NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

December 1, 2016

DAL: DHCBS 16-11
Subject: Emergency Preparedness Requirements for Home Care and Hospice Providers

Dear Administrator:

The purpose of this letter is to provide guidance to Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), Hospices, and Licensed Home Care Services Agencies (LHCSAs), (agencies) in emergency preparedness requirements and guidance in developing an emergency preparedness plan. An emergency is any type of man-made (e.g. explosions, fires, chemical and biological attacks) or natural (e.g. floods, blizzards, pandemic, tornadoes and earthquakes) event. The event can be state or county wide, regional, local or limited to the agency operation (e.g. power outage, computer malfunction, illnesses, flooding). An emergency can be anything that may disrupt the normal ability of the agency to provide services or pose risks to staff and the agency.

Regulatory requirements

Regulations found in 10 NYCRR Sections 766.9(c) for LHCSAs; 763.11(a)(10) for CHHAs and LTHHCPs; 794.1(m) for Hospices; require that providers have an emergency preparedness plan that includes agency specific procedures to be followed to assure the health care needs of patients continue to be met. The governing authority or operator shall: “ensure the development of a written emergency plan which is current and includes procedures to be followed to assure health care needs of patients continue to be met in emergencies that interfere with delivery of services, and orientation of all employees to their responsibilities in carrying out the plan:”

Emergency Preparedness Plan

Each agency is required to have an emergency preparedness plan. The purpose of this plan is to ensure specific procedures are in place that will ensure the continued delivery of services to patients with minimum interruption during an emergency. Agencies should identify the types of emergencies that could impact their capacity to provide services to its patients in order to develop an effective preparedness plan. The plan must be reviewed at a minimum annually and as needed. All staff must receive training during orientation and annually to their roles and responsibilities when the plan is implemented.

The plan must address communications, resources, staff responsibilities, and patient activities and must include the following elements:

- Patient Roster: The agency must maintain a patient roster that is inclusive of all patients receiving services. The roster is used to facilitate rapid identification, and location of patients at risk.

  The patient roster must contain at a minimum:

  - patient name, address and telephone number;
  - emergency contact telephone number of family, caregiver and/or healthcare proxy;
  - Patient Classification Level (see attachment);
  - Transportation Assistance Level (TAL) (see attachment);
  - identification of patients dependent on a ventilator;
  - identification of patients dependent on the use of electricity for their health care needs; and
  - any other specific patient information that may be critical to first-responders.

- A "Call Down" list: A call down list is a staff roster with telephone numbers, and is used during an emergency to notify staff of the emergency and how/what they should do;

- An emergency communications procedure if the telephone/computer network become disabled;

- An up to date contact list of community partners that includes the local health department, local emergency management, emergency medical services, and law enforcement;

- A procedure for how the agency will respond to requests for information by community partners in an emergency;

- A procedure for participation in agency specific or community-wide disaster drills and exercises. The agency is required to conduct at least one drill/exercise annually;

- A procedure staff should employ when a patient refuses to evacuate in an ordered evacuation. The procedure may include guidance for the staff to help them mitigate the situation including the use of approaches and reasoning for persuading the patient to evacuate; appropriate notifications; and education that staff must evacuate when ordered.

The goal of emergency preparedness is to maintain continuity of care to patients, maintain the agency's ability to operate, ensure patient and staff safety, maximize resources, and ensure an orderly response to an emergency situation. Agencies should review and revise their emergency preparedness plans, and policies and procedures as appropriate to comply with the requirements outlined in this letter.

Health Commerce System

The Department uses the Health Commerce System (HCS) as the primary communication vehicle during emergencies for targeting communications and obtaining information. Agencies are required to establish and maintain a current HCS account. Agencies must have designated HCS coordinator(s) responsible for updating agency information and assigning and updating

roles in the agency's HCS Communication Directory. Agency HCS information should be reviewed at a minimum, on a monthly basis.

For the purpose of emergency preparedness, agencies are required to assign the following roles to appropriate staff:

- Administrator;
- Director of Patient Services;
- Emergency Response Coordinator; and
- HCS Coordinator.

In addition, current information must be maintained for the:

- 24/7 Facility Contact; and
- Office of the Administrator.

Emergency Response Drills

Agencies are required to participate in emergency response drills conducted by the Department through the HCS Health Emergency Response Data System (HERDS). The Department periodically conducts emergency response drills in order to:

- familiarize agencies with the communication methods used during an emergency;
- inform agencies about the information needed before, during and after an emergency event to help them develop systems to enable quick access to this information;
- familiarize agencies with the survey tools (HERDS) used to collect information; and
- allow the Department to test the communication and data collection systems prior to a real emergency event.

Home Care Emergency Response Surveys

HERDS surveys are the Department's primary means of collecting information from agencies during an emergency. Surveys will be used to collect information for the assessment of the status of the emergency response by home care agencies, identifying specific and general issues and working to resolve such issues. Agencies should be prepared to report the following information:

- agency contact information;
- agency's ability to serve current case load and surge capacity;
- anticipated staffing needs;
- total patient census with patient classification levels;
- number of patients dependent on electricity for their health care needs (*for example oxygen concentrators, wound vacuums, IV pumps, DME dependent on electricity to function)*;
- number of patients dependent on a ventilator;
- patient census by county;
- patient census, classification level, TAL, reported by county only for patients in the evacuation area(s) if applicable; and
- evacuation and repatriation status if applicable.

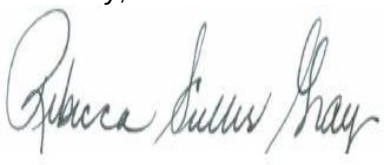
Emergency preparedness trainings, tools, and resources that may be useful can be found on the Health Commerce System and at the following websites:

http://homecareprepare.org/

http://www.health.ny.gov/environmental/emergency/health_care_providers/

The Department appreciates your cooperation and efforts in ensuring effective Emergency Preparedness planning. If you have questions please email to: homecare@health.ny.gov.

Sincerely,



Rebecca Fuller Gray, Director
Division of Home & Community Based Services

Attachments

DHCBS 16-11
Attachment

Home Health Agency Patient Classification Levels

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

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

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

Reviewed: October 2016

TALS Guidance Document

Transportation Assistance Level (TAL) Scale

Purpose:

To provide a universally recognized scale for the rapid assessment of the transportation assistance needs of patients/residents during a non-emergent, **planned evacuation**.

Principle:

For the purpose of an evacuation, patients/residents shall be assessed for their transportation assistance needs and assigned a level [TAL]. TALs are intended for use by any healthcare professional familiar with transportation modalities. TALs can be useful for logistical planning and movement of transportation resources (e.g. buses, vans, ambulances) during evacuation of a healthcare facility or home-bound patient. TALs are subject to change over time, but their use facilitates the staging of estimated transportation resources.

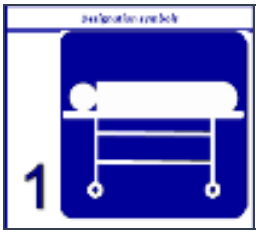
Objectives:

TALs provide a scale that is recognized and used statewide during a **planned evacuation** for the rapid assessment of transportation assistance needs of patients or residents. The scale can be used for planning and just in time re-assessment of patient/resident transportation assistance needs. The scale is not a clinical triage scale, nor does it prescribe care mechanisms. The continuity of clinical care is an independent issue and should be addressed concurrently with transportation modality.

The potential for regional/local planning variations, while upholding the integrity of the core nomenclature, is recognized. This is particularly applicable to areas of the state that have diverse transportation issues such as rural environs as opposed to the more transportation rich suburban and metropolitan regions. Special circumstances will be considered and transportation complexity will be evaluated by individual healthcare facilities and/or regions.

Levels:

For the purposes of evacuation, patients/residents shall be categorized into one of three levels. The mobility level may influence the number of staff needed to transport the patient/resident, the type of movement device required, the loading area they are relocated to and the type of transportation asset required for evacuation. The following mobility levels shall be used:

Non-ambulatory [TAL–1]	
Non-ambulatory patients/residents are those who require transport by stretcher. For emergency movement down stairs, they may be transferred to backboards, basket litters, or other appropriate devices, or rescue-dragged on their mattresses. ***Note:*** Rescue-drag is to be used as a last resort only. These patients/residents will be identified with a 'gurney' symbol when assessed for evacuation. These patients/residents are clinically unable to be moved in a seated position, and may require equipment ranging from oxygen to mechanical ventilators, cardiac monitors, or other biomedical devices to accompany them during movement. They may require clinical observation. These patients/residents may require one to two staff members (one clinical, one non-clinical) for movement, with additional staff as needed to manage life support equipment. Ambulance transport is required and in special circumstances (e.g. severe flooding) helicopter transport may be needed. These individuals must be accompanied by a clinical provider appropriate to their condition (e.g. EMT, paramedic, clinical staff member).	
Wheelchair [TAL–2]	
Wheelchair patients/residents are those who are unable to walk due to physical or medical condition. They are stable, without any likelihood of resulting harm or impairment from wheelchair transport or prolonged periods of sitting, and do not require attached medical equipment or medical gas other than oxygen or a maintenance intravenous infusion during their relocation or evacuation. These patients/residents will be identified with a wheelchair symbol when evaluated for evacuation. They can be safely managed by a single non-clinical staff member. They may be transported as a group in a wheelchair-appropriate vehicle (e.g. medical transport van or ambulette) with a single staff member or healthcare facility-designated person accompanying them.	
Ambulatory [TAL-3]	
Ambulatory patients/residents are those who are able to walk the distance at a reasonable pace from their in-patient location to the designated loading area without physical assistance, and without any likelihood of resulting harm or impairment. These patients/residents will be identified with a 'walking figure' when assessed for evacuation. Ambulatory patients/residents shall be escorted by staff members, but may be moved in groups led by a healthcare facility-designated person. The optimum staff-to-patient ratio is 1:5. They can be transported as a larger group in a passenger vehicle (e.g., bus, transport van, or private auto) with a healthcare facility-designated person accompanying them.