Capitol Region Emergency Planning Committee
RESF-8 Health and Medical – Long Term Care Facilities Planning
Meeting
February 11, 2010
Duncaster, 40 Loeffler Road, Bloomfield CT

Attendance was taken on forms that were collected and are retained at the CRCOG office.

The meeting opened at 8:08 a.m. with 12 people present.

Scott Aronson of Russell Phillips and Associates facilitated the meeting. A document was distributed identifying outstanding actions resulting from prior meetings. Each of these was discussed and progress identified.

- Key documents identified are now in electronic format and will be added to the plan.
- Questions have been written for DPH/OEMS to review for granting authority to transport LTCF patients between facilities by calls to 911 in a disaster.
- Oral assurances have been given to allow CMS guidelines to be followed for billing for a patient transferred to another facility. But there has been difficulty in meeting with a DSS representative – the key contact has been on medical leave for the past 6 to 8 weeks. Efforts will continue to hold a broad meeting to obtain written confirmation.
- The listing of subcategories of care was resolved on November 12.
- Discussion remains to develop a template for an agreement to be reviewed by DPH for granting authority to exceed licensed bed capacity. (See discussion, below)
- Department of Emergency Management and Homeland Security (DEMHS) is applying to obtain a Government Emergency Telecommunications System (GETS) card for each facility in the project. These cards can authorize a priority telephone line be opened during a disaster when all circuits are busy and otherwise not available.
- The process is continuing to identify where a facility would call to activate the notification / activation (the Everbridge) system. DEMHS is providing Everbridge hardware to every public safety answering point (PSAP) where 911 calls are answered. Thus, the maintenance of this system will be supported by state 911 funding. Other details and an algorithm of call receiving and information dispersal is pending.
- The transportation survey from the website was updated yesterday. It is now presented in a format later applicable to the entire state. Some of this data from prior work is already on the forms. Remaining Region 3 data can now be entered to complete the listings for this region.
- Procurement of bar coded labels is in process and they should be available soon.
- The structure for coordination of LTCF and regional coordination centers will be discussed by another group at the end of this meeting. (See addendum on page 4).
- Start up training of LTCH staff and leaders will begin on April 15. This will lead to well-defined ongoing training programs running continuously after October 1.
- Facilities should forward to Mr. Aronson a list of their major vendors. He will select a group of the key vendors to be invited to the next meeting on March 11. Mr. Centrella will follow up with a special invitation to CL&P as this group works on other planning initiatives with CRCOG.

- The documentation process required for W-10, other forms and medical records for each evacuated (transferred) patient needs to be formalized This will identify the payer procedures that will be followed. A meeting in March will be scheduled.
- A "best practices" guideline will be developed in April from a meeting with experts to define procedures preparing for an influx of patients. These guidelines will probably be on separate tracks – as for example to receive a group of patients in a short period of time as the sending facility had to move rapidly, or for a longer interval of time where the situation may allow for planning before patients are evacuated. This guideline will also identify the tiers of officials and agencies that will need to be contacted (*e.g.*, local emergency managers, emergency 911 or non-emergency PSAP number, *etc.*)

Mr. Aronson identified a recent incident that showed the need to begin working early with local officials – even before the plan is finished. One long term care facility needed to move a group of patients and requested the local emergency manager open a school gymnasium to serve as a temporary stop-over point. This request was quickly denied. It was later identified that using schools this way presents many problems for the school board and community. They are not open 24/7. Unbudgeted staffing would be required. Security for a large campus would be a problem. There was no emergency power available. It was finally worked out that perhaps an assisted living facility or a senior center might have made a more appropriate temporary stop-over point. It was also agreed upon that later, if a sudden emergency happened and alternative facilities such as these were not available, schools might be the only alternative. By collaboratively working together before the emergency, facility and community officials can better understand the needs and problems each is facing, reducing delay and frustration when a request has to be made.

The newly established website and its survey forms were demonstrated by projection on a screen. Mr. Aronson walked through the screens where corporate and facility staff can log in, complete each of the data entry forms, and review data already entered. During this presentation, several agreements were reached:

1. Residential care facilities should be added now to this website.
2. If there is no data to be entered in a box, a "0" or "none" should be allowed to communicate the entry was not overlooked.
3. An entry should be listed under stop-over agreements: "Do you have a current agreement? __Y __N." This will allow a facility to record when planning is in process even if not yet completed.

It was noted that after a section has all its data entered, these entries must be manually saved before going on to other sections. Otherwise, recently added data will be lost.

This project is being heavily supported by the Department of Public Health. Announcements and directives are being sent from DPH to encourage completion of data entry and planning activity.

Mr. Aronson reported on November 12, 2009 that the Attorney General ruled that authority cannot be given for a facility to exceed 10% of their licensed capacity. A study was then made of what other states have done. A broad acceptance was found that in a disaster, allowing facilities to temporarily surge above their licensed capacity is a more effective and safe way to meet the needs of patients. Such authorities are embraced in the neighboring states of Massachusetts and Rhode Island. Then it was learned that during the recent H1N1 outbreak, school infirmaries in Connecticut requested waivers to exceed their normal authorized bed capacities. For some schools, sending sick students home was not possible as they lived in other parts of the country. An agreement was developed and signed that allow affected schools to temporarily exceed their usual licensed capacities. It was decided to follow this accepted precedent by revising this school agreement to meet the needs of long term care facilities. A detailed review led to the following recommendations:

- The agreement should state a valid time period of 2 years, because it would cover future, unforeseen events requiring immediate decision-making,
- The ratio of surge over census to should be 10% (instead of 50%)
- Require the facility has documentation of its approval of the region's LTCF-MAP plan.
- Include under point 3: notification to the local fire marshal during an event but only of the surge would exceed the licensed bed capacity. Other officials might also be added (*e.g.,* building inspector if the certificate of occupancy would be affected.)
- A template should be developed for the written report to DPH after an event occurs. This template should be circulated to the group for its further comments. Once operational, the affected facility or facilities should file its written report with DPH "within a reasonable time."
- Eliminate in item 3 the words …"at all times…" In a disaster, quick action must be taken. During the time when the initial surge of patients being received, all supporting resources probably won't be immediately available.

Discussion took place on one item in the survey concerning payer reimbursement. Some facilities are dual certified for Medicare and Medicaid. Some are not. Identification of each of these certifications would guide decisions on where to send patients in a disaster and expect reimbursement. It was agreed to add "Medicaid certified? Y N " to the survey.

It was agreed that the two professional associations for long term care should review the final draft of the agreement being developed concerning proper procedures to allow the sending facility to continue to bill for services. At least one of the associations might convene a meeting with insurers once agreement is reached to explain these financial procedures. It was suggested that The Connecticut Association of Healthcare Facilities might be the appropriate group to do this.

The main meeting was adjourned

Addendum

Following the primary meeting, a small group of subject-matter-experts met to discuss and resolve a question defining the focus for decision-making and staffing to coordinate efforts in an actual event. It was decided to add the following notes to the meeting minutes.

General agreement was reached that each LTCF will establish its coordination or command center to focus on its single facility needs. If the regional mutual aid plan is activated, a LTCF coordinating group could then be activated. This could be located at a facility [not necessarily the one(s) affected by the disaster] somewhere within the region. Its role would be to respond to requests for coordination of resources based in the LTCF group and to maintain a situational awareness. If the CREPC emergency plan is activated, a regional coordinating center (RCC) will be established. If both the LTCF coordinating group and the RCC are operational at the same time, depending on the nature and scope of the event, a decision can be reached at the RCC to:

- Liaison the two operations by communications (radio, phone), or
- Send a representative of RESF-8 from the RCC to the LTCF coordinating group location, or
- Request someone from the LTCF coordinating group come to the RCC.

As part of this discussion, it was noted that the LTCF bed capacities will soon be logged onto the WebEOC and this information would then be available at all levels.

John Shaw, chairman of RESF-8, has initiated a region-wide discussion to include LTCF planning in this health and medical group. Under consideration is an appointment of a representative from the LTCF Steering Committee to be its representative on RESF-8. These operational liaison roles and relationships will be greatly enhanced when this appointment is made.

Respectfully submitted,

Cressy Goodwin
Recorder