

Capitol Region Emergency Planning Committee
RESF-8 Health and Medical – Long Term Care Facilities Planning
Special Expertise Committee Meetings
November 10, 2009
Public Safety Complex
East Hartford, Connecticut

Four committees 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 all sessions as was Carmine Centrella from the CRCOG staff. The regional project was defined as creating a system or process for managing patients in long term care facilities in a disaster situation. 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 home or other facilities. It was generally stated that each of the four committees was to review documents and information previously distributed. These include surveys, tracking and inventory forms, lists of resources and agencies, and other tools that will be used 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 in times a disasters.

Committee on EMS / Transportation / Resident Tracking

The meeting opened at 8:05 a.m. with 14 people present.

The group first reviewed the broad steps that will be taken in response to a disaster. Items of relevance that were discussed were placed on a whiteboard (*see attachment 1, below*). The following points were highlighted as topics to be focused on at this meeting:

- Where will patients be going?
- Managing patients before evacuation
 - Holding and triage
 - Medications
 - Medical Records
- Who is to be notified?
- Managing the media
- If multiple facilities are involved, how will coordination be achieved

Reviewing the algorithm document distributed, it was concluded there is a need for a standard notification procedure for the region. This is especially true if multiple facilities are involved – independent notifications of local, regional and state level authorities can create confusion and delay appropriate responses. An initial concept was developed: call 911; then contact either RICS or CMED to begin the coordination of regional resources.

The discussion did not resolve the question if CMED or RICS should be initially contacted by the local facility. The primary and back up roles each would play in managing the mutual aid plan will require further discussion.

An emerging communication system for sending notifications was identified. The functions and utility of this “Everbridge system” needs to be explored to identify its role.

It was identified that long term care facilities have not recently been involved in incident command training (ICS). *This ICS training will be important before the mutual aid plan becomes operational, and will be promoted at the end of the planning project.*

The transportation survey document was reviewed. Recommendations were offered and recorded by Mr. Aronson. *It was agreed that these completed forms would be of help to both RICS and/or CMED in managing the logistics of transportation.*

It was then suggested that a family reunification area at any facility could be at the designated stop over point. This would reduce traffic in the patient loading area.

Patient tracking forms were reviewed. In the discussion, it was agreed that having bar coded stickers available would be of great help in coordinating information. Two dimensional bar codes with legible visual numbers printed on them as well would also prepare the future when there may be electronic data transfers available. *It was agreed to develop the specifications of bar code purchase further and request CRCOG procure sufficient supplies for training and actual use for the 78 facilities within the region.*

The medical record, equipment transfer documents were reviewed. *It was recommended that the form be printed in triplicate - one copy to be given to the transporting service provider. Several items on the form were changed with Mr. Aronson making notes.*

A discussion was held on the need for changing state regulations or legislation to allow the maximum number of area ambulances to respond to a disaster. If a local EMS provider in a certain classification has two vehicles locally based, both can not respond to a local facility. Part of this problem is the inability of some EMS groups to participate in the statewide public safety mutual aid agreement. There is also the restriction that prevents an advanced life support (e.g., paramedic) vehicle from being reimbursed when they respond. *Discussion on the issue of regulatory and legislative change for EMS responses to a disaster needs to be continued.*

The summary of transportation resources form was distributed and discussed.

The meeting was adjourned at 10:05 a.m.

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Committee on Communications

The meeting opened at 10:15 a.m. with 16 people present.

The typical communications capabilities at long term care facilities were identified:

- Community telephone service
- Emergency (red) telephone service
- Fax
- Cell phones
- Wireless systems such as Nextel
- Internet connectivity
- Fire alarm systems connected to the local fire department
- Messenger

It was recommended that each facility receive a “GETS card” (Government Emergency Telephone Services). In the event the local telephone circuits are overloaded due to heavy traffic, the GETS card can open a priority telephone line for dedicated use by the facility. As GETS cards can only be applied for by governmental agencies, and a majority of the 78 facilities are privately owned, *Mr. Gustafson stated he would pursue filing an application through the Department of Emergency Management and Homeland Security (DEMHS), a state agency.* This was done successfully in Massachusetts.

The document identifying local and regional emergency contacts was discussed. Several modifications were suggested with Mr. Aronson taking notes. *It was suggested that facilities might consider using the MEDNET radio system as an added tool.* This is a statewide system now in place for hospitals and other agencies.

Technical details of the emerging Everbridge notification system were discussed. Also discussed were mapping and other displays that could show at a regional center the geographical area of a widespread event such as a flood, permitting calls into potentially affected facilities to identify any problems.

The roles of coordination – facility, local, regional and state – were discussed. *It was agreed a defined protocol is needed for an immediate emergency and another for an insidious or evolving event, further clarifying the chain of notifications and coordination roles.* Part of this is the need to define expectations for a sequence of escalating coordination efforts.

*It was agreed there needs to be a definition of and consistent use of the terms: **notification**, and **activation** communications.*

It was then identified that training and peer support will be needed to encourage facilities to notify outside agencies as early as possible in an expanding event and not wait until

patients finally need evacuation. One of the plan’s objectives is to provide outside resources that can allow the facility to “defend in place,”

It was suggested that local EMS providers could encourage facilities that have not yet completed their survey forms by making personal visits to the administrators.

The meeting was adjourned at 12:10 p.m.

Committee on Regional Coordination Center (RCC) Operations

Following lunch, the meeting opened at 1:04 p.m. with 11 people present.

It was discussed that the mutual aid plan might want to identify two separate communications systems – the primary and a back up.

The functions and sequence of activating the regional emergency support plan (RESP) and establishing an RCC were outlined.

After s discussion, it was agreed that the Regional Coordination Center (RCC) would provide the ICS staff including the planning section chief. Representatives of the long term care facilities reporting to the RCC would become technical support experts.

It was again identified a more detailed algorithm is needed to define the sequence of notification communications needed for both an emergent and an insidious event. Mr. Goodwin agreed to assist is clarifying and creating such a diagram.

It was clarified that the long term care facilities will be managing their mutual aid plan. Many events can and will be managed locally. The regional resources (CMED, RICS and RCC) will not be involved unless they are requested.

The meeting was adjourned at 2:50 p.m.

Committee on Supplies / Equipment / Vendors.

The meeting opened at 2:58 p.m. with 10 people present.

Several sample vendor lists were distributed and reviewed. Additional categories were suggested with Mr. Aronson noting these. The group was reminded to consider vendors to help a facility to remain functional and “defend in place” as well as evacuate.

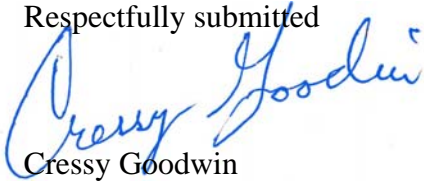
A draft memorandum of understanding was distributed and reviewed. It was noted that except for the facility requesting a signed MOU, each document does not identify any of the other regional facilities. It was recognized that many vendors might not be willing to sign these, but asking will help facilities to make decisions. It will also assist regionally to make prioritization of requests to different vendors if multiple facilities need support.

Each facility may need to review and update each of their MOUs periodically. A check should be made with the corporate compliance officer at each facility.

It was also agreed that the RCC will assist the facilities in preparing the required contemporary documentation required later for federal reimbursement in a nationally declared emergency. But each facility bears the responsibility for this documentation.

The meeting was adjourned at 4:00 p.m.

Respectfully submitted



Cressy Goodwin
Recorder

Attachment 1 (first committee session above)

