies of health insurance cards

Have on hand

- A seven-day supply of essential medications[1]
- Cell phone
- Standard telephone (that does *not* need to be plugged into an electric outlet)
- Flashlights and extra batteries.
- Emergency food
- Assorted sizes of re-closeable plastic bags for storing, food, waste, etc.

[1] *Consult with your physician and/or health plan to determine if you are able to obtain additional medication.*

- Small battery-operated radio and extra batteries
- **A**ssemble a first aid kit (Appendix A)

Evacuation Plans:

- Know where the shelter is located that can meet your special needs
- Plan for alternate locations
- Plan for transportation to a shelter or other location.
- "Have a "grab bag" prepared (Appendix B)
- Arrange for assistance if you are unable to evacuate by yourself

Shelter–in-Place

- Maintain a supply of non-perishable foods for seven days
- Maintain a supply of bottled water; one gallon per person
- Be prepared to close, lock and board/seal windows and doors if necessary
- Have an emergency supply kit prepared (Appendix C)

Pets

- Have a care plan for your pet
- Locate a shelter for your pet (hotel, local animal shelter etc.) Emergency shelters will not accept animals.
- Extra food and/or medications, leashes, carriers, bowls, ID tags etc.

Special Needs Considerations

Speech or communication Issues

- If you use a laptop computer for communication, consider getting a power converter that plugs into the cigarette lighter

Hearing Issues

- Have a pre-printed copy of key phrase messages handy, such as "I use American Sign Language (ASL),""I do not write or read English well, "If you make announcements, I will need to have them written simply or signed"
- Consider getting a weather radio, with a visual/text display that warns of weather emergencies

Vision Issues

- Mark your disaster supplies with fluorescent tape, large print, or Braille
- Have high-powered flashlights with wide beams and extra batteries
- Place security lights in each room to light paths of travel.

Assistive Device Users

- Label equipment with simple instruction cards on how to operate it (for example, how to “free wheel” or “disengage the gears” of your power wheelchair) Attach the cards to your equipment.
- If you use a cane, keep extras in strategic, consistent and secured locations to help you maneuver around obstacles and hazards.
- Keep a spare cane in your emergency kit.
- Know what your options are if you are not able to evacuate with your assistive device.

Emergency Preparedness References

The National Organization on Disabilities Emergency Preparedness Initiative:
http://www.nod.org/emergency/index.cfm

Emergency Preparedness for People with Disabilities:
http://www.ilrcsf.org/Publications/prepared/pdf/Emergency_Preparedness.pdf

Emergency Evacuation Preparedness: Taking Responsibility for Your Safety--A Guide For People with Disabilities and Other Activity Limitations By June Isaacson Kailes, Disability Policy Consultant:
http://www.cdihp.org/evacuationpdf.htm

FEMA—Federal Emergency Management Agency: Individuals With Special Needs
http://www.fema.gov/plan/prepare/specialplans.shtm

Disability Preparedness Center
http://www.disabilitypreparedness.gov/

Disability Preparedness DHS
http://www.disabilitypreparedness.gov/

The Centers for Disease Control and Prevention: Emergency Preparedness
http://emergency.cdc.gov/

The Red Cross: http://www.redcross.org/services/0,1103,0_313_,00.htm

Food and Drug Administration: State Health Departments
http://www.fda.gov/oca/sthealth.htm

Ready.gov
http://www.ready.gov/

Local web sites:

Family Emergency Preparedness Plan

Family plan should address the following:
- Evacuation routes.
- Family communications.
- Utility shut-off and safety.
- Insurance and vital records.
- Evacuation plan
- Caring for animals

Evacuation Routes
Draw a floor plan of your home. Use a blank sheet of paper for each floor. Mark two escape routes from each room. Make sure children understand the drawings. Post a copy of the drawings at eye level in each child's room. Establish a place to meet in the event of an emergency, such as a fire.

Family Communications
Your family may not be together when disaster strikes, so plan how you will contact one another. Think about how you will communicate in different situations. Complete a contact card for each family member. Have family members keep these cards handy in a wallet, purse, backpack, etc. You may want to send one to school with each child to keep on file. Pick a friend or relative who lives out-of-state for household members to notify they are safe.
Below is a sample contact card.

Utility Shut-off and Safety
In the event of a disaster, you may be instructed to shut off the utility service at your home.

Natural Gas
Natural gas leaks and explosions are responsible for a significant number of fires following disasters. It is vital that all household members know how to shut off natural gas.

If you smell gas or hear a blowing or hissing noise, open a window and get everyone out quickly. Turn off the gas, using the outside main valve if you can, and call the gas company from a neighbor's home

Because there are different gas shut-off procedures for different gas meter configurations, it is important to contact your local gas company for guidance on preparation and response regarding gas appliances and gas service to your home. When you learn the proper shut-off procedure for your meter, share the information with everyone in your household.
CAUTION – If you turn off the gas for any reason, a qualified professional must turn it back on. NEVER attempt to turn the gas back on yourself.

Water
Water quickly becomes a precious resource following many disasters. It is vital that all household members learn how to shut off the water at the main house valve.
•Cracked lines may pollute the water supply to your house. It is wise to shut off your water until you hear from authorities that it is safe for drinking.
•The effects of gravity may drain the water in your hot water heater and toilet tanks unless you trap it in your house by shutting off the main house valve

Preparing to Shut Off Water
• Locate the shut-off valve for the water line that enters your house.
• Make sure this valve can be completely shut off. Your valve may be rusted open, or it may only partially close. Replace it if necessary.
• Label this valve with a tag for easy identification, and make sure all household members know where it is located.

Electrical
Electrical sparks have the potential of igniting natural gas if it is leaking. It is wise to teach all responsible household members where and how to shut off the electricity.

Preparing to Shut Off Electricity
• Locate your electricity circuit box.
• Teach all responsible household members how to shut off the electricity to the entire house.

Insurance and Vital Records
Obtain property, health, and life insurance if you do not have them. Review existing policies for the amount and extent of coverage to ensure that what you have in place is what is required for you and your family for all possible hazards.

If you live in a flood-prone area, consider purchasing flood insurance to reduce your risk of flood loss. Buying flood insurance to cover the value of a building and its contents will not only provide greater peace of mind, but will speed the recovery if a

flood occurs. You can call 1(888) FLOOD 29 to learn more about flood insurance.

Money
Consider saving money in an emergency savings account that could be used in any crisis. It is advisable to keep a small amount of cash or traveler's checks at home in a safe place where you can quickly access them in case of evacuation.

Evacuation: More Common than You Realize
Ask local authorities about emergency evacuation routes and see if maps may are available with evacuation routes marked.

Evacuation Guidelines

Always:	If time permits:
Keep a full tank of gas in your car if an evacuation seems likely. Gas stations may be closed during emergencies and unable to pump gas during power outages. Plan to take one car per family to reduce congestion and delay.	Gather your disaster supplies kit.
Make transportation arrangements with friends or your local government if you do not own a car.	Wear sturdy shoes and clothing that provides some protection, such as long pants, long-sleeved shirts, and a cap.
Listen to a battery-powered radio and follow local evacuation instructions.	Secure your home: Close and lock doors and windows. Unplug electrical equipment, such as radios and televisions, and small appliances, such as toasters and microwaves. Leave freezers and refrigerators plugged in unless there is a risk of flooding.
Gather your family and go if you are instructed to evacuate immediately.	Let others know where you are going.
Leave early enough to avoid being trapped by severe weather.	
Follow recommended evacuation routes. Do not take shortcuts; they may be blocked.	

Be alert for washed-out roads and bridges. Do not drive into flooded areas.	
Stay away from downed power lines.	

Caring for Pets

Animals also are affected by disasters. Use the guidelines below to prepare a plan for caring for pets.

Guidelines for Pets Plan for pet disaster needs by:

- Identifying shelter.
- Gathering pet supplies.
- Ensuring your pet has proper ID and up-to-date veterinarian records.
- Providing a pet carrier and leash.

Take the following steps to prepare to shelter your pet:

- Call your local emergency management office, animal shelter, or animal control office to get advice and information.
- Keep veterinary records to prove vaccinations are current.
- Find out which local hotels and motels allow pets and where pet boarding facilities are located. Be sure to research some outside your local area in case local facilities close.
- Know that, with the exception of service animals, pets are not typically permitted in emergency shelters as they may affect the health and safety of other occupants.

Kit Locations

Since you do not know where you will be when an emergency occurs, prepare supplies for home, work, and vehicles (see Appendix A, B & C).

Home

Your disaster supplies kit should contain essential food, water, and supplies for at least three days. Keep this kit in a designated place and have it ready in case you have to leave your home quickly. Make sure all family members know where the kit is kept. Additionally, you may want to consider having supplies for sheltering for up to two weeks.

Work

This kit should be in one container, and ready to "grab and go" in case you are evacuated from your workplace. Make sure you have food and water in the kit. Also, be sure to have comfortable walking shoes at your workplace in case an evacuation requires walking long distances.

Car

In case you are stranded, keep a kit of emergency supplies in your car. This kit should contain food, water, first aid supplies, flares, jumper cables, and seasonal supplies.

Practicing and Maintaining Your Plan

Once you have developed your plan, you need to practice and maintain it. For example, ask questions to make sure your family remembers meeting places, phone numbers, and safety rules. Conduct drills such as drop, cover, and hold on for earthquakes. Test fire alarms. Replace and update disaster supplies.

For additional Information on emergency preparedness go to the following web site.
http://www.fema.gov/pdf/areyouready/basic_preparedness.pdf

Staff Emergency Preparedness Plan

Established a family preparedness plan

- Have a family communication plan
- Identify a point of contact that is out-of-town or in another state
- Escape routes
- Evacuation plan
- Plan for pets

Know your agency's emergency preparedness plan

- Know who to report to and procedures to follow
- Be prepared to assume tasks/roles out of your ordinary job description
- Ensure credentials (Identification cards, professional license, any local or state credential needed to move around restricted areas) are up to date and with you
- Know how supplies will be procured for patients
- Know the agencies communication tree

Have the automobile equipped

- Full tank of gas - identify gas stations that have emergency/backup power
- Maps of the area
- Shovel
- Blankets
- Portable battery operated or crank radio
- Cell phone charger
- Portable battery operated or crank flashlight
- Booster cables
- Bottled water and non-perishable high energy foods, such as granola bars, raisins and peanut butter
- Flares
- Tie repair kit
- Fire extinguisher
- First aid kit (Appendix C)

Have alternative communication devices available for use

- charged cell phone
- portable phone
- satellite phone

XII. The Business Continuity Plan

A business continuity plan will enable the organization to plan for continuing operations after a disaster. This tool differs from the other emergency preparedness tools in the packet in that it addresses recovery rather than response. The tool is designed to address all aspects of business operations that might be impacted regardless of whether the event results in a minor disruption of services or a complete destruction of the organization's infrastructure. For home care agencies, business continuity plans will need to revolve around the ability to maintain adequate staff and remain solvent.

BUSINESS CONTINUITY PLAN

Category	**Planning**	**Preparation**
Administrative	Establish a steering committee for planning	__Develop policies and procedures for business recovery __ Test and rehearse plans __Engage staff and management
Staffing	Identify critical staff necessary for operations	____Minimal number of staff for operations __ Minimum number of staff for each position Clerical_____ Nursing _____ Therapy_____ HCAs _____ MSWs_____ Data entry _____ Systems maintenance _____ Human resources _____ Other _____ ___ Determine alternate roles for each position ____ Identify staff to be cross trained
Financial	Cash on hand Establish credit line Insurance policy	Secure the amount necessary to maintain operations for several months _____ Bank phone number: _____ Contact person : _____ Amount of credit of credit line:

		_____ Insurance company name and phone # _____ _____ Contact person: _____ Secure policy off site _____
Alternate site for operations	Identify an alternate site Staff to work from home. Identify which staff will be available Outsourcing functions	Secure additional space or arrange for an alternate location to conduct business __ local hotels ___ local churches ____ Municipal buildings ____Maintain a current list of staff members prepared to work from home ____Provide staff with a written procedure for working from home ____Companies identified for outsourcing and services provided
Supplies/ Vendors	Inventory necessary supplies and equipment Establish amount needed to maintain operations Develop a plan with vendors to maintain inventory at alternate site(s)	Stockpile supplies and equipment Office Supplies/# required _____ _____ _____ Patient Supplies/# required _____

	Examine where additional equipment and machines can be purchased at reduced prices or consider storing, rather than discarding, old equipment that is currently being replaced.	_____ _____ _____ Vendors/Phone/Contact _____ _____ _____ Potential to secure extra: ___ computers ___ fax machines ___ phones ____copiers
IT and software	Develop and test procedures for recovering critical systems Develop and test a system to access data bases off site	____Identify at least two people in the organization who can implement the plan for recovery and data access procedures ____Develop a manual system for documentation
Communication	Ensure alternate communication mechanisms are available	Capability for: __cell phones __satellite phones __landline phones __ ham radio __ Two way radios
Building restoration Salvage Contractors	Maintain a list of contractors needed for building integrity Execute an arrangement with a salvage company Examine the savage company's capability to prevent and remove mold if water damage	__ Heating/AC __ Electrical __ Plumbing __ Roofing __ Windows __ Building blueprints Name/phone /contact ___ contractors

	were to occur	
Fixed Assets	List fixed assets to keep off site	_ photographs _ listing of assets and value
Other Considerations	Tenant/Landlord Agreements	Understand the rights and responsibilities of both parties

APPENDICIES

Appendix A (1)

First Aid Kit

Assemble a first aid kit for your home and one for each car. The following are recommended items to be included in a comprehensive first aide kit. Attachment A(2) is a list of recommended items for a basic first aid kit.

- Sterile adhesive bandages in assorted sizes
- 2-inch sterile gauze pads (4-6)
- 4-inch sterile gauze pads (4-6)
- Hypoallergenic adhesive tape
- Triangular bandages (3)
- 2-inch sterile roller bandages (3 rolls)
- 3-inch sterile roller bandages (3 rolls)
- Scissors
- Tweezers
- Needle
- Moistened towelettes
- Waterless alcohol based hand sanitizer
- Antiseptic
- Thermometer
- Tongue blades (2)
- Tube of petroleum jelly or other lubricant
- Assorted sizes of safety pins
- Cleansing agent/soap
- Latex gloves (2 pair)

- **Non-prescription drugs**
- Sunscreen
- Aspirin or non-aspirin pain reliever
- Anti-diarrhea medication
- Antacid (for stomach upset)
- Syrup of Ipecac (use to induce vomiting if advised by the Poison Control Center)
- Laxative
- Activated charcoal (use if advised by the Poison Control Center)

Contact your local American Red Cross chapter to obtain a basic first aid manual.

Source: American Red Cross

Attachment A (2)

Basic First Aid Kit

-

- Two pairs of Latex or other sterile gloves
- Sterile dressings
- Cleansing agent/ soap
- Antibiotic ointment
- Adhesive tape
- Adhesive bandages (variety of sizes)
- Eye wash solution
- Thermometer
- Scissors
- Prescription medication and/or supplies
- Aspirin and non-aspirin pain relievers

Source: The Department of U.S Homeland Security
www.ready.gov/america/getakit/firstaidkit.html

Additional resources:
www.pep-c.org
www.72hours.org

Appendix B

Emergency Preparedness Kits

Prepare different kits for different places and situations (**Carry on You, Grab-and-Go, Bedside, Home)**

- A "carry-on you" kit is for the essential items, such as medications, contact names and phone numbers, health information etc., you need to keep with you at all times.

- "Grab-and-go kits" are easy-to-carry kits you can grab if you have to leave home (or school, workplace, etc.) in a hurry. They have the things you cannot do without but are not so big or heavy that you cannot manage them.

- A "home kit" is your large kit with water, food, first aid supplies, clothing, bedding, tools, emergency supplies, and disability-specific items. It includes all the things you would most likely need if you had to be self-sufficient for days either at home or in an evacuation shelter.

- A "bedside kit" has items you will need if you are trapped in or near your bed and unable to get to other parts of your home.

- A "car kit" has items you will need if stranded in your car.

- Keep important items in a consistent, convenient and secured place, so you can quickly and easily get to them. (Items such as teeth, hearing aids, prostheses, canes, crutches, walkers, wheelchairs, respirators, communication devices, artificial larynx, sanitary aids, batteries, eyeglasses, contact lens with cleaning solutions, etc.)

Emergency Supplies Kits (Carry on You, Grab-and-Go, Bedside, Home,)

- Emergency health information
- Cell phone
- Standard telephone (does not need to be plugged into an electric outlet)
- Essential medications
- Other medications
- Flashlights and extra batteries. (People with limited reach or hand movement should consider low cost battery-operated touch lamps.)
- Extra batteries for oxygen, breathing devices, hearing aids, cochlear implants, cell phone, radios, pagers, PDAs.
- Copies of prescriptions
- Emergency food
- Assorted sizes of re-closeable plastic bags for storing, food, waste, etc.
- Sturdy work gloves to protect your hands from sharp objects you may try to lift or touch by mistake while walking or wheeling over glass and rubble
- Lightweight flashlight (on key ring, etc.)
- Small battery-operated radio and extra batteries

- Signaling device you can use to draw attention to you if you need emergency assistance (whistle, horn, beeper, bell(s), screecher)
- A container that can be attached to the bed or nightstand (with cord or Velcro) to hold hearing aids, eyeglasses, cell phones, etc., oxygen tank attached to the wall, wheelchair locked and close to bed. This helps prevent them from falling, flying or rolling away during a earthquake or other jarring, jolting event
- A patch kit or can of "sealant" to repair flat tires and/or an extra supply of inner tubes for non- puncture-proof wheelchair/scooter tires Keep needed equipment close to you so you can get to it quickly If available, keep a lightweight manual wheelchair for backup

Source: http://www.ready.gov/

Appendix C

Supply List

From the Department of Homeland Security
http://www.ready.gov/america/getakit/index.html

Recommended Items to Include in a Basic Emergency Supply Kit:

- Water, one gallon of water per person per day for at least three days, for drinking and sanitation
- Food, Store at least a three-day supply of non-perishable food
- Dust mask, to help filter contaminated air and plastic sheeting and duct tape to shelter-in-place
- Moist towelettes, garbage bags and plastic ties for personal sanitation
- Wrench or pliers to turn off utilities
- Can opener for food
- Local maps
- Battery-powered or hand crank radio and a NOAA Weather Radio with tone alert and extra batteries for both
- Flashlight and extra batteries
- Whistle to signal for help
- Sterile gloves (if you are allergic to Latex).
- Sterile dressings to stop bleeding.
- Cleansing agent/soap and antibiotic towelettes to disinfect.
- Antibiotic ointment to prevent infection.
- Burn ointment to prevent infection.
- Adhesive bandages in a variety of sizes.
- Eyewash solution to flush the eyes or as general decontaminant.
- Prescription medications you take every day such as insulin, heart medicine and asthma inhalers. You should periodically rotate medicines to account for expiration dates.
- Prescribed medical supplies

Additional Items to Consider Adding to an Emergency Supply Kit:

- Glasses
- Infant formula and diapers
- Pet food and extra water for your pet
- Important family documents such as copies of insurance policies, identification and bank account records in a waterproof, portable container
- Cash or traveler's checks and change
- Emergency reference material such as a first aid book or information from www.ready.gov
- Sleeping bag or warm blanket for each person. Consider additional bedding if you live in a cold-weather climate.
- Complete change of clothing including a long sleeved shirt, long pants and sturdy shoes. Consider additional clothing if you live in a cold-weather climate.
- Household chlorine bleach and medicine dropper – When diluted nine parts water to one part bleach, bleach can be used as a disinfectant. Or in an emergency, you can

use it to treat water by using 16 drops of regular household liquid bleach per gallon of water. Do not use scented, color safe or bleaches with added cleaners.
- Fire Extinguisher
- Matches in a waterproof container
- Feminine supplies and personal hygiene items
- Mess kits, paper cups, plates and plastic utensils, paper towels
- Paper and pencil
- Books, games, puzzles or other activities for children

Emergency Supply Kits for Purchase

Emergency Preparedness Service
http://www.emprep.com/
1-888-626-0889 - 206-762-0889

Homeland Preparedness
http://www.homelandpreparedness.com/
(800) 350-1489

Emergency Essentials
http://beprepared.com/Default.asp
1-800-999-1863