Table S1: Summary of tools and training resources identified from this review

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| **Name** | **Description** | **Appraisal** | **Link to Access** |
| Practice software systems  [12] | Software systems used by general practitioners can be adjusted to identify vulnerable patients based on patient records. Examples of programs are: **Medical Director** and **Best Practice** | * Computer-generated alerts/recommendations should be followed by face-to-face discussion * Has not been evaluated | N/A |
| Planning Guidebook for Non-Medical Emergencies  [18] | Outlines four steps to preparedness, and steps to achieve them.   1. Emergency contact information 2. Evacuation Plan 3. Medical and Identification Documents 4. Emergency Reserves and Supplies   Template for this information to be recorded is provided | * Specific to home-haemodialysis patients/ diagnostic-focused approach * Unclear who is responsible for using this resource/how it should be used * Has not been evaluated | <https://www.nxstage.com/wp-content/uploads/2018/04/Planning-Guidebook-for-Non-Medical-Emergencies.pdf> |
| Checklist for Assessing Client and Caregiver Preparedness  [23] | Lists factors to look for to assess client and caregiver preparedness They are:   * Safety check of the home * Identification of shutoffs for utilities * Inventory of household possessions * Evaluation of personal and home owner insurance * Development of an evacuation plan * Dissemination of Emergency Information List * Stock for the home and car of the six basics: water, food, first aid supplies, clothing and bedding, tools and emergency supplies and special items * Use an evacuation box | * No scoring or administration guidance provided * Rationale for checklist items not stated * Has not been evaluated | In article |
| South Caroline Department of Health and Environmental Control (SC-DHEC) [21] | Booklet addresses disaster preparedness planning that can be distributed to all home health agency clients. It includes:   * A preparedness kit description * Information about Red Cross and special needs medical centres | * Information provided is very brief (less than 2 pages) * Hazard specific information is not provided * Simple language is used * Checklist items are not specific to people with disabilities, generic items only * Basic information about shelters is given, but locations are not listed | <https://www.scdhec.gov/sites/default/files/Library/CR-006430.pdf> |
| 5 Action Steps to Preparedness online module  [22] | Identifies 5 critical action steps to achieve emergency preparedness and justifies the rationale for, and how to perform these steps. | * No condition or disability specific considerations/ information is included * Surveys were used to evaluate module and workshop. Results of survey suggested satisfaction with the training format and content, increased awareness of client preparedness role and steps toward improved personal, agency and client preparedness * Little insight was provided regarding participants willingness and skill level to enact this role in practice and how this has been influenced by participating in the workshop. * Clients not involved in evaluation process * Efficacy of module on practice not stated/explored | Link to module: <https://ncdp.columbia.edu/library/preparedness-tools/5-action-steps-to-preparedness/> |
| Emergency Preparedness for the Home healthcare nurse  [25] | * Outlines responsibilities of providers, sources of further information and prompting questions to strengthen enactment of them. * A table to assess a patient’s hazard vulnerability is provided with guidance on using this in practice. The table lists possible natural, human and technological emergencies and enables the user to rate the probability of, risk associated and preparedness for these events. This score can be translated into a level of risk. * This tool helps identify situations that pose the most risk for patients, increasing risk awareness and prompting engagement in preparedness * A generic list of recommended supplies is provided. Consideration should be given to the availability of food, water, medication and supportive supplies, specific to the needs of the patient. | * Detailed instructions for use not provided * Rationale not stated * Not evaluated for use in practice | In article |
| Disaster Planning Guide for Home Healthcare Providers  [33] | Identifies key provider responsibilities in preparedness as:   * Assessing needs * Preparing supplies * Making a plan * Household pet and service animal considerations * Emergency plan review * Questions prompt thinking about risk and preparedness for each of these responsibilities is provided * Template provided to capture emergency reference information- contact numbers of family and support network and medication details. | * Template to capture emergency reference is concise, however no instructions for use are provided | In article |
| Disaster Preparedness Recommendations for Major Chronic Illness  [32] | * Outlines recommendations for patients and providers that can be used to guide the actions and responsibilities of providers, specific to the conditions of cancer, cardiovascular disease, chronic kidney disease, chronic respiratory disease and diabetes. | * Limited guidance is provided on how to enact these recommendations * The recommended actions proposed in this paper reflect the view that emergency preparedness is the joint responsibility of patients and providers * Recommendations take an impairment-focused approach to disability. | In article |
| Home-Based Primary Care Disaster Preparedness Toolkit  [30] | * The toolkit is based on best practices identified from the field. It takes into account an all-hazards approach, evacuation and understanding how to shelter-in-place. It also allows the identification of the additional and unique needs of each community- i.e. local hazards. * The toolkit is structured as a table that lists each applicable standard and element from the USA Joint Commission requirements. Aligned to each element are the suggested source documents to accomplish the identified task. * The toolkit provides examples of the varied preparedness roles that could be undertaken by the multidisciplinary members of a home-based primary care team, helping different provider types understand their roles and contributions in enabling preparedness. * These documents provide checklists, suggestions and concrete examples of tools that would be useful to home-based-primary care programs. * Length of time in the program manager role was not found to be associated with perceived helpfulness * The all hazards approach, link to Joint Commission guidelines, its evidence-based foundations and specificity towards the type of client (e.g., veterans) and the contributions that can be made by each discipline appealed to respondents | * Respondents reported that they would still need/benefit from training on how to implement the tool in practice, as well as mentioning that the tool was too lengthy. * Focus on provider responsibilities in organisational preparedness * This tool has not been implemented or evaluated for its use by providers on the frontline of community care * Clients were not included in the evaluation process. | Full resource not available  Screenshot and description of toolkit provided in text |

*Table S2: Summary charting of included articles*

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| **Citation** | **Study Methods** | **Role and Capacity of Providers** | **Tools and Training Resources** | **Appraisal** |
| **Australia** | | | | |
| [12] | Not stated | * General practitioners (GP) are ideally placed to identify vulnerable patients and refer them to services that may assist them in enhancing their disaster resilience * They are the most accessed health service in Australia | * Adjustments can be made to practice software systems to enable vulnerable patients to be identified using patient records and refer them to community support services | * In order to be effective, computer-generated, individualised recommendations should be followed by face-to-face discussion which can be delivered by a GP, nurse practitioner or community service provider * A trial of such system has not been performed and is required to evaluate its effectiveness, efficiency and acceptability to patients, GPs and practice staff |
| **Japan** | | | | |
| [32] | **Literature Review**  Electronic searches conducted using PubMed and Google Scholar, using search terms ‘disaster\*’, ‘chronic disease\*’, and ‘guidelines. Studies published in English, between January 1, 2001 – June 30, 2014, from developed countries only | * Providers can contribute to enhancing the disaster preparedness of their patients through the provision of education, particularly in relation to the nature and extent of their condition. * Providers should also assist the development of plans and kits for disaster preparedness * Providers can give patients individualised recommendations | * Outlines condition-specific recommendations for patients and providers that can be used to guide the actions and responsibilities of providers | * Limited guidance is offered in this paper on how to enact these recommendations * The recommended actions proposed in this paper reflect the view that emergency preparedness is the joint responsibility of patients and providers * Recommendations take an impairment-focused approach to disability. |
| **New Zealand** | | | | |
| [13] | Three surveys were created and distributed to participants. Results were analysed using descriptive statistics  Client (70)  Support worker (53)  Management (15)  N = 138 | * Support workers are well-placed to engage with vulnerable communities because of their existing, trusted relationships with their clients. * Community based organisations are unlikely to provide direct support to clients during an emergency. They can enhance the emergency preparedness of their clients by improving their personal support networks and supporting their participation in emergency preparedness activities | * Support workers and management report the need for training to support staff in understanding and undertaking this role. | * No guidance is provided in this paper on how to implement this recommendation in practice, and what ‘emergency preparedness activities’ entails is not specified |
| **South Korea** | | | | |
| [14] | **Scoping Review**  Studies, articles and grey literature published in English, between 2000 and 2014.  N = 15 | * Design plans for evacuation and shelter accommodation that are accessible and functional for vulnerable groups * Survey risks and resources in the community * Educate community personnel about the about the evacuation of people with disabilities according to types of disability * Be knowledgeable about managing emergency and functions of key organisations * Inform stakeholders of the role of OT in disaster preparedness and management * Partner with key organisations and stakeholders * In order to enable social inclusion of people with disabilities in disaster management in preparedness, a shift from hospital-based therapy to community-based practice is recommended | * Not stated | * The roles identified are described in a skeletal manner only. No guidance is provided to implement these roles in practice. |
| **United States of America** | | | | |
| [15] | Not stated | * Public health professionals   can play an active role in increasing the disaster preparedness of vulnerable older adults with chronic disease needs by:   * Developing inter-agency partnerships to strengthen emergency response. Providing appropriate public information on emergency preparedness in appropriate formats |  |  |
| [16] | Semi-structured interviews with 31 practitioners and leadership at 5 Veteran’s Health Administration Home-Based Primary Care Programs regarding disaster preparedness for patients.  Transcripts analysed using constant comparative analysis techniques.  Program Managers (6)  Nurse Practitioner (5)  Registered Nurse (10)  Social Worker (4)  Physical Therapist (1)  Occupational Therapist (3)  Psychologist (2)  (N=31) | * Sites were required to develop their own policies regarding disaster preparedness. * Sites varied in their policies and initiatives to prepare patients. Examples of practice were: * Scheduled drills every six months. * Making frequent phone calls to prepare patients for inclement weather. Phone calls were made using risk categorisation sheets. At one site, one team member (unspecified) was responsible for alerting all practitioners of the weather/hazard risk, and then each practitioner was responsible for contacting their patients. At other sites, a program director, nurse practitioner and social worker were responsible for contacting all patients. * Preparedness information and education was primarily provided in the initial visit. There were challenges to this approach, as often practitioners reported that they aimed to deliver too much information, that the process become ineffective, particular for clients with cognitive impairment or that were very frail. * The focus of their role in preparedness for patients was reported as emphasising individual responsibility and self-sufficiency of patients. Practitioners remarked the importance of recognising the rights of their clients to make their own choices. The role of the program and its practitioners is supportive, and involves educating the patient and assisting with the identification of caregivers and other resources that can be utilised by the patient * Three of the five sites involved shared this view of the role of the program and practitioners, and at these sites, the social worker was either the lead or contributed to disaster assessment and education in a major way. * At the other two sites, the social worker was either not aware or not involved in disaster assessment and education. At one of these sites the occupational therapist was primarily responsible for providing training to staff. * When different service groups were tasked with leading preparedness activities, differing perspectives in how preparedness activities were actualised resulted. When the social worker was in charge, the majority of the assessment focussed on the patient’s support structures. Such variations have the potential to lead to inadequate attention being given to the certain patient needs, if other types of professionals do not provide adequate input into preparedness policy and training. * Staff understanding of their role in an emergency is crucial to the success of the preparedness plan. * Sites that practiced drills more frequently felt more prepared and more comfortable with their preparedness protocols | * Practitioners reported a need for more training on how to individualise and tailor patient education to their patients, particularly those experiencing cognitive impairment. * The level of education provided to the patient varied between practitioners. Some practitioners reported being unfamiliar with the content of the preparedness binder provided to patients, and others reported only providing the binder without any additional or supplementary verbal education. | * There is a lack of nationwide consistency in the preparedness policies of home-based primary care program, as each program develops their own. * Practitioners report challenges in engaging and motivating patients in disaster preparedness activities – i.e. home evacuation drills. * Factors such as financial situation and availability of social networks impacted the patient’s willingness to engage. As some patients had challenges obtaining food, water and medication for daily use, there were challenges in obtaining advance prescriptions and additional food and water, as a preparedness measure. * Practitioners report challenges in finding time to review and understand preparedness information as well as incorporate it into visits. It was often not prioritised. * The primary-care focus of these programs was reported to limit the amount and type of preparedness activities conducted with patients. |
| [17] | Semi-structured interviews with 21 home health and personal care administrators across Georgia and Southern Carolina. Transcripts analysed for disaster preparedness themes  Health and personal care administrators from Georgia (12) and Southern California (9) | * Definition of disaster varied between type of agency. Patients of personal care agencies were usually more dependent on staff, and as such a disaster was viewed any disruption to the continuity or delivery of care, whereas health agencies perceived disasters as large-scale events that disrupt the function of the agency as a whole. * Personal care agencies appeared to take a more holistic responsibility of their client’s well-being, whereas home health agencies appeared to view their role as strictly about providing medical care and relied upon family members to develop preparedness plans for patients. It is unclear if or how personal care agencies specifically worked to strengthen patient’s personal preparedness. The limited training or resources reported to be received by providers, questions the effectiveness of the education provided to patients. * Personal care agencies spent more time with patients. This shaped their perception of responsibility for preparedness. * Home health agencies focussed on ensuring continuity of medical care in the event of an emergency and were less involved in increasing patient’s personal preparedness. | * 7 out of 21 respondents had not received any formal disaster training. Many relied on past experience with disasters to inform their practice. |  |
| [18] | Not stated | * Providers can enable the emergency preparedness of home-haemodialysis patients by assisting their engagement in the following key preparedness activities: * **Building a list of contacts:** Providers can assist patients in identifying a local emergency contact, out of area contacts, first responders, local emergency shelters, pharmacies, hospitals and clinicians * **Devising an evacuation plan:** Providers can assist patients plan for immediate evacuation. They must know whether the patient can evacuate immediately, independently or requires support. If support is required, this role should be allocated to a specific person/people. A location to evacuate to should be specified, with a person/people allocated to meet the patient at this location. This plan should also consider the route and method of transportation utilised by the patient to reach this evacuation point, with consideration of traffic incidents and road and public transport closures in the event of emergencies. Patients should be advised to map out and practice driving different evacuation routes that head in different directions depending on circumstances. * **Get it down on paper:** Providers can assist the patient write down a preparedness plan on paper. This plan should include information about the patient’s dialysis prescription, allergies, medications, medical history and most recent labs if possible. * **Preparing a disaster kit:** Providers can assist patients put together a disaster kit. The contents of a general disaster kit are provided in this paper, however items specific for a home-haemodialysis population are not specified. * **Keep Supplies on Hand:** A complete seven-day back up inventory of supplies- dialysate bags, cartridges, saline, tubing and treatment medications should be kept on hand. Providers can assist in obtaining these supplies. | * The NxStage planning guidebook is available at: <https://www.nxstage.com/wp-content/uploads/2018/04/Planning-Guidebook-for-Non-Medical-Emergencies.pdf> can be utilised by patients individually, or in collaboration with providers to implement the above recommendations, as well as identify and mitigate risks. | * The NxStage planning guidebook has not been evaluated for efficacy |
| [19] | Semi-structured interviews and constant-comparative analysis  Care Manager/Coordinator (5)  Nurse (5)  Social Worker (4)  Physician (3)  Therapist – recreational/respiratory (2)  Other hospital coordinator (2)  (N= 21) from spinal cord injury and/or disorder centres (N=7) in the US that had sustained a natural disaster since 2003.  Veterans with spinal cord injuries and/or disorders (N= 19) | * A range of activities intended to improve disaster preparedness and facilitate planning among Veterans with spinal cord injury and/or disorders were described, and invoked in the course of routine care these were: * Plans were initially developed by patients, and providers were able to assist the further development of this plan, by prompting patients to consider and address the limitations of their plans * Encouraging patients to cultivate strong relationships with local agencies, neighbours, and other community members may strengthen disaster preparedness and resilience | * Providers designed spreadsheets and templates to record veteran contact details, next of kin, and the specifics of their preparedness plans. This information was reviewed and updated with patients at clinic appointments * Tools developed as part of routine care can provide a link to veterans if and when a disaster occurs. Providers who utilised a spreadsheet to monitor patient preparedness reported the view of preparedness as an ongoing process. * Incorporation of an emergency preparedness curriculum into pre-existing classes offered to newly injured veterans, annual health fairs and printed materials * Use of the spreadsheet enabled providers to reinforce preparedness information seasonally, particularly at times when risk of local hazards was high, i.e. during hurricane season * Home-based patients were mailed letters and preparedness manuals containing local health and emergency contacts, as well as scenarios that they should be prepared to confront * Basic tools such as resource checklists, vulnerable patient lists, templates to record plans are perceived as helpful for both providers and patients. These tools help to promote shared knowledge and support efficient communication between providers, and between providers patients | * Home-based care offers an opportunity to check the extent of patients preparations and identify potentially ‘high risk’ patients in the community * Strategies implemented enabled ongoing development and evaluation of patient preparedness plans, increasing familiarity with existing plans and risk awareness * Disaster preparedness should be built into routine patient care. Opportunities for providers and patients to have candid conversations about the threats posed by disasters and the corresponding preparedness should be integrated into the flow of clinical work. Utilising existing clinical practices and infrastructure may be a means of doing so. |
| [1] | Not stated | * Not stated | * A function-based approach to disaster preparedness would be beneficial for all individuals. This article proposes a framework built on five essential function-based needs (C-MIST): * Communication Needs * Medical Needs * Maintaining Functional Independence Needs * Supervision Needs * Transportation Needs | * C-MIST offers a framework for the consideration of functional limitations broadly, as well as prompts that they are addressed in a preparedness plan * C-MIST is an approach to thinking and planning, however does not provide specific direction in meeting the needs or risks identified * In order to enable preparedness and resilience for people with disabilities and/or functional limitations, their inclusion in such processes must be fostered. Considering and compartmentalising people with disabilities and/or functional limitations as separate to the wider population has caused their exclusion, reduced engagement in preparedness and increased negative consequences in disaster situations. |
| [20] | Retrospective study evaluating the preparedness and response measures for Hurricane Katrina. In-depth interviews were conducted with leadership at five home health agencies  Top two administrative staff members at five home health agencies  (N=10) | * Provide patients and caregivers with disaster preparedness education * Identify patients that are high risk | * Patients signed forms indicating that an agency representative had explained the agency’s emergency protocol and that they had understood and agreed with it. * Agencies prepared and left folders at patient’s homes with information on evacuation procedures, how to prepare kits, which shelters they should evacuate to, contact numbers, and how to contact the agency if they needed assistance. * Agencies kept lists of patients at particularly high risk, or that had transportation needs. * Staff training was reported to be provided unevenly prior to Hurricane Katrina. Some agencies provided routine and comprehensive training, however the format and effectiveness of this is not stated. | Key lessons learnt were:   * Not limiting preparedness education and information to written documents. * Assessing patient’s familiarity with the written plan * Coordinate with other agencies, and assist their understanding of patient needs * Identify patients reluctant to evacuate * Practice drills |
| [21] | Administrators of home and personal care agencies were interviewed to develop a telephone survey instrument. The telephone survey was conducted with administrators of home and personal care agencies. Grounded theory and thematic analysis were used to analyse data.  Personal care agency administrators (16)  Home health care agency administrators (5) | * Perception of roles in and levels of preparedness varied greatly between sites and agencies.   **Personal Care Agencies:**   * Agencies that were moderately prepared indicated that they assisted clients develop plans. One site commented that at the initial visit, and every 30 – 60 days, this plan is reviewed, and the patient’s home is reviewed for safety. During this, practitioners report prompting patients to consider their potential plans and actions in a number of emergency scenarios. * Providers report providing clients with emergency numbers and hazard-specific advice and education. The extent and source of this information is unclear. * Agencies that were more prepared articulated the process of developing a plan with patients. A template was used to record this plan, as well as list local emergency contacts. A copy of this plan was kept with the patient and the agency. This template is not provided. These agencies provided written instructions and recommendations for clients. * The more prepared the agency, the more specific their plans to coordinate with other agencies and services during an emergency. * Some agencies did not recognise or believe that they had a responsibility to assist clients with preparedness.   **Home health Agencies:**   * Patients were provided with written preparedness information in the form of a booklet upon admission that details emergency preparedness information and their responsibility as a patient. Providers also provide the patient with recommendations on what to do in an emergency. |  |  |
| [22] | Survey used to evaluate user knowledge and satisfaction with the 5 steps to preparedness online educational module  Direct service delivery personnel of community human service organisations (N=143) | * The inclusion of community human service organisation’s direct service delivery personnel, who have intimate knowledge of their client’s vulnerabilities and can best identify specific key issues and planning considerations can enhance emergency preparedness * Engaging direct service delivery personnel in participatory and collaborative training workshops that provide meaningful tools to help them assist their clients is required | * The Columbia Regional Learning Centre developed a participatory workshop that leverages the knowledge and experience of direct service delivery personnel to inform and create client preparedness tools that address personal preparedness and functional needs * Results of survey suggested satisfaction with the training format and content, increases in awareness of a client preparedness role and steps toward improved personal, agency and client preparedness | * No insight was provided regarding participants willingness and skill level to enact this role in practice and how this has been influenced by participating in the workshop. |
| [23] | Not stated | * Home health nurses are well positioned to convey disaster education to their clients and caregivers * They must be able to assess the client and caregiver’s willingness to learn, ability to learn and ability to self-care to prepare them to manage and adapt in an emergency * The managers of home health agencies must be able to evaluate, teach and reinforce the disaster preparedness skills needed the home health nurse, in order for them to be able to enact this role in practice. This includes the development and implementation of relevant tools and training to assist the nurse’s knowledge and skills in disaster preparedness. This can be in the form of checklists, training, supervision and mentoring * The home health nurse should encourage and assist their client and their caregiver to compile the following information including personal details, medical details and equipment needs and distribute it to their emergency contact people | * A checklist is provided to assist nurses assess client and caregiver preparedness. Steps outlined are: * Safety check of the home * Identification of shutoffs for utilities * Inventory of household possessions * Evaluation of personal and homeowners insurance * Development of an evacuation plan * Dissemination of Emergency Information List * Stock for the home and car of the six basics: water, food, first aid supplies, clothing and bedding, tools and emergency supplies and special items * Use an evacuation box | * This checklist provides a guide of steps to be taken to assess and ensure preparedness of clients and caregivers, however doesn’t provide specific guidance in implementing these steps. |
| [24] | Questionnaire developed to reflect national guidelines for preparedness focussed on the following (1) demographic information (2) specific recommendations for preparedness (3) perceived level of preparedness (4) perceived barriers to preparedness  Descriptive statistics used to analyse findings  Patients of Dauphin and Bronx County (N=1024) | * Physicians should participate in disaster planning by providing anticipatory guidance regarding preparedness, with consideration given to the unique issues faced by their patients * Respondents that had discussed community evacuation plans with their primary care physician were more likely to have a family response plan * Families that discussed preparedness with their primary care physician were more likely engage in national recommendations for preparedness * Suggested strategies include distributing informational pamphlets, web based resources, instructional videos in offices or waiting rooms, or email reminders. |  | * It is unclear how physicians, can or have engaged in this role. More information is needed regarding strategies and tools that can be used by physicians to incorporate preparedness information in consultations, and the effectiveness of these. |
| [25] | Not stated | * **Learning possible events and response plans** * Provides some possible sources of this information * Recommends that once this information has been learnt, families, extended families and neighbours need to be informed of the patient’s needs in such an event. * **Assess threat risk** * **Learn community warning systems** * Details sources of this information * **Assess patient and environment resources** * Assess home for potential barriers in case of emergency. Provides some prompting questions to identify barriers. Also prompts consideration of the patient’s family and social networks and the level of assistance they would require in an emergency. * **Build a personal support network** * This network can include anyone the patient trusts and who can be trusted to check on the patient in case of emergency * They should know the patient’s capabilities and needs, and be available to offer help within minutes of an emergency * They should be provided a complete written assessment of the patient’s needs and include copies of emergency contact information, a medical information list, disability-related supplies and special equipment list, evacuation plans and any other relevant documents * Arrange specifically how the network will contact the patient in an emergency, provide education regarding the use of patient care equipment and practice moving essential equipment and supportive devices. * **Prepare and stock supplies:** | * A table to assess a patient’s hazard vulnerability is provided with guidance on using this in practice. The table lists possible natural, human and technological emergencies and enables the user to rate the probability of, risk associated and preparedness for these events. This score can be translated into a level of risk. * This tool helps identify situations that pose the most risk for patients, increasing risk awareness and prompting engagement in preparedness * A generic list of recommended supplies is provided. Consideration should be given to the availability of food, water, medication and supportive supplies, specific to the needs of the patient. |  |
| [26] | Not stated | * Providers should identify high-risk populations and identify what can be done to eliminate or decrease their vulnerability * Suggests providers assess populations at risk for special needs during a disaster and develop plans to care for them during a disaster |  | * No further guidance is offered to implement these recommendations in practice with clients |
| [33] | Not stated | * Identifies key responsibilities in preparedness as: * **Assessing needs** * **Preparing supplies** * **Making a plan** * **Household pet and service animal considerations** * **Emergency plan review** | * Template provided to capture emergency reference information- contact numbers of family and support network and medication details. | * Vague guidance, in the form of questions to prompt thinking about risk and preparedness for each of these responsibilities is provided |
| [27] | Concept Paper | * Occupational therapy contributions in disaster preparedness are identified as: * Ensuring planned emergency sites are organised in ways that minimise environmental barriers * Help employers design plans to evacuate workers with disabilities effectively * Train staff and volunteers to work in shelters for people with special needs * Obtaining knowledge of available resources and understanding of local response plans   These contributions are only briefly mentioned, with no detail provide on how to perform these in practice |  |  |
| [28] | The 2006 – 2007 Behavioural Risk Factor Surveillance System (BFRSS) of 6 states surveyed respondents regarding their general emergency preparedness.  Chi square analysis examined the relationship between general preparedness levels and disability status  Respondents of 2006 – 2007 BFRSS who identified as having a disability  (N= 188,288) | * Proposes that emergency preparedness for people with disabilities could be facilitated by physically connecting with people with disabilities for the specific purpose of providing disaster preparedness education, to address issues of exclusion and lack of information or misinformation. * Suggests that health care providers that provide home health services could assist home health planning by providing information in the client’s home | * Brochures created by the National Organization on Disability outline disaster readiness tips for people with mobility, cognitive and sensory disabilities. These brochures contain information on readiness, evacuation and preparing an emergency kit. * Limitations of these resources include focus on ‘type’ of disability without considering other factors influencing preparedness for people with disability i.e. level of education, health literacy and financial resources. These resources are only published in English, and their ease of access could be enhanced by offering publication in multiple language including Braille and use of simple language. These resources are no longer accessible online. | * People with disabilities need to be empowered and supported to take initiative to improve their own preparedness * Challenge to this approach is that many people with disabilities do not require or receive home health services |
| [29] | 32 semi-structured interviews with practitioners and leadership at 5 Veterans Health Administration Home Based Primary Care Programs (3 urban, 2 rural)  Interview transcripts analysed using content analysis techniques  Multidisciplinary teams member (n=32) working in selected sites (n=5)  Nurse Practitioner (5)  Registered Nurse (10)  Social Worker (3)  Physical Therapist (1)  Occupational Therapist (3)  Psychologist (2)  Program Manager (6) | * The responsibility for conducting the disaster assessment component of the initial patient assessment fell to four different types of professionals- nurse practitioner, registered nurse, occupational therapist or physical therapist. * Each practitioner has varying and specialist skills that impact their ability to conduct this assessment- for example, occupational therapists and physical therapists were identified as suitable for the role as they are responsible for obtaining adaptive equipment for patients. * Roles of practitioners varied between sites * Social workers were often responsible for assessing the caregiving situation and home life * Physical therapists and occupational therapists were most likely to report the use of a non-standardised, self-developed template that noted the patient needs and characteristics- i.e. portable oxygen dependency, falls risk, emergency preparedness- as well as the risk and safety features presented by their environment- i.e. availability of fire extinguishers or escape route from home. * Providers reported being able to gauge the level of information that was being retained by clients and being able to tailor the delivery of information to highlight aspects particularly pertinent to that client. * Two of the occupational therapists in the study reinforced the importance of ensuring that the client assume responsibility for their own preparedness, with the clinician supporting this process. These clinicians perceived their role as equipping their client with the education and skills and providing recommendations to enable preparedness, whilst respecting their right to make their own decisions. * Providers who valued the importance of disaster preparedness in their own lives were more likely to engage their clients. * The role of home-based primary care in disaster preparedness was described as fostering patient’s self-sufficiency and the availability of support networks in case of a disaster situation. It is still unclear what this role looks like in practice. | * Templates and tools used to assess or record the initial assessment of disaster preparedness of patients varied widely among sites, with some sites not having a template in place * Providers reported that existing resources for patients could be improved, particularly by increasing the specificity, direction and accessibility they offer- i.e. detailing items to be included in an emergency kit and ensuring they are more reader-friendly. * Template based on emergency priority rating scale to establish risk categorisation or non-disaster specific template |  |
| [30] | An online survey was sent to all Veteran’s Health Administration (VHA) program managers (N=146) to assess the utility of this toolkit among VHA home-based primary care programs.  Descriptive statistics were used to describe the characteristics of each site. Bivariate analyses using chi-square tests tested the associated between length of time at the program and the helpfulness of the toolkit in three distinct areas- tool clarity, comprehensiveness and overall impression.  Program managers of VHA Home-Based Primary Care Programs  (N=77) |  | * The toolkit is based on best practices identified from the field. It takes into account an all-hazards approach, evacuation and understanding how to shelter-in-place. It also allows the identification of the additional and unique needs of each community- i.e. local hazards. * The toolkit is structured as a table that lists each applicable standard and element from the Joint Commission requirements. Aligned to each element are the suggested source documents to accomplish the identified task. * The toolkit provided examples of the varied preparedness roles that could be undertaken by the multidisciplinary members of a home-based primary care team, helping different provider types understand their roles and contributions in enabling preparedness. * These documents provide checklists, suggestions and concrete examples of tools that would be useful to home-based-primary care programs. * Length of time in the program manager role was not found to be associated with perceived helpfulness * The all hazards approach, link to Joint Commission guidelines, its evidence-based foundations and specificity towards the type of client- veterans- and the contributions that can be made by each discipline appealed to respondents | * Respondents reported that they would still need/benefit from training on how to implement the tool in practice, as well as mentioning that the tool was too lengthy. * This tool has not been implemented or evaluated for its use by providers on the frontline of community care * Clients were not included in the evaluation process. |
| [9] | 7 Semi-structured interviews were conducted with practitioners and leadership.  Transcripts were analysed constant-comparative analysis techniques  Individuals in leadership positions, as well as practitioners in nursing, occupational therapy, social work and psychology. | * The occupational therapist was responsible for conducting an emergency risk assessment within 30 days of a new patient being admitted to the service. It is unclear what this assessment entailed. * Providers noted that this information was not always reviewed at the initial evaluation. Reasons for this are not described. * All follow up activities regarding disaster preparedness were referred to the occupational therapist on the team. * The two occupational therapists on the team described self-developed templates to assess and monitor preparedness, and a high level of variation in practice between sites. These templates are not provided, or described in detail. Assessment tools are reported to revised based on experiences with patients, but it is unclear how and how often this happens. It is unclear how much consultation occurs between these two clinicians regarding the revision of this tool. * Other team members – excluding occupational therapists- reported that the occupational therapist would provide additional disaster preparedness information to patients, however the occupational therapists included in the study reported that this was not extensive. This demonstrates a lack of clarity surround a provider’s perception of their own roles in preparedness as well as their understanding of the roles of other team members. | * Patients were provided with an information handbook containing disaster preparedness information at the initial evaluation. The provider conducting this evaluation- usually a nurse practitioner or registered nurse, was responsible for reviewing this information with the patient and caregiver if present, at this initial evaluation. The contents and extent of this information is unclear, however it appears to include questions surrounding evacuation, the provision of safety devices such as smoke alarms, and the availability of caregiver support in an emergency. * The primary challenges identified by respondents to patient engagement in emergency preparedness activities included cognitive impairments, patient’s willingness to invest in preparedness activities, and limited resources. Patient’s required additional support from providers to implement recommendations to ensure preparedness, as well as monitor and review preparedness levels. * Provider recommendations included training to focus on strategies to engage patients and encourage them to participate, more consistent time spent on patient education, formalisation of the initial assessment, and having emergency preparedness be formally addressed on a more consistent basis * Leadership reported that providers received formal training on how to prepare their patients for a disaster, however the format and efficacy of this is unknown. None of the providers included in this study mentioned this training when probed. * Past experience with disasters appeared to form the bulk of preparedness amongst respondents. * Educational resources available being unsuitable for use with patients, with content being too overwhelming or uninviting. As well as this, most respondents felt they not have the time to regularly review or update these resources. Strategies to overcome this included using larger font and uncomplicated language. * Limited training or experience in effectively conveying this information to patients * Lack of time to adequately cover disaster preparedness as well as other responsibilities * Difficulty motivating patients to take preparedness steps, particularly in regions were disaster risk was perceived as low. | * Policies were self-developed by each site * There are benefits and limitations when multiple professionals are responsible for enabling preparedness. Each profession has a differing scope of practice, and inclusion of multiple professions allows for robust intervention. However, when various team members are responsible for assessment and delivery of information regarding preparedness, responsibilities may fall through the cracks. A standardised preparedness template has been suggested to avoid this limitation. |
| [31] | **Literature Review**   * Be pre-experimental/case study/descriptive studies * Appear in a peer reviewed journal * Focus on a program strategy that examined emergency preparedness activities on the part of home health care providers * Be published in English and implemented in the United States   (N=11) | * Actions taken by providers in included studies to ensure patient care in an emergency included: * Triaging patients by assigning a risk category * Creating a patient phone tree so that staff could efficiently contact patients in the event of an emergency * Identifying patient transport needs, which included identifying options for evacuating patients and how to share this information with community and hospital disaster planners * Registering patients who are dependent on essential electrical equipment with utility companies * Conducting emergency drills with patients | * Resources identified to assist patient education and preparedness fell under four main themes: * Developing an emergency response and evacuation plan * Preparing an emergency kit * Compiling emergency reference information * Pet considerations | * What should be included in each of these resources differed between sources. The lack of consistency across the included studies underscores a gap in understanding patient needs and how home health agencies can most appropriately use their role to address these needs. |