CONNECTIONCT LONG TERM CARE MUTUAL AID PLAN (LTC-MAP)
Annual Education Conferences
April 29 – May 3, 2019

Andy McGuire & Brad Austin

Agenda

Morning Session

8:00am   Check-In & Registration
8:30am   Welcome and Introductions
8:35am   Regional Healthcare Coalitions Updates
8:45am   CMS EPP (E-Tag) Deficiency Updates
9:45am   Break
10:00am  Lessons Learned from Recent Facility Evacuations
11:00am  Preparing for the 2019 Annual Full-Scale Exercises
11:30am  Steering Committee Meeting (RSC Members Only)
Regional Healthcare Coalitions / ESF#8 Updates

The Future of HPP
Setting a Path for Connecticut’s Healthcare Preparedness System
HPP FOA – What’s New?

1. Encourage additional HCC membership
2. Designate lead or co-lead hospital and 1 FTE
3. Encourage hospital partnerships with NDMS
4. Develop state and HCC specialty surge annexes
5. Complete HCC Surge Estimator Tool
6. Flexibility for geographically isolated areas (FAR 4 + 60 miles between hospitals)

Encourage Additional HCC Membership

The four core members of HCCs will remain the same. However, HPP encourages additional representation from these functional entities that are required to support acute health care service delivery. These are not limited to the following:

- Medical supply chain organizations
- Pharmacies
- Blood banks
- Clinical labs
- Federal health care organizations
- Outpatient care centers

In addition, all HCC inpatient facilities, must demonstrate existing transfer agreements specifically to the following specialty care centers:

- Pediatric centers
- Trauma and burn centers
Designate Lead or Co-Lead Hospital and 1 FTE

1. All HCCs must designate a lead or co-lead hospital or health care organization.
2. All HCCs should fund at least 1.0 FTEs to support the following role requirements:

**CLINICAL ADVISOR**
- Provide clinical guidance and coordination pertaining to acute medical surge readiness and response for CBRNE, trauma, burn, and pediatric emergencies. Individual must be clinically active and should be from the lead or co-lead hospital or health care organization.

**HCC READINESS AND RESPONSE COORDINATOR**
- Oversee planning, training, exercising, operational readiness, financial sustainability, and evaluation of the HCC.

Develop State and HCC-Level Specialty Surge Annexes

- Awardees and HCCs will develop complementary state and coalition-level annexes to their base surge capacity/trauma mass casualty response plan to manage a large number of casualties with specific needs.
- Five annexes will be developed and tested over the course of five years in this order:
  - Pediatric → FY 2019
  - Burn → FY 2020
  - Infectious Disease → FY 2021
  - Radiation → FY 2022
  - Chemical → FY 2023
Encourage Hospital Partnerships with NDMS

Hospitals should enter into formal agreements with the National Disaster Medical System (NDMS) to serve as receiving facilities if they:

1. Meet the eligibility criteria for participation in the NDMS
2. Are members of HPP-funded HCCs

This is intended to improve the awardee's and HCC's surge capacity and enhance hospital preparedness in response to a medical surge event.

Complete HCC Surge Estimator Tool

HCCs must complete the HCC Surge Estimator Tool to support coalitions in determining surge capacity. Three distinct variables drive rapid development of surge capacity and vary significantly between hospitals:

1. Use of all available "staffed" beds, including closed units that could be rapidly re-opened with appropriate staff but are otherwise equipped and appropriate for inpatient care
2. Use of pre-induction, post-anesthesia, and procedural area beds that can be used for temporary inpatient care, usually at an intermediate care (telemetry) or higher level
3. Ability to generate space or reduce the numbers of patients requiring evacuation by early discharge of appropriate current inpatients to support surge discharge
Integrate with Regional Pilot Programs

For those jurisdictions in which a Regional Disaster Health Response System (RDHRS) state-level or regional entity has been identified, HCCs must integrate their planning, training, exercising and response, and evaluation and situational awareness activities.

HPP Capabilities

• Foundation for Healthcare and Medical Readiness
• Healthcare and Medical Response Coordination
• Continuity of Healthcare Service Delivery
• Medical Surge
## CMS Emergency Preparedness Program (E-Tags) Deficiencies

### Top 10 Most Cited E-Tags in CT / MA / RI / Nationally

<table>
<thead>
<tr>
<th>TAG</th>
<th>Description</th>
<th>CT</th>
<th>MA</th>
<th>RI</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001</td>
<td>Establishment of the Emergency Program (EP)</td>
<td>4</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0004</td>
<td>Develop EP Plan, Review &amp; Update Annually</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>0006</td>
<td>Plan Based on All Hazards Risk Assessment</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0007</td>
<td>EP Program Patient Population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0009</td>
<td>Local, State, Tribal Collaboration Process</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0013</td>
<td>Development of EP Policies &amp; Procedures</td>
<td>7</td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>0015</td>
<td>Subsistence Needs for Staff &amp; Patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0018</td>
<td>Procedures for Tracking of Staff &amp; Patients</td>
<td></td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>0020</td>
<td>Procedures for Evacuation &amp; Primary / Alternate Communications</td>
<td></td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>0022</td>
<td>Policies &amp; Procedures for Sheltering in Place</td>
<td></td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>0023</td>
<td>Policies &amp; Procedures for Medical Documentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0024</td>
<td>Policies &amp; Procedures for Volunteers &amp; Staffing</td>
<td>7</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>0025</td>
<td>Arrangement with other Facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0026</td>
<td>Roles Under a Waiver Declared by Facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0029</td>
<td>Development of Communication Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0030</td>
<td>Names &amp; Contact Information</td>
<td>8</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0031</td>
<td>Emergency Officials Contact Information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0032</td>
<td>Primary &amp; Alternate Means for Communications</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0033</td>
<td>Methods for Sharing Information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0034</td>
<td>Information on Occupancy &amp; Needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0035</td>
<td>LTC Sharing Plan with Patients &amp; Families</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>0038</td>
<td>Emergency Preparedness Training &amp; Testing</td>
<td>3</td>
<td>8</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>0037</td>
<td>Emergency Preparedness Training Program</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>0039</td>
<td>Emergency Preparedness Testing Requirements</td>
<td>10</td>
<td>1</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>0041</td>
<td>LTC Emergency &amp; Standby Power Systems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0042</td>
<td>Integrated Health Systems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Top 10 Most Cited E-Tags in CT / MA / RI / Nationally

<table>
<thead>
<tr>
<th>TAG</th>
<th>Description</th>
<th>CT</th>
<th>MA</th>
<th>RI</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001</td>
<td>Establishment of the Emergency Program (EP)</td>
<td>4</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0004</td>
<td>Develop EP Plan, Review &amp; Update Annually</td>
<td>6</td>
<td>3</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>0013</td>
<td>Development of EP Policies &amp; Procedures</td>
<td>7</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>0024</td>
<td>Policies &amp; Procedures for Volunteers &amp; Staffing</td>
<td>7</td>
<td>2</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>0026</td>
<td>Roles Under a Waiver Declared by Secretary</td>
<td>6</td>
<td>7</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>0030</td>
<td>Names &amp; Contact Information</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0035</td>
<td>LTC Sharing Plan with Patients &amp; Families</td>
<td>4</td>
<td>4</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>0036</td>
<td>Emergency Preparedness Training &amp; Testing</td>
<td>3</td>
<td>8</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>0037</td>
<td>Emergency Preparedness Training Program</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>0039</td>
<td>Emergency Preparedness Testing Requirements</td>
<td>10</td>
<td>1</td>
<td>9</td>
<td>1</td>
</tr>
</tbody>
</table>

You must IDENTIFY someone who will be responsible for the review and updating of the Training & Testing Program.

Who has this responsibility in your facility?
Who and What are we training on?

+ All staff, including individuals providing onsite services under arrangement and volunteers.
+ Training is to be consistent with their expected roles.

Training & Testing Programs Summary

2018 Top National E-Tag Citations E0036, E0037 & E0039:

+ Initial training for new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role.
+ Provide training at least annually, include unannounced drills.
+ Demonstrate staff knowledge of emergency procedures.
Training Requirements:

Consider a training matrix by staff types or expected roles:

<table>
<thead>
<tr>
<th>General Employees &amp; Individuals providing onsite services under arrangement and volunteers</th>
<th>Charge Nurses / Department Managers</th>
<th>Incident Management Team</th>
<th>Individual responsible for Emergency Management &amp; ICM Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS / HEMS &amp; IAMS Overview</td>
<td>ICS-700A - ANS: An introduction</td>
<td>ICS-700A - ANS: An introduction</td>
<td>E-Tag 0037 #1 in CT &amp; #8 Nationally</td>
</tr>
<tr>
<td></td>
<td>IS-100-AHC - Introduction to incident command for healthcare</td>
<td>IS-100-AHC - Introduction to incident command for healthcare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IS-200-FHA - Applying ICS for Healthcare Organizations (ICS 200)</td>
<td>IS-200-FHA - Applying ICS for Healthcare Organizations (ICS 200)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IS-200-FHA - Applying ICS for Healthcare Organizations (ICS 200)</td>
<td>IS-200-FHA - Applying ICS to Healthcare Organizations (ICS 200)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IS-600.2 ** National Response Plan</td>
<td>IS-600.2 ** National Response Plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ICS 900* - Intermediate Incident Command System</td>
<td>ICS 900* - Intermediate Incident Command System</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ICS-600 ** Advanced Incident Command</td>
<td>ICS-600 ** Advanced Incident Command</td>
<td></td>
</tr>
</tbody>
</table>

All employees, at a minimum, must complete a basic overview orientation to Incident Command System (ICS).

Person(s) who may, at any time assume incident commander & several staff positions within ICS for different planning or for special training or for training incident commander. Person(s) who are likely to fill the command & general staff position within ICS. Person(s) with the Emergency Preparedness coordinator responsibilities.

---

Consider a training matrix by staff types or expected roles:

<table>
<thead>
<tr>
<th>General Employees</th>
<th>Clinical Staff, including nursing &amp; physicians FTEs</th>
<th>Department Managers &amp; Asst. Managers</th>
<th>Incident Management Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS / HEMS &amp; IAMS Refresher</td>
<td>ICS / HEMS &amp; IAMS Refresher</td>
<td>ICS / HEMS &amp; IAMS Refresher</td>
<td>E-Tag 0037 #1 in CT &amp; #8 Nationally</td>
</tr>
<tr>
<td>Activation of the plan(s), including code words and immediate actions</td>
<td>Activation of the plan(s), including code words and immediate actions</td>
<td>Activation of the plan(s), including code words and immediate actions</td>
<td></td>
</tr>
<tr>
<td>Communications Plan</td>
<td>Communications Plan</td>
<td>Communications Plan</td>
<td></td>
</tr>
<tr>
<td>Fire Response Plan</td>
<td>Fire Response Plan</td>
<td>Fire Response Plan</td>
<td></td>
</tr>
<tr>
<td>Missing Resident Plan</td>
<td>Missing Resident Plan</td>
<td>Missing Resident Plan</td>
<td></td>
</tr>
<tr>
<td>Lock Down Plans: training based on assigned duties in plan</td>
<td>Lock Down Plans: training based on assigned duties in plan</td>
<td>Lock Down Plans: training based on assigned duties in plan</td>
<td></td>
</tr>
<tr>
<td>Other emergency procedures for specific events, as determined by the the plan and training plan</td>
<td>Other emergency procedures for specific events, as determined by the plan and training plan</td>
<td>Other emergency procedures for specific events, as determined by the plan and training plan</td>
<td></td>
</tr>
<tr>
<td>Managing Resources During a Disaster</td>
<td>Managing Resources During a Disaster</td>
<td>Managing Resources During a Disaster</td>
<td></td>
</tr>
<tr>
<td>Managing Security During A Disaster</td>
<td>Managing Security During A Disaster</td>
<td>Managing Security During A Disaster</td>
<td></td>
</tr>
<tr>
<td>Loss Of Central Service Plans</td>
<td>Loss Of Central Service Plans</td>
<td>Loss Of Central Service Plans</td>
<td></td>
</tr>
</tbody>
</table>
Who and What are we Testing?

+ The facility will test staff competence in their knowledge of the Emergency Preparedness Program through the use of a post training quizzes and formal / informal evaluations during drills and exercises.

Testing Requirements:

+ You must conduct at least two (2) exercises to test your emergency plan annually.
+ Activations – if documented properly, can count as one (1) exercise.
Training & Testing Programs

**Exercise #1**

+ Participate in a “Full Scale Exercise” that is Community Based (LTC-MAP).
+ If a Community Based Exercise is not available, conduct a facility based one.
+ Document attempts to engage your community partners. You must try!!

---

**Exercise #2**

+ Conduct an additional exercise that may include, but is not limited to:
  + A second “full-scale exercise” that is community-based, or individual facility-based.
  + A tabletop (TJC wont accept) exercise that includes a group discussion, a narrated clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
Full-Scale Exercise (FSE)

+ Full-scale exercise is defined as any operations-based exercise (drill, functional, or full-scale exercise) that assesses a facility’s functional capabilities by simulating a response to an emergency that would impact the facility’s operations and their given community.

+ “Boots on the Ground” types of response
  - Setting up a Surge Area and moving mock residents into it.
  - Activating the Command Center and functioning in NHICS roles with Job Action Sheets (JAS).
  - Establishing a Triage / Intake Area, staffing and equipping it, and moving mock residents through it.

Facility Based Exercise

+ Option if a FSE is not available.

+ Facility-based includes, but is not limited to:

  - Hazards specific to a facility based on the:
    ▪ Geographic location
    ▪ Resident population
    ▪ Facility type
    ▪ Potential surrounding community assets (i.e. rural area versus a large metropolitan area).
Types of Exercises:

Tabletop Exercise (TTX)

+ A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

+ FYI – The Joint Commission does not accept TTX Exercises

Types of Exercises:

Drill

+ If you activate your Command Center, etc.
Training & Testing Programs Summary

Have ready for your Surveyors:

For Each Exercise:
- After Action Report (AAR)
- Improvement Plan (IP)
- LTC MAP Regional Participation Report

+ Maintain Documentation of Every Exercise

Establishment of the EP Program

Based off the Four Core Elements of Emergency Preparedness:
+ Risk Assessment and Emergency Planning
+ Communication Plan
+ Policies and Procedures
+ Training and Testing
Establishment of the EP Program

Develop Your Emergency Preparedness

+ Establish Team Leader
+ Establish Team Membership (may be an existing team)
  - **Multi-disciplinary**: include clinical, admin & support
+ Scalable to the organization: 2-3 or a larger group
+ Meet regularly:
  - **Monthly**: until program is up and running
  - **Quarterly**: for continued sustainability
+ Include community partners, as necessary and appropriate (Emergency Management, Police, Fire, EMS, Regional EM, Healthcare Coalitions, etc.)

---

Establishment of the EP Program

Develop Your Emergency Preparedness Team

**Sunnyvale Nursing & Rehab EPP Team**

**Meeting Agenda**

June 1, 2017
9:00 AM

1) Review of any recent events
   a) Developing an After Action Report & any Improvement Plans
2) Review of existing or drafts of new plan:
   a) Communications Plan Updates
   b) Active Shooter Plans – Local PD attending
3) Upcoming or scheduled training or exercises
4) Review of ongoing improvement plans:
   a) From Mitigation Plans
   b) From Event & Exercise After Action Improvement Plans
5) Other issues from the group

---

32 | Copyright © Jensen Hughes. All rights reserved. jensenhughes.com | philipstlc.com

33 | Copyright © Jensen Hughes. All rights reserved. jensenhughes.com | philipstlc.com
Establishment of the EP Program

Assess & Manage Your Current Program

Your Emergency Preparedness PROGRAM

Risk Assessment

Policies & Procedures

All Hazards Planning

Community Involvement

Exercises

Training

Develop the EP Plan, Review Annually

Develop Your Emergency Operations Plan (EOP)

+ The LTC facility must develop and maintain an Emergency Preparedness Plan that must be reviewed and updated at least annually.

- Based on your Risk Assessment (HVA)
- Addresses resident population, services provided and continuity of operations
- Collaboration with local, state, and federal partners
Why an Emergency Operations Plan (EOP)?

+ Required!
+ Documents and Guides Planning Efforts
+ Provides ACTION PLANS / GUIDES to use during a disaster
+ Provides a FOUNDATION for decision-making at the time of a disaster

Emergency Operations Plan (EOP)

How to Document the Emergency Operations Plan (EOP)?

+ LTC Facility Leaders, including the Medical Director, participate in planning activities to develop an EOP
+ Use the HVA and collaborate with community partners
  - Document “the LTC Facility’s efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts”
+ Ensure the Incident Command System is integrated into and consistent with the community's
Sample Table of Contents

EMERGENCY PREPAREDNESS PROGRAM: Policies and Planning

- PROCEDURES APPLICABLE TO ALL HAZARD RESPONSES
- INCIDENT COMMAND SYSTEM
- FULL BUILDING EVACUATION PLAN
- EMERGENCY PROCEDURES FOR SPECIFIC EVENTS
- EMERGENCY LISTS
- C.O.O.P. & RECOVERY PLAN

APPENDICES

Emergency Operations Plan (EOP)

- Procedures Applicable to All Hazard Responses
- Nursing Home Incident Command System (NHICS)
- Emergency Procedures for Specific Events
- Continuity Of Operations And Recovery Plan

“THIS IS WHY → THIS IS HOW”
Policies & Procedures for Volunteers & Staff

Procedures Applicable to All Hazards Responses

+ Managing Security and Safety during a Disaster

+ Management of Staff during a Disaster

+ Management of Utilities during a Disaster

+ Managing Residents during a Disaster

+ Managing Resources and Assets during a Disaster

Management of Staff During a Disaster

+ Notification Of Off Duty Staff
  - Phone Trees – simple, but need updating!
  - Mass Notification Systems

+ Disaster Staffing Options

+ Loss Of Parking / Inability To Commute To The Facility
Management of Staff During a Disaster

+ Labor Pool
+ Labor Pool Unit Leader
+ Sign in / out
+ Location, room set up
+ Virtual?

Emergency Credentialing Plan: the facility will manage the activities of individuals who receive disaster privileges:
- Verify ID (duplicate ID)
- Working under observation of facility staff
- Verification with state licensing authorities (within 72 hours)

+ Managing all “volunteers” and outside assistance
Management of Staff During a Disaster

+ Staff Sheltering:
  - Sheltering Managers
  - Locations, supplies, activities

+ Staff Families & Pets?
  - Will you allow it?
  - Where will they be housed?
  - Agreements or Instructions:
    ▪ What to bring (pets): kennel, medications, food
    ▪ What is not allowed: alcohol, firearms
    ▪ What are expectations: volunteer, help out, quiet times

Critical Incident Stress Debriefing (CISD) For Staff
Nursing Home Incident Command (NHICS)

Brief History:

+ Adopted for use in the 1970’s California Fire Service – based on military hierarchy
+ Virtually all first responders agencies utilize ICS
+ Key Concepts:
  - Unity of Command
  - Common Terminology
  - Management by Objective
  - Flexible and Scalable
**Nursing Home Incident Command (NHICS)**

**Why Do We Need NHICS?**

+ Events can drag on!
+ Events can go sideways!
+ Provides continuity of care during an emergency
+ Provides for delegation of authority and succession plans
+ Provides a process for:
  - Communications
  - Cooperation
  - Collaboration of officials during an event

---

**Nursing Home Incident Command (NHICS)**

The First Phase of Every Unexpected Event is **CHAOS:**

+ Leadership is critical to:
  - Set the tone of calm
  - Assess the situation
  - Prioritize actions
  - Guide the response

**Decisions need to be made about what to Do:**

— NOW!
— Next and then Later
Nursing Home Incident Command (NHICS)

How do you Manage?

There is always someone in CHARGE!

NHICS – A System for Command And Control:

[Diagram of NHICS Standard IMT]

50 | Copyright © Jensen Hughes. All rights reserved.  

51 | Copyright © Jensen Hughes. All rights reserved.
NHICS – Positions

**Incident Commander (IC):** The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site.

**Mission:** Organize and direct the Nursing Home Command Center (NHCC). Give overall strategic direction for incident management and support activities, including emergency response and recovery. Authorize total facility evacuation if warranted.
Nursing Home Incident Command (NHICS)

Key Concept

The Incident Commander (IC) position is the only position that is ALWAYS activated, and the authority and responsibility for the incident management belongs to them.

Key Concept

When a function is needed and the position is not activated, the duties are fulfilled by the next highest activated position or as assigned by the IC.
UNIFIED COMMAND
Fire Service / Police
statutorily are responsible,
BUT the facility needs and
objectives need to be
represented by the Facility
Incident Command System

Nursing Home Incident Command (NHICS)

NHICS – Positions

**Operations Section Chief:** Responsible for all tactical incident operations and implementation of the Incident Action Plan. In NHICS, the Operations Section includes two subordinate Branches: Infrastructure and Resident Services.

**Mission:** Develop and implement strategy and operations to carry out the objectives established in the Incident Action Plan (IAP). Oversee the direct implementation of nursing home’s resident care and services, and infrastructure operations.

**Resident Services Branch Director:** Branch under the Operations Section responsible for the following functions: admission, transfer, and discharge; nursing, medical records and psychosocial.

**Mission:** Coordinate and supervise all aspects of resident care and services including nursing services (including management of incident-related trauma and special needs, as well as routine care), psychosocial care (residents, staff, and dependents), and movement into and out of the facility. Implement and monitor the facility’s resident identification and tracking system for both incoming residents or for facility residents evacuating to an offsite destination.

**Infrastructure Branch Director:** Branch under the Operations Section responsible for the following functions: Dietary, Physical Plant/Security and Environmental.

**Mission:** Organize and manage the services required to sustain and repair the nursing home’s infrastructure operations including power/lighting, water/sewer, HVAC, buildings and grounds, medical gases, medical devices, structural integrity, environmental services (cleaning, disinfection, housekeeping, and laundry), and food services.
NHICS – Positions

**Planning Section Chief:** Responsible for the collection, evaluation, and dissemination of operational information related to the incident, and for the preparation and documentation of the Incident Action Plan. This Section also maintains information on the current and forecasted situation and on the status of resources assigned to the incident.

**Mission:** Oversee all incident-related data gathering, situational information and analysis regarding incident operations and assigned resources. Collect, process and maintain accurate and complete incident files, including a record of the Nursing Home’s response and recovery activities, decisions and key communications. Develop projections to inform long range planning, prepare situation summaries and maps, conduct planning meetings, and prepare the Incident Action Plan (IAP). Disseminate the new IAP to all assigned NHCC staff at the beginning of each Operational Period.

**Scribe/Runner:** May be assigned to any section in NHICS but is most commonly assigned to the Planning Section.

**Mission:** Maintain accurate and complete documentation for the assigned section or branch, in addition to a wide range of clerical tasks. For example, during facility evacuation or intake of emergency orders, they may move supplies and equipment or assist with basic data entry.

**Logistics Section Chief:** Section responsible for providing facilities, services, and material support for the incident.

**Mission:** Organize and direct those operations associated with maintenance of the physical environment of the facility and the NHCC. This includes adequate levels of personnel, food, equipment, information technology/systems and all supplies to support incident activities. Arrange and coordinate transportation and transport needs for all ambulatory and non-ambulatory residents, personnel and material resources.

**Finance/Administration Section Chief:** Responsible for all administrative and financial considerations surrounding an incident.

**Mission:** Monitor the utilization of financial assets and the accounting for financial expenditures. Supervise the documentation of expenditures and cost reimbursement activities. Ensure thorough investigation and documentation of incident-related claims, and the screening of volunteers. Contribute to the Incident Action Plan (IAP).
**Nursing Home Incident Command (NHICS)**

**Customize to Your Facility**

Assign Positions 2-3 Deep (at least the Command & Management Staff)

Customize Job Descriptions (Job Action Sheets)

Provide Checklists for Positions

Develop Tool kits (Vests, Clip Boards, Signs, Forms, etc.)

**Operationalize the Plan**
Nursing Home Incident Command (NHICS)

Incident Action Plan (IAP) Quick Start Guide

Roles Under a Waiver Declared by Secretary

1135 Waivers, How do they affect you?

+ Presidential Declaration:
  - Stafford Act or National Emergencies Act
+ HHS Secretary:
  - Public Health Emergency Declaration
Examples of 1135 Waiver Authorities

- Conditions of Participation
- Licensure for Physicians or others to provide services in affected state
- Emergency Medical Treatment and Labor Act (EMTALA)
- Stark Self-Referral Sanctions
- Medicare Advantage out of network providers
- HIPAA

Roles Under a Waiver Declared by Secretary

1135 Waivers

+ Policies and procedures.
  - The role of the LTC facility under a waiver declared by the Secretary, in accordance with Section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.
The LTC Facility must develop and maintain an emergency preparedness communications plan that must be **reviewed and updated at least annually.**

**Names and contact info for:**
- **Staff, providers, residents physicians, hospitals, volunteers**
- **Federal, state, tribal, regional, and local Emergency Management agencies, State Licensing Agency, Ombudsman**

**Primary and alternate means for communication internally and externally**

**Communicating with staff, residents, & families**
Emergency Communications Plan that details how:

- You will communicate with residents and families during a disaster or emergency event
- Provide details about your Emergency Operations Plan
- How you will address a disaster internally
LTC Sharing Plan with Patients & Families

**Sharing Emergency Preparedness Plan with Residents**

+ How you will address specific disasters:
  - Establishing Incident Command
  - Sheltering in place
  - If forced to evacuate the building. How you will evacuate
  - Fire procedures

LETS TAKE A 15 MINUTE BREAK
Lessons Learned from Recent Facility Evacuations

Evacuation

A review of the water leak and resultant evacuation of a skilled nursing facility in Duxbury, MA November 9-10, 2018

BAY PATH AT DUXBURY NURSING & REHABILITATION CENTER
Timeline of Events

Friday, November 9, 2018

+ Ongoing construction / repairs of the roof.
+ Significant rain storm that day compromised the roof and began leaking into clinical units.
+ Initial decision to shelter in place in unaffected units.
+ Duxbury FD on scene very quickly reporting a major water leak, requesting a strike team of ambulances to the scene.

6:00 PM Duxbury FD on scene assisting with internal movement of residents (from affected to non-affected units).
Timeline of Events

Friday, November 9, 2018

+ 8:30 PM Evacuation of facility began
  - Local FD Ambulances and Mutual Aid from surrounding towns.
  - Fallon Ambulance requested.
  - Majority of initial evacuations were to sister facilities in Regions 4A/B, 4C & 5.

+ 10:40 PM Mass DPH contacts the MassMAP Backup Resource Officer after they were contacted by the Regional EMS Coordinator.
+ 11:00 PM Disaster Struck Facility (DSF) contacts the MassMAP Resource Officer who sends out a notification Only message to MassMAP Regions 4 A/B, 4C & 5 Steering Committee Members only.
+ 11:10 PM Mass DPH sends HHAN message to all Region 5 MassMAP members requesting they complete emergency reporting as additional beds are needed to accommodate all residents being evacuated.
Timeline of Events

**Friday, November 9, 2018**

+ Emergency Reporting, Region 5:
  - Bay Path at Duxbury was only facility reporting an "Operational Issue"
  - 20% of facilities reported (24 of 119)

<table>
<thead>
<tr>
<th>Facility</th>
<th>City</th>
<th>Last Report</th>
<th>Total Licensed</th>
<th>Total Open</th>
<th>Male</th>
<th>Female</th>
<th>Either</th>
<th>Vest Dependent</th>
<th>Dementia Secured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 4 A/B</td>
<td></td>
<td></td>
<td>59063</td>
<td>110</td>
<td>17</td>
<td>34</td>
<td>50</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Region 4 C</td>
<td></td>
<td></td>
<td>4037</td>
<td>51</td>
<td>22</td>
<td>18</td>
<td>11</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Region 5</td>
<td></td>
<td></td>
<td>11631</td>
<td>125</td>
<td>47</td>
<td>50</td>
<td>30</td>
<td>0</td>
<td>11</td>
</tr>
</tbody>
</table>

Timeline of Events

**Saturday, November 10, 2018**

+ 3:30 AM Evacuation concluded
+ 7:58 AM MassMAP Emergency Reporting System deactivated
Preparing Residents for Evacuation

+ Prepared medications and medical records to go with residents.
+ Minimal personal belongings went with residents at the time of evacuation.
+ Clothing and other personal items were collected the next day and delivered to residents.
+ Holding Area Operations:
  - Medication cart
  - Portable oxygen
  - Laptop computers
  - Recreation / activities
  - Nourishment cart
  - Portable radios used to communicate to the Command Center

Nursing Home Incident Command Center

+ Located in the front lobby with an adjacent office.
+ All Department Heads were on scene within one hour of activation.
+ Good corporate support.
+ Clinical liaison – corporate clinician.
+ Facility Administrator.
Communications

+ Coordinated all communications from the Facility Incident Command Center.
+ Staff Recall – DSF utilized VoiceFriend to notify all off-duty staff of the need to respond to facility to assist with the evacuation.
+ Media – Statement prepared by corporate and released to the press.
+ DPH Reportable Incident – Initial notification on the evening of 11/9 and then follow up detailed report the next day.

Communications

+ Electronic Medical Records (PointClickCare)
  - Arranged for access to EHR by all sister facilities with the corporate structure utilizing the same system.
  - Non-sister facilities started new charts on their own system. Relied on paper charts transported with the residents.
+ All evacuated residents were discharged and admitted into the RAFs.
Transportation Coordination

- On scene transportation coordination by Duxbury FD and Fallon Ambulance.
- No MassMAP members transportation resources utilized.
- Staging area for vehicles on the property.
- Holding Area - Check-out process for residents / validation.
- Resident tracking by EMS with facility staff.

Resident Accepting Facilities (RAFs)

10 Resident Accepting Facilities

- Plymouth
- South Shore
- Colonial
- Highland Manor
- John Scott House
- Hancock
- Harbor
- Brighton
- West Yarmouth
- Bridgewater

*sister facilities called in influx staff and then redeployed current staff from the DSF.
Challenges / Barriers

+ Transportation Resources
  - All residents transported by ambulances.
  - No MassMAP member transportation utilized but many were available.
  - The transportation / Evacuation survey process was not utilized.
  - How will this affect residents long term?
  - What was the final cost of the evacuation?
  - Tracking Medical Records / Staff & Equipment?

Challenges / Barriers

+ Pre-planning for evacuation
  - Participate in the annual full-scale exercises.
  - Knew the process for full building evacuation and utilizing the Resident Emergency Evacuation Forms and Tracking Sheets
  - Fire Department was persistent and did not want to wait on paperwork / medical records to be prepared to go with residents. They were following their on scene procedures for rapid transport.

+ Need bags or containers for resident belongings.
Successes / Strengths

+ Being Prepared
  - Participating in the Annual MassMAP Full-Scale Exercises
+ Team effort was amazing!
  - Corporate
  - Local

As of the end of January 2019 the facility has still not opened the 2 affected units that were water damaged on 11/9/2018.

ST. CLARE, NEWPORT, RI

This is not a drill

A review of the National Grid gas outage and resultant evacuation of a skilled nursing facility in Newport, RI January 21-29, 2019
Monday, January 21, 2019

+ 11:00am: Frozen natural gas valve in Portsmouth that provides service to customers in Middletown and Newport caused the flow of natural gas to be restricted and pilot lights to extinguish.
+ As a safety precaution, gas was shut off to a significant area in Middletown and Newport.
+ 350 customers in Middletown and Newport were initially impacted.
+ RI Department of Health / Healthcare Coalition of RI contacted Newport Hospital and the eight nursing homes and assisted living residences in those municipalities.
+ 7:30pm: ESF leads were notified that due to safety issues in the gas distribution system due to continued low pressure, National Grid was going to turn off gas to an additional 6,700 customers.
+ The State EOC was being fully activated, due to concerns about the low temperatures, projected to have wind chills down to -12°F.

Tuesday, January 22, 2019

+ 6700 National Grid customers in Newport (6400) and Middletown (360) remain without gas.
+ 9:05am: Governor’s Emergency Command Update, National Grid reported that it would take 2-3 days to go into every home/business to have gas service turned off, then they will re-introduce gas into the distribution system, pressurize the system, and then go into every home/business again to re-light the pilots (this step was anticipated to take longer than turning all of the gas services off).
+ 9:30am: At St. Clare, the temperature of the building had dropped into the 60s overnight. Given the expected duration of the gas outage and the complexities of piping in external heat, the decision was made to evacuate the facility (which included both nursing home and assisted living residents). Additionally, to evacuate off Aquidneck Island, in case the event expanded.
In anticipation of the evacuation decision, St. Clare had already begun the following:

− Copied all face sheets and MD orders
− Complete Transportation Evacuation Surveys
− Identifying bed types required (e.g. male vs. female, secure unit etc.)
− Established a Command Center in a space that had electric heat
− Made notification to municipal partners, families and residents

**Tuesday, January 22, 2019**

+ 9:55am: The Center for Emergency Preparedness Response (CEPR) activated the LTC-MAP, requesting members to report available beds and transportation.
+ 78% Reporting
  − 3 Operational Issues
  − 672 Open beds
    ▪ 214 Male
    ▪ 254 Female
    ▪ 204 Either
    ▪ 104 Dementia Secured
11:00am: 4 staff members from the Healthcare Coalition of RI (HCRI) and CEPR, as well as 2 Facilities Regulation staff arrived at St. Clare.

A second command center was setup, building tour conducted and held an all-hands briefing including a safety briefing.

Worked through the process of evacuation, bed matching and securing transportation.

- T/E Survey identified high number of BLS ambulances needed.

RI DMAT deployed an Environmental Control Unit to provide heat inside select areas of the facility while the evacuation occurred at the request of RIDOH.

- The Unit was set up and functioning at 2:22pm.

Healthcare Coalition of Rhode Island (HCRI) offsite staff contacted Resident Accepting Facilities (RAFs) to confirm bed assignment and clinical contact information.

HCRI contacted St. Clare Administrator to identify which residents were being assigned to which RAF.

St. Clare Administrator handed off info to Nursing Supervisor.

Nursing Supervisor contacted RAF for clinical handoff.

RAF confirmed with HCRI which residents they would receive.

HCRI would notify St. Clare Administrator that the transport could be booked.

The last bed was secured at 6:05pm.
Challenges to Bed Matching

+ Assisted Living Facilities had apartment availability, but no furniture.
+ Families and residents requested geographically close locations, which changed where residents were initially placed.
  - This caused confusion with the Resident Accepting Facilities (RAFs).
+ One resident was released to family, but was returned to the facility later that night, and another resident that went with family required placement in the ensuing days.

Preparing Residents for Evacuation

+ Contacted all families, asking if they could take their loved one home, as well as requesting assistance with transportation.
+ Prepared 3-5 days' worth of clothes and medication.
+ Gathered equipment and supplies to be sent with residents.
+ Facilitated the evacuation of those residents who went home with their family (29 out of 86 total, 2 SNF, 27 ALF)
Finding transportation assets
- Staging area for vehicles / Staging Area Manager
- Holding Area - Check-out process for residents / validation
- Resident tracking

+ Six ambulance companies provided BLS ambulances and wheelchair vans (31 residents).
+ Two Resident Accepting Facilities (RAFs) provided transportation resources.
+ Friends and family provided transportation for those who were going home.
+ Confirmed with all facilities, through the evening, arrival of residents and notified families.
+ Last ambulance pulled out of driveway at 10:45pm.
+ Confirmed the last resident arrived at destination at midnight.
A total of 87 residents were accounted for in the evacuation:
- 29 individuals were able to go home with friends or family.
- 2 residents were securely off-site already.
- 56 were transported to 15 other nursing homes / assisted living communities.

Resident Accepting Facilities (RAFs)

15 Resident Accepting Facilities
- The Bridge at Cherry Hill
- The Cedars – Cedar Crest
- Charlesgate
- Coventry Skilled Nursing
- Elderwood at Riverside
- Grand Islander
- Linn Health Center
- Roberts Health Centre
- Sakonnet Bay
- Scalabrini Villa
- South Kingstown Nursing
- St. Antoine Residence
- St. Elizabeth Manor
- Village House
- The Villa at St. Antoine
In the days after the evacuation...

ESF-8 contacted each of the Resident Accepting Facilities (RAFs) to follow up.
- All 15 RAFs reported that the residents were faring well.
- No operational issues or concerns were reported.

Both the Administrator of St. Clare, Newport and CEPR emailed the Administrators of the RAFs to provide them information about the LTC-MAP, including a copy of the MOU.

Ongoing Recovery Operations

St. Clare, Newport:
+ Conducted daily in-person checks with all the displaced residents and delivered additional personal items during these daily visits.
+ Provided CNA staffing to 3 of the RAFs.
+ Staffed a Nurse and Receptionist 24/7, with security overnight.
+ Housekeeping and laundry staff conducted a deep cleaning of the building (working in pairs in residents’ rooms to ensure accountability).
+ Dietary staff deep cleaned the kitchens.
+ Worked with their pharmacy, Omnicare, to continue to receive medications, which staff distributed to the RAFs during the daily visits.
+ Coordinated and provided transportation for residents to doctors appointments.
Ongoing Recovery Operations

St. Clare, Newport:

+ MOU calls for the resident to remain on the DSF’s census.
  - MDSs still needed to be completed and provide insurance companies with updates on the skilled nursing residents.
+ The MDS coordinator for St. Clare made contact with all RAFs MDS Coordinators, identifying who was affected and coordinated the retrieval of all documentation.
+ The Financial Services Director contacted all RAF Finance Directors and reviewed with them the MOU as well as sharing rates of reimbursement.
+ Blue Cross Blue Shield was the only insurance company that required we discharge our skilled resident and have them admitted at the RAF.

Recovery Communications

Daily:

+ Calls between CEPR and St. Clare, Newport
+ Emails to RAFs
+ Facebook posts
+ Mass texts to staff

Once:

+ Conference call with St. Clare, Newport and RAFs
  - Patient experience
  - Documentation
  - Reimbursement
  - Repopulation plans
Nothing is ever easy…

Wednesday, January 23, 2019

+ ~6:00pm - St. Clare was making arrangements to have the sprinkler system drained as a precaution
  - A pipe burst near the parking garage, rendering it non-functional.
  - The entire wet and dry system for the whole building had to be drained.
  - A fire watch was mandated by the State Fire Marshalls office until the heat was back on and no danger of the pipes and pressurizing tanks freezing.

Gas Restoration

Friday, January 25, 2019

+ Repressing of the gas lines for the island was completed around 9:00pm
+ St. Clare was considered a high priority facility for being restored.
+ Gas was not fully restored and lit until Saturday, 1/26 at 2:35pm.
+ National Grid broke the roll out switch on the domestic hot water heater in the process of relighting.
+ The sprinkler vendor arrived that evening to complete work on repairing the sprinkler system.
Repopulation of the Facility

Monday, January 28, 2019

+ Families eager to come back right away.
+ The building needed to come back up to a stable temperature and needed to ensure no other issues would arise (e.g. leaking pipes etc.)
+ Repopulation planned in two phases:
  − Monday: 30 Assisted Living residents and 15 SNF residents that comprised one unit and had been at one RAF together
  − Tuesday: Remainder of the SNF: 41 residents

Repopulation of the Facility

+ St. Clare, Newport provided Expectation Documents to all RAFs so they knew what to send with returning residents.
  − Included time and date of scheduled transportation that was arranged.
  − Requested that all belongings return with the resident, and clothing be bagged separately from medications.
+ St. Clare, Newport asked for report of any new infectious outbreaks, infestations while residents were in the care of RAFs.
+ Standard nurse to nurse clinical handoff report.
Repopulation of the Facility

Nearly as difficult as getting everyone out...

+ Logistically speaking, this was quite difficult.
  - 1 moving company
  - 5 facility vehicles
  - 6 ambulance companies
  - 30+ family members

Repopulation of the Facility

Three Receiving Areas...

+ 1) Front desk - Residents greeted and escorted to the next area.
+ 2) Temporary Command Center - Signed in as arrived and by what type of transportation.
+ 3) Final Area - Medical equipment and personal clothing was deposited for wiping down and laundering and medication reconciliation was completed.
+ From here they were escorted to their apartments / rooms.
+ All families notified as residents returned.
+ Last resident came through the door at 6:30pm on Tuesday, January 29, 2019.
Transportation Resources
- Not enough wheelchair vans
- Commercial transport companies sent their wheelchair van drivers home at the end of the day limited the number of drivers available.
- This affected the timeliness of evacuation, even though beds had been secured hours before.

Medical Records
- St. Clare, Newport provided copies of MD orders
- The EMAR and ETAR as a scanned document (not faxed) would have been better for RAFs, as well as more thorough medical information to support care at the RAFs.
- It was suggested to send the entire chart to the RAFs.

Contact Information
- Primary contact information for facilities not updated on the LTC-MAP website.
- Challenges with repopulation on Monday for one facility that learned of the 10am transportation pickup appointment at 9am.
Welcome Home!

Slide content created and shared by Alysia Mihalakos, MPH, Chief, CEPR and Dawn Lewis and Joseph Repucci from HCRI for the After Action Hotwash held on February 27, 2019

Preparing for the 2019 Annual Full-Scale Exercises
Region 4: October 1, 2019: 9:00am – 12:45pm
+ Region 1 LTC Coordinating Center supporting

Region 3: October 2, 2019: 9:00am – 12:45pm
+ Region 2 LTC Coordinating Center supporting

Region 1: October 3, 2019: 12:00pm – 3:45pm
+ Region 5 LTC Coordinating Center supporting

Region 2: October 7, 2019: 12:00pm – 3:45pm
+ Region 3 LTC Coordinating Center supporting

Region 5: October 8, 2019: 9:00am – 12:45pm
+ Region 4 LTC Coordinating Center supporting
2019 Full Scale Exercises

All LTC-MAP Members are to be Disaster Struck Facilities (DSFs)

Expected Actions:
- Establish Command Center
- Establish Holding Areas
- Movement of Residents (Internal)
- Placement of Residents at RAFs
- Community Partner Involvement
- Inject Responses
- Documentation / Forms
- After Action Report

Onsite Visit:
- RPA Consultant
- LTC-MAP Steering Committee Member
- Healthcare Coalition (HCC)
- No right or wrong answers
- Ability to ask questions

Let’s Work Together

We Can Do It
Welcome to the Connecticut Hospital and Long Term Care Mutual Aid Plan Facility Information Website

Long Term Care Mutual Aid Plan (LTC-MAP) and Healthcare Mutual Aid Plan (HMARP) for Evacuation and Resources / Assets

This plan establishes a course of action and an agreed commitment among participating hospitals, nursing homes, and assisted living residences to assist each other as needed in the time of a disaster.

Assistance may come in the form of:
- Providing pre-designated evacuation locations for patients during a disaster and/or
- Providing or sharing supplies, equipment, transportation, staff or pharmaceuticals to a facility when a disaster overwhelms their own community or exceeds the capability of internal emergency operations plans.

Why is this initiative underway?

It has been identified in local, regional, and national disasters that each community must have a proactive disaster plan and all disasters start locally. To supplement the State of Connecticut Emergency Support Function 8 (ESF 8 - Health & Medical) operations, this unique plan, coordinated in Region 3 through the Capital Region Council of Governments (CRCOG)/Capitol Region Emergency Planning Committee (CREPC) and in Regions 1, 2, 4, & 5 through the Regional ESF 8 group, will work to prepare all of the healthcare facilities to stand together in a disaster with preplanned resources and assets.
Andy McGuire, CEM, EMT-P
Fire & Emergency Management Consultant
Andrew.McGuire@jensenhughes.com

Brad Austin
Fire & Emergency Management Consultant
Brad.Austin@jensenhughes.com

jensenhughes.com
phillipslk.com