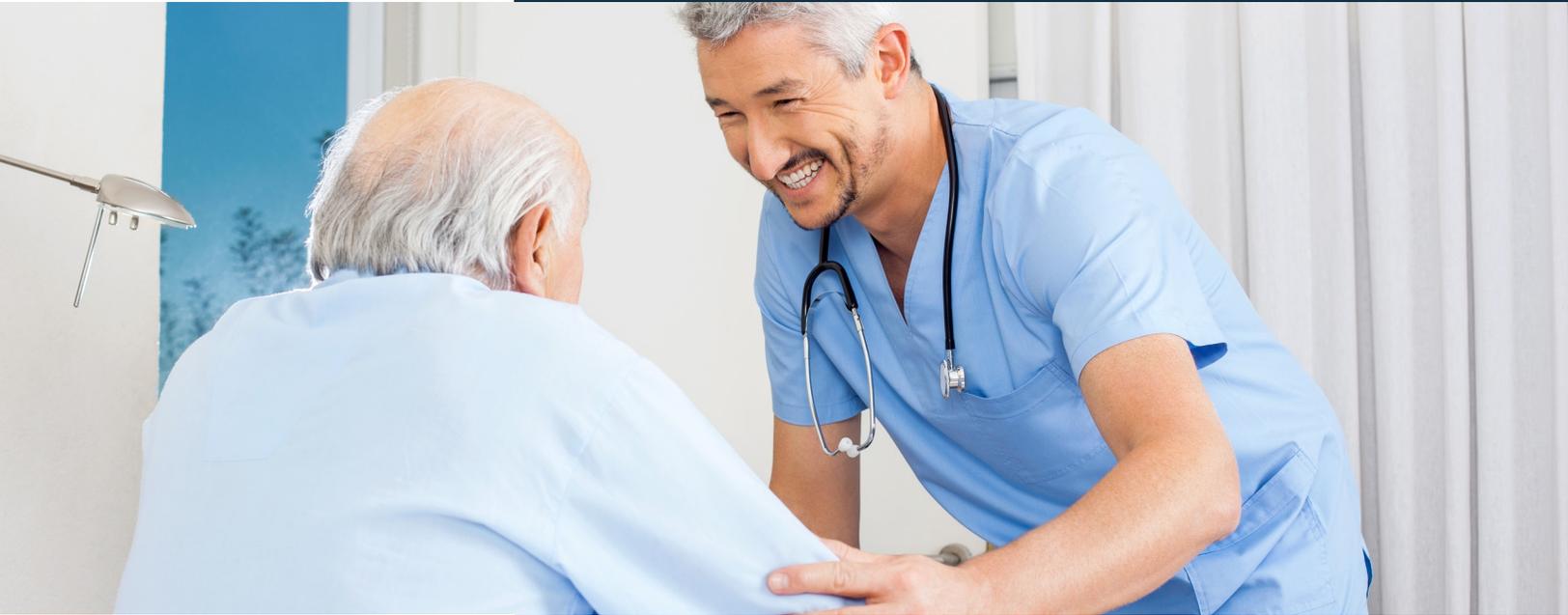




TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

HOSPICE & EMERGENCY PREPAREDNESS: Experiences from the Field



In many areas of the country, homecare and hospice agencies—while providing critical services to patients and their loved ones—have not traditionally been part of the emergency preparedness landscape. The CMS Emergency Preparedness Rule, combined with recent events requiring these providers to evacuate patients, prioritize care, or provide health care volunteers, is changing this notion across the United States. Dr. John L. Hick (ASPR TRACIE's senior editor) interviewed Sheryl Pierce, RN, MS, who currently serves as the corporate quality assurance performance improvement director for Therapy Health Services (Texarkana, TX) to learn more about the changing role of homecare and hospice agencies in community resilience.

■ John Hick (JH)

Please describe your current role, and explain how long you have been in the hospice field.

■ Sheryl Pierce (SP)

I am a registered nurse and have been in nursing since 1967. Before joining Serenity, I worked in a 500-bed hospital, which had an affiliated 120-bed skilled nursing facility with a hospice unit. I have been with Serenity/Therapy Health Services since 2010—in a more local position for six years, and now in a corporate role. When I was in Texas, I conducted an award-winning disaster drill with two states—Texas and Arkansas—and many counties regarding infection control. Members from both state departments of health and the American Red Cross also participated in the drill. Since then, I have been traveling to our corporate hospices across the country getting their emergency preparedness programs off the ground.

■ JH

Congratulations on the award! Can you tell us more about the lessons learned from the drill and how your hospices are addressing them?

■ SP

In 2014, when two nurses in Dallas contracted Ebola, both of them stated that they hadn't received enough training to deal with a highly infectious disease. At the same time, a hospital in one of the smaller communities we serve in Arkansas was experiencing a meningitis outbreak that also

sickened some staff. Had they been trained in the proper use of personal protective equipment (PPE), they could have gotten a better and quicker handle on the outbreak. I reached out to my FEMA contact in Dallas to see if I could do an infectious disease exercise based on FEMA's PrepareAthon! methodology (and funded by our corporation), and my request was granted. I invited community partners to do the drill, and we went through the proper donning and doffing of PPE. During the exercise, we practiced with the PPE we would use in the event of another meningitis case, since we agreed that was a more likely scenario. We were all pleasantly surprised that 400 invitees participated in the exercise! Since then, I have been traveling to local community health care agencies, especially extended care facilities, to work on similar planning and exercises. I have also set up a group that travels and does similar training for private home care and hospice providers. I have had the privilege of going to all our corporate hospices and setting their programs up and doing drills with them.

In 2016, Sheryl Pierce accepted the Federal Emergency Management Agency's (FEMA) Individual and Community Preparedness Award for outstanding efforts in disaster preparation.

■ JH

Is there better integration between hospice and emergency management now?

■ SP

Absolutely. In January 2017, Biloxi, Mississippi, was hit by a tornado. The following June, a tropical storm spawned another tornado in the same area, and we were so pleased to see how many changes had been made between the two incidents. In January, shelters admitted our home health and hospice patients, but they put them with the general public. This was problematic for two reasons: one, our patients typically have compromised immune systems. And two, while shelter staff assigned our patients shower times, they didn't realize that many of our patients needed a different way to maintain their hygiene because of mobility and other challenges. In June, the shelters actually had a separate area for home health and hospice patients so they weren't exposed to the general public. They stocked the area to be sure there was enough electricity, oxygen concentrators, and similar equipment for those patients. They had also set up a more mobile and private bathing system.

■ JH

Can you explain your experiences with the new CMS rule? For example, how are you meeting your requirements? Are you using specific resources or tools?

■ SP

Our agencies across the country are on pace to meet the requirements. In Chicago and Costa Mesa, California, nursing homes and hospices have been invited to join health care coalitions. In Hawaii, they are invited to be part of the exercises. In Mississippi, our agencies must have their communications plans finished before the deadline—we are using their plan as a template for our other states and agencies. I'm grateful I learned more about ASPR TRACIE at a workshop. We've used and shared [ASPR TRACIE's Evaluation of Hazard Vulnerability Assessment \(HVA\) Tools](#) and the [Hazard Vulnerability/Risk Assessment Topic Collection](#) a lot. All of our plans and policies are based on information we found at this site!

[Access the ASPR TRACIE Homecare and Hospice Topic Collection for reports, toolkits, and guidance specific to providers and patients.](#)

■ JH

Do you provide your clients with any emergency preparedness materials or education?

■ SP

We give our clients a complete set of emergency preparedness plans, and we go over the materials with them. In Texas, we focus on tornadoes. In California, we focus on earthquakes. In Hawaii, we focus on nuclear disasters, hurricanes, and tsunamis.

■ JH

What about patients who use durable medical equipment at home?

■ SP

Realistically, we know that 2–4 hour battery backups are not going to cut it during an emergency. If our patients have oxygen and a concentrator, our durable medical equipment company has to furnish a 12-hour battery to ensure that we have enough time to evacuate them. Everything is electronic, but the city has a backup database of patients in the community with needs and intensities. They are prioritized and the teams know who to go to and when.

■ JH

What's the best part about the CMS regulations and related activities?

■ SP

The fact that homecare and hospice are finally recognized as being just as medically important as hospitals. These agencies have been left out for many years for no reason. Our nurses can be excellent resources in disaster shelters, for example.

When hospice and homecare agencies fail to plan for disasters, both staff and consumers may be challenged by the response and, in some cases, patients may wind up in unfamiliar hospitals or shelters. These agencies must help consumers, their caretakers, and the staff who serve them understand what they need to do in emergencies and work with the community to ensure that shelters are prepared for their unique needs. Sometimes, shelters are unable to provide the type of support these consumers require (or may be unaware of how to provide it), but trained staff, proper equipment, and appropriate shelter space can go a long way toward keeping consumers safe destination can be identified. Also, having a plan to triage services provided is important when staffing and access are compromised or the demands on the agency increase during a disaster. Though not addressed in this interview, the ability of homecare to accept new patients can be a critical component of hospital surge capacity, as it allows safe discharge of patients that might otherwise have to remain as inpatients.

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