

Capitol Region Emergency Planning Committee
RESF-8 Health and Medical – Long Term Care Facilities Planning
Workshop Meetings
November 12, 2009
Apple Rehab, 21 Waterville Road, Avon, Connecticut

Two working groups separately convened during the day. Each had attendance lists created that are now held at the CRCOG offices. Scott Aronson of Russell Phillips and Associates facilitated these meetings. John Shaw, chairman of Regional ESF-8 was present at both sessions as was Carmine Centrella, Homeland Security Planner from the CRCOG staff. The regional project was defined as creating a system or process for managing patients in long term care facilities during a disaster. There are two major functions for the plan to cover: early intervention to provide resources and support for patients to shelter in place, and more immediate intervention to evacuate patients to their homes or other facilities. It was generally stated that each of the two working groups was to review documents and information previously distributed. These include surveys, tracking and inventory forms, lists of resources and agencies, and other tools. The purpose is to develop a Long Term Care Mutual Aid Plan (LTC-MAP) for facilities within the Department of Emergency Management and Homeland Security (DEMHS) Region 3. The structures, procedures and protocols for managing patients in a disaster will also be developed to allow this mutual aid plan to become operational.

Working Group: Categories of Care, Documentation and Records and Resident Tracking

The meeting opened at 8:15 a.m. with 14 people present.

The group first reviewed the broad steps that will be taken in response to a disaster. Two situations were identified separately:

- A “fast out” situation with a sudden emergency such as a fire within the facility,
- A “more time available” situation, such as a loss of heat or a request to receive residents from other facilities.

Reviewing the algorithm document distributed, it was concluded there is a need for two separate branches to be defined, one to manage an emergency evacuation and the other to manage resources. Calling 911 was identified as an immediate activation link. The center that receives 911 calls to activate fire, police and EMS response can also provide notification and activation links to other resources such as the local emergency management director (EMD). A ten digit phone number to the local 911 public safety answering point might be more appropriate than 911 to use to encourage facility staff to call.

The state is currently developing a new notification system, and this “Everbridge” system could be used to send alerting messages to facilities agencies including long term care facilities. It has been proposed this system be installed in all 78 long term care facilities in the DEMHS Region 3 to send and receive such notification information.

An important highlight of the mutual aid plan was discussed – it has to be flexible and expandable:

- Flexible in that it can be used for a variety of different disasters from fire to flooding to storm emergencies.
- Expandable in that it will support a small effort needed to provide resources to shelter in place all the way to the total evacuation of one or more large facilities.

Terri Golek reviewed the recent evacuation of the Apple Rehabilitation Center in Meriden. Several other past actual events and situations were reviewed to illustrate the need to develop common approaches. It was noted that in times of emergencies, local, regional and state level responders will be using the standardized Incident Command System (ICS) as their responses become organized. ICS training for long term care facility staff will be stressed at the end of this planning effort to improve integration of joint activities.

Several draft and sample forms were discussed. These included:

- LTC Special Care Categories
- Resident Medical Record and Equipment Tracking Sheet
- Controlled Substance Receiving Log
- Influx of Resident Log
- Disaster Tag

Mr. Aronson made detailed notes of the recommended changes and suggested improvements to these forms. Among the broad areas of agreements, the following were identified:

1. *Any resident who will be evacuated and who has a dedicated CCPD, that cyclist needs to accompany the resident.*
2. *Identification of smokers is necessary as some facilities do not provide patient care space for smokers.*
3. *The ability to provide one-on-one continuous care should be addressed at the time of the incident..*
4. *Listing the capability to care for patients in restraints is another suggestion: some facilities do not restrain patients and could not receive this category of patients in an evacuation*
5. *Attachment D: Interview / walk-through survey form*

The issue of transfer of patient documents and medical records was then discussed. *One strategy was identified: work started early to identify common electronic data fields among the region's facilities could lead to a later system allowing printing of disaster forms such as patient tags and logs populated with all appropriate information during a disaster.*

Bar coded stickers and their use to coordinate information was discussed.

Controlled substances transfer forms would mitigate against loss. At the Meriden evacuation discussed earlier, narcotics were transferred after the patients had been evacuated. “Proof of

use forms” was also identified as important to send. Another option would be to not send medications, but let the receiving facility initiate medications from their own pharmacy. The steps of documentation and process of transferring patients were discussed in detail. Mr. Aronson made notes to create revised documentation for later review.

The appropriate identification of documents and the timing of their transfer between the sending and receiving facilities require further discussion to determine if a unified policy can be developed for transfer of medications for the region.

Criteria for billing was discussed as established in a September 2007 CMS FAQ and its protocol. A disaster struck facility may continue to bill for the patients transferred to another facility unless it cannot be reopened. After all facilities have returned to normal, funds can be transferred between facilities for the patients evacuated. *Questions were raised about the details of billing procedures and billing for medications (transferred and not transferred with the patient). More discussion is needed.*

Draft content of a tag for each patient was discussed. The application and function of such tags were identified and several issues were raised. It was noted tags may be altered or removed by the patient. *It was suggested that a plastic sleeve or holder for the tag would help, as perhaps pinning the tag where the patient cannot easily reach them. Another option might be to use a marker to write on the patient’s skin the assigned number. This will require more discussion at a later time.*

An area will be needed on the property but away from where public safety personnel responding to the emergency will be working. This can be called a stop-over point or holding area. Patients can be rapidly moved for their safety and security, and wait for processing and loading for transportation. Each long term care facility is responsible for manning this area and planning is needed to provide this.

Attachment D: the Interview / walk-through form for surge capacity was distributed outlining the points for a physical survey of a facility to identify essential processes and locations. This process is now underway in parts of Massachusetts. *It was suggested and agreed that having people outside a facility do such a walk through would be very useful. Mr. Aronson suggested if people are willing, some of our representatives could participate in Massachusetts. It was also agreed to meet before or after this group’s next meeting at a Connecticut Region 3 facility to conduct such a survey. Avery Heights volunteered for this, and the times for the planned December 10 survey visit meeting will be announced.*

The meeting continued to the next working group without adjournment

Working Group: Surge Capacity and Credentialing

The meeting opened at 11:35 a.m. with 14 people present.

The process of surging capacity and alternatives for credentialing staff coming in to a receiving facility were discussed. Most facilities have adopted the Joint Commission model for this, which includes processes for signing in, verification and supervision. The Capitol Region Medical Reserve Corps (MRC) is a group in Region 3 that could be called in for some events. The Medical Reserve Corps has pre-credentialed personnel available. Other alternatives for verification of credentialing were discussed. *The issue of credentialing volunteer and other staff arriving to help in a surge will require more discussion.*

Increasing oxygen availability was another topic that received detailed attention. Central was the question of a facility transporting a quantity of oxygen tanks in their own vehicles between facilities. One suggestion was made – contract with the oxygen vendor to transfer these tanks in approved, marked vehicles.

The meeting was adjourned at 12:00 p.m.

Working Group: Administrators, Owners, FLIS, DSS, MOY and Payer Challenges.

Following lunch, the meeting opened at 1:05 p.m. with 20 people in attendance

Mr. Aronson reprised the project and prior discussion for the newly arriving participants. It was stressed that the outcome will be a Long Term Care Mutual Aid Plan (LTC-MAP) created by the facilities for use by the facilities. Defined this way, it will neither be a regional plan for CREPC nor a DPH state plan. *Future decisions will be needed to define how resources will be obtained to support continued training, planning and oversight of the functions in the plan. Perhaps this can be by subscriber subscriptions or perhaps by grants from DPH.*

The planning assumptions are based on 100% occupancy. If a facility has 100 beds, but only 90 are filled, the 10% surge overage would be 10 additional patients, regardless of current census.

The working group will have to look at issues of liability and culpability. Some of these include:

- *The transfer of medical records between facilities.*
- *Should the receiving hospital start a new medical record and if so, how is that new record communicated back when the patient is returned?*

- *Reimbursements to disaster-struck facilities and receiving hospitals (CMS FAQ 2007). Also, what other payer issues need to be resolved?*
- *Should patients be “transferred” or “discharged and then admitted?” What paperwork would be required of either decision?*
- *How is the problem of different billing rates between disaster-struck and receiving facilities managed?*

It was decided to assign an initial review of these issues of to a subgroup, for a report back with recommendations. Therese Sanderson, Miriam Parker and Michael Landl agreed to work on this task.

It was noted the “W-10 Form” is a DSS form and DSS representatives need to be at the table when this is discussed. Barbara Cass from DPH agreed to contact DSS and brief this agency on the discussion to date.

The meeting adjourned at 3:24 p.m.

Respectfully submitted

Cressy Goodwin
Recorder