# CONNECTICUT
# LONG TERM CARE MUTUAL AID PLAN
# (LTC-MAP)

## REGIONAL FACILITY EVACUATION & RESOURCE / ASSET SUPPORT FULL-SCALE EXERCISES OCTOBER 2 – 6, 2017


## AFTER ACTION REPORT & IMPROVEMENT PLAN

Report Date: December 1, 2017

Report Prepared By:

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Fire and Emergency Management for Healthcare Facilities

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# EXERCISE OVERVIEW

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|---|---|
| **Exercise Name** | **2017 Connecticut LTC-MAP Regional Facility Evacuation & Resource / Asset Support Full-Scale Exercises** |
| **Exercise Dates** | Region 1: October 2, 2017 12:00pm - 3:45pm<br>Region 2: October 3, 2017 9:00am - 12:45pm<br>Region 3: October 4, 2017 9:00am - 12:45pm<br>Region 4: October 5, 2017 9:00am - 12:45pm<br>Region 5: October 6, 2017 9:00am - 12:45pm |
| **Scope** | These Full-Scale Exercises took place the week of October 2, 2017 for all LTC-MAP Members. The focus of these exercises was the full evacuation of two Disaster Struck Facilities (DSF) per region that created an opportunity for all participating LTC-MAP members in the region to effectively practice and test their plans to be Resident Accepting Facilities (RAFs) and manage an influx of residents. A core focus of this exercise was also having the LTC Coordinating Centers assist and coordinate appropriate resident placement from the DSFs to the RAFs. An evacuation of this type is a complex event that requires detailed planning. To ensure an effective exercise, Subject Matter Experts (SMEs), multiple long-term care facilities (leadership and clinical representation), and local representatives from numerous agencies took part in exercise observation and evaluation. |
| **Mission Area(s)** | Response |
| **Public Health Preparedness Capabilities and Healthcare System Preparedness Capabilities with Associated Functions** | The capabilities listed below, as identified in the Healthcare Preparedness Capacities, National Guidance for Healthcare System Preparedness, published in January 2012, provide the foundation for development of the exercise objectives and scenario. The purpose of this exercise is to measure and validate performance of the following capabilities and their associated critical tasks:<br><br>**HSP Capability 1:** Healthcare System Preparedness<br>Function 1: Develop, refine or sustain Healthcare Coalitions<br>Function 6: Improve healthcare response capabilities through coordinated exercise and evaluation<br>Function 7: Coordinate with planning for at-risk individuals and those with special needs<br><br>**HSP Capability 3:** Emergency Operations Coordination<br>Function 3: Support healthcare response efforts through coordination of resources |

| | |
|---|---|
| | **HSP Capability 6:** Information Sharing<br>Function 1: Provide healthcare situational awareness that contributes to the incident common operating picture (includes resident tracking)<br><br>**PHP Capability 6:** Information Sharing<br>Function 2: Develop, refine, and sustain redundant, interoperable communication systems<br><br>**PHP Capability 10:** Medical Surge<br>Function 1: The Healthcare Coalition assists with the coordination of the healthcare organization response during incidents that require medical surge<br>Function 3: Provide assistance to healthcare with surge capacity and capability<br>Function 5: Provide assistance to healthcare organizations regarding evacuation and shelter in place operations |
| **Threat or Hazard** | Extreme weather emergency: 70-80 MPH winds were experienced in multiple communities resulting in downed trees, structural damage, loss of normal power, and unreliable generator power for some facilities. |
| **Scenario** | High winds impacted multiple Nursing Homes and Assisted Living Residences resulting in full evacuations of some facilities. The evacuation of multiple facilities took place in each region. Mock residents (paper residents) were evacuated to other facilities due to building structural damage, unreliable generators, and loss of normal power. |
| **Sponsor** | **Connecticut Long Term Care Mutual Aid Plan (LTC-MAP)**<br>**Funded by: The Connecticut Department of Public Health and Plan Members** |

| | Participating Organizations |
|---|---|
| **Participating Organizations** | Connecticut Department of Public Health – Facility Licensing & Investigations Section (FLIS), Operations |
| | Disaster Struck Facilities (Identified in After Action Report) |
| | Local Fire Departments, EMS and Emergency Management Officials (Associated with the DSFs and RAFs) |
| | Region 1 LTC Coordinating Center: Lord Chamberlain, Stratford |
| | Region 2 LTC Coordinating Center: Whitney Center, Hamden |
| | Region 3 LTC Coordinating Center: Regional Coordinating Center, Manchester |
| | Region 4 LTC Coordinating Center: Harrington Court, Colchester |
| | Region 5 LTC Coordinating Center: Masonicare at Newtown, Sandy Hook |
| | Regional Healthcare Coalitions / ESF#8s |
| | Resident Accepting Facilities (Identified in After Action Report) |
| | Russell Phillips & Associates, LLC |

**Points of Contact**

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**Acronyms**

| | |
|---|---|
| **ALS:** | Advanced Life Support (Ambulance) |
| **BLS:** | Basic Life Support (Ambulance) |
| **CT DPH:** | Connecticut Department of Public Health |
| **DSF:** | Disaster Struck Facility |
| **EMS:** | Emergency Medical Services |
| **ESM:** | Escalating Situation Member |
| **LTC CC:** | Long Term Care Coordinating Center |
| **NHICS:** | Nursing Home Incident Command System |
| **RCC:** | Regional Coordinating Center (Region 3 only) |
| **RAF:** | Resident Accepting Facility |
| **RPA:** | Russell Phillips & Associates |

# EXECUTIVE SUMMARY

## MAJOR STRENGTHS

The major strengths identified during this exercise are as follows:

- **Community Partner involvement.** LTC-MAP members from around the state took this full-scale exercise as an opportunity to invite and work with community partners. Local Fire Departments, EMS, Emergency Management Directors and Local Health Departments were onsite in member's command centers to help manage the simulated disaster, build relationships and work together.

**Photo: Command Center - Alzheimer's Resource Center, Region 3**

- **Facility based After Action Improvement Plan.** To assist LTC-MAP Members with compliance to the Centers for Medicare & Medicaid Services (CMS) new regulations, Russell Phillips & Associates (RPA) developed a Facility After-Action Report and Improvement Plan. If plan members completed the after-action section and developed an improvement plan they will meet their requirement of participation in a Full-Scale Exercise. In addition, a plan-wide After Action Report is provided and will document the members exercise participation, strengths and areas for improvement.

- **Members correctly handled Social Media injects.** In today's society, it is a very real probability that you may be forced to deal with inappropriate social media posts by your staff. LTC-MAP members were given an inject that stated staff were taking photos of residents and posting them on social media outlets and many members quickly and appropriately handled this "complication". Reviewing the responses to this inject, it was identified that many facilities and communities already had policies in place related to use of social media. Furthermore, many of the members who did not have a formal policy in place regarding this issue have taken this opportunity to develop one.

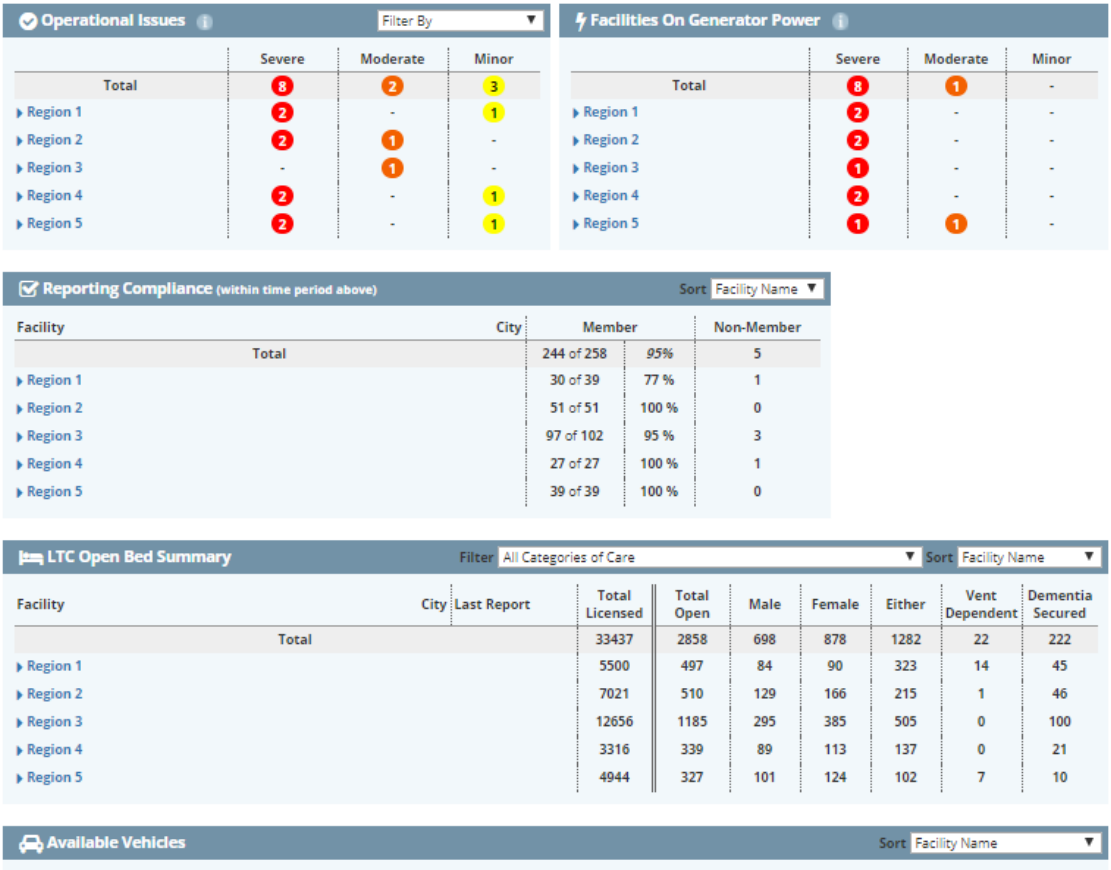
**Photo: Disaster Cart - Governor's House Rehabilitation and Nursing Center, Region 3**

- **Disaster Carts.** Based on tools previously provided by the Mutual Aid Plan, it was great to see during this year's exercises that members have started to design and implement "disaster carts". There is a lot to store and have readily available in an emergency, such as Incident Command Center binders, forms and general emergency preparedness equipment. Members are embracing the opportunity to better organize their supplies and emergency equipment to be in a "ready-state" to respond to disasters.

- **Surge Areas Identified and Set up.** Members successfully identified and set up surge areas. These internal plans were the result of members implementing LTC-MAP provided plans and lessons learned from previous exercises. This process helped members visualize how the setup process would be performed in a true emergency. Many of the members took photos of their surge areas and placed the photos in their internal emergency operations plan.

**Photo: Surge Area - Hamden Rehabilitation and Health Care Center, Region 2**

- **Ability of the LTC Coordinating Centers to assist the DSFs.** The primary objective of the LTC Coordinating Centers is to identify open beds based on their Categories of Care, identify transportation that are available by plan members and track all resident movement from the DSFs to the RAFs. During these exercises the staff at the LTC Coordinating Centers were very successful in utilizing the new dashboard feature on the web based management system to quickly manipulate data to support the evacuating facilities and those with other operational issues.



**Operational Issues** — Filter By

| | Severe | Moderate | Minor |
|---|---|---|---|
| Total | 8 | 2 | 3 |
| Region 1 | 2 | - | 1 |
| Region 2 | 2 | 1 | - |
| Region 3 | - | 1 | - |
| Region 4 | 2 | - | 1 |
| Region 5 | 2 | - | 1 |

**Facilities On Generator Power**

| | Severe | Moderate | Minor |
|---|---|---|---|
| Total | 8 | 1 | - |
| Region 1 | 2 | - | - |
| Region 2 | 2 | - | - |
| Region 3 | 1 | - | - |
| Region 4 | 2 | - | - |
| Region 5 | 1 | 1 | - |

**Reporting Compliance** (within time period above) — Sort: Facility Name

| Facility | City | Member | | Non-Member |
|---|---|---|---|---|
| Total | | 244 of 258 | 95% | 5 |
| Region 1 | | 30 of 39 | 77 % | 1 |
| Region 2 | | 51 of 51 | 100 % | 0 |
| Region 3 | | 97 of 102 | 95 % | 3 |
| Region 4 | | 27 of 27 | 100 % | 1 |
| Region 5 | | 39 of 39 | 100 % | 0 |

**LTC Open Bed Summary** — Filter: All Categories of Care — Sort: Facility Name

| Facility | City | Last Report | Total Licensed | Total Open | Male | Female | Either | Vent Dependent | Dementia Secured |
|---|---|---|---|---|---|---|---|---|---|
| Total | | | 33437 | 2858 | 698 | 878 | 1282 | 22 | 222 |
| Region 1 | | | 5500 | 497 | 84 | 90 | 323 | 14 | 45 |
| Region 2 | | | 7021 | 510 | 129 | 166 | 215 | 1 | 46 |
| Region 3 | | | 12656 | 1185 | 295 | 385 | 505 | 0 | 100 |
| Region 4 | | | 3316 | 339 | 89 | 113 | 137 | 0 | 21 |
| Region 5 | | | 4944 | 327 | 101 | 124 | 102 | 7 | 10 |

**Available Vehicles** — Sort: Facility Name

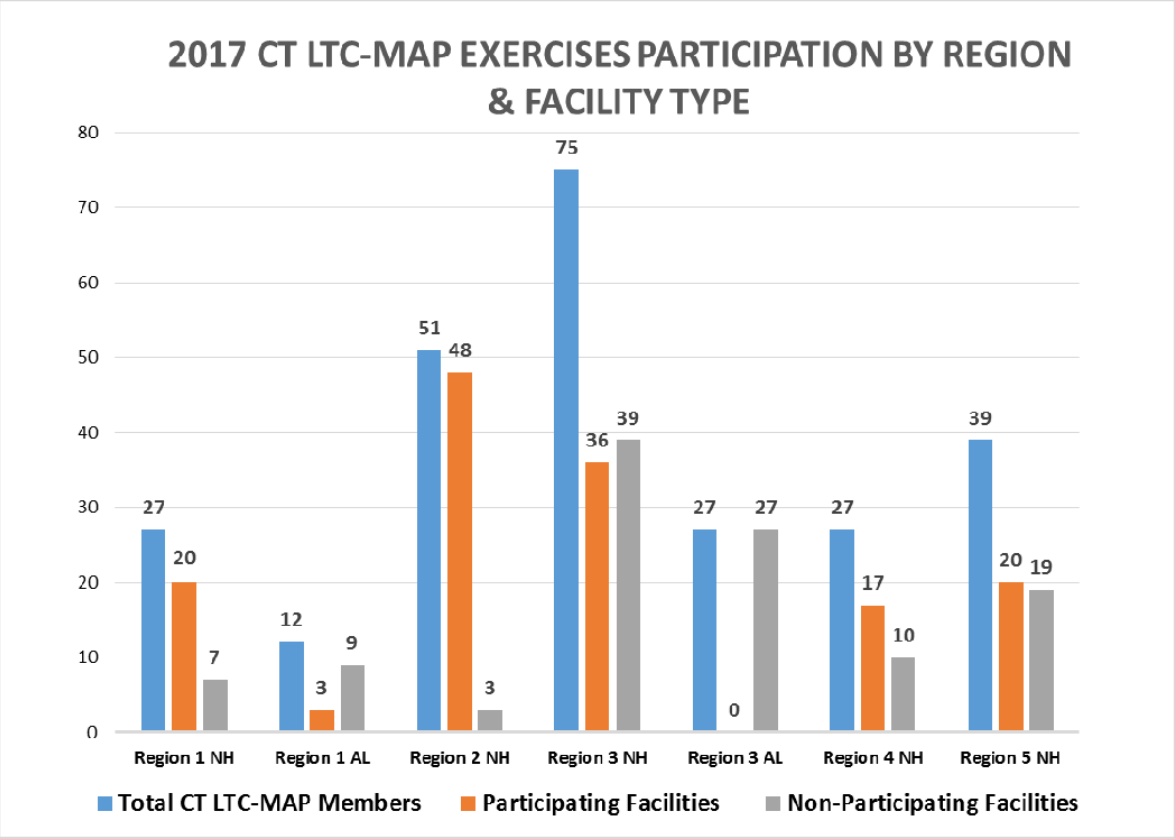
## PRIMARY AREAS FOR IMPROVEMENT

Throughout the exercises, opportunities for improvement were identified to enhance the ability of the LTC-MAP members to respond and assist during an incident. The primary areas for improvement are as follows:

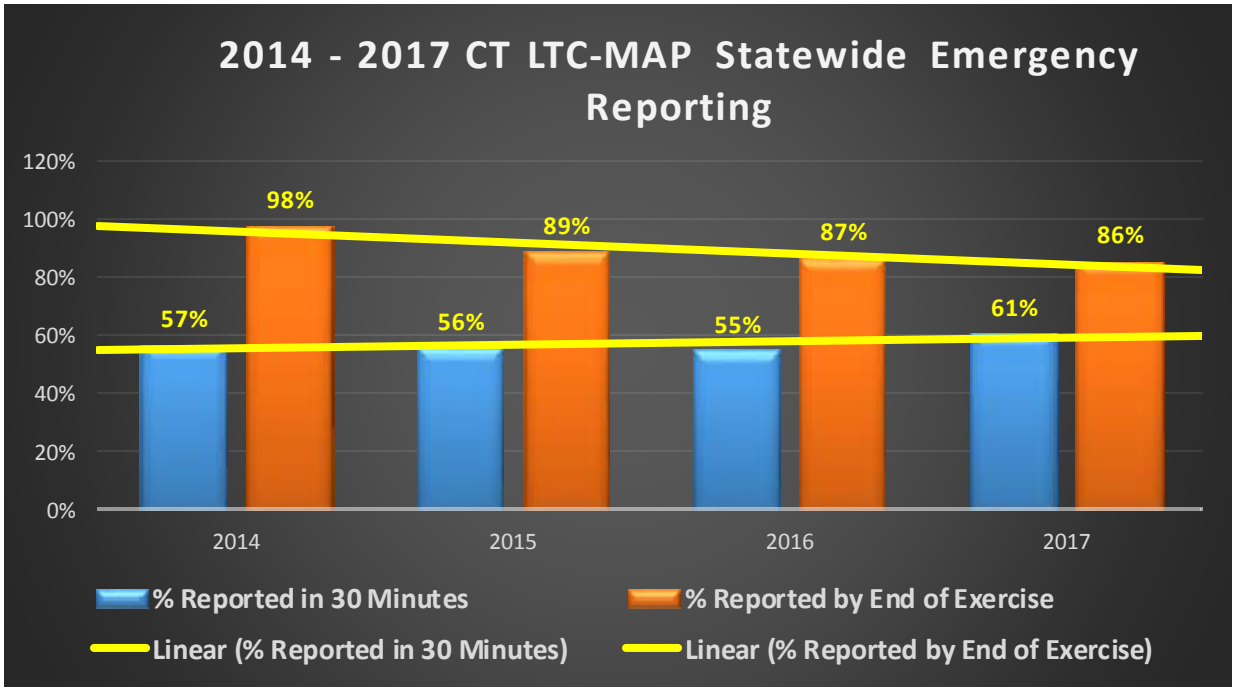
- **Plan Member Participation Report:** The new CMS regulations that took effect on November 15, 2017 state that Nursing Homes are to participate in a full scale exercise each year. RPA developed a Facility Participation Report to document the facilities degree of participation in these full-scale exercises. The following benchmarks were established to document a facilities level of participation:

1. Completion of Emergency Reporting:
    - Within the first 30 minutes of plan activation
    - By the end of the exercise (2.5 hours from plan activation)
    - Did not complete
2. Submitted Social Media Statement
3. Submitted Press Statement
4. Submitted Photos of the following areas:
    - Command Center
    - Triage/Intake Area
    - Surge Area
5. Updated Transportation Evacuation Survey on the LTC-MAP website
6. Submitted the Online Questionnaire
7. Participated on the post exercise hot wash conference call

During the exercises some facilities participated at an increased level from previous years and met many of the benchmarks that were established. The lower levels of participation were primarily seen among the Region 3 and 5 nursing homes and Region 1 and 3 Assisted Living communities. RPA will review improving participation with the Nursing Homes and Assisted Living Communities in these respective regions in 2018. Reference Appendix C for the Plan Member Participation Report by region.



- **Reporting Compliance – All Regions:** There has been a steady decline with overall emergency reporting compliance from 2014 to 2017. Despite the overall decline, emergency reporting within the first 30 minutes has slightly increased (See graphs below for regional specific comparison).




The overall decline is attributed to several factors: leadership changes, contact information not being updated on the website, facilities not receiving the Everbridge messages to complete their reporting and some facilities simply chose not to participate in the exercise. In addition, the Region 1 Assisted Living communities had just joined the plan over the summer of 2017 and had not developed emergency reporting competency as of the exercises.

- **Transportation Evacuation Survey:** Many members did not complete or update their surveys as requested. Prior to the exercises, we requested that all members complete an updated Transportation Evacuation Survey. This survey is to determine transportation needs for all the residents within the facility, community or region.

- **Command Center Locations:** Several members reported having to move their Command Centers due to poor layout, poor location or inadequate resources. Command Centers can be crowded, noisy and tough to manage during an emergency if they are not in proper locations. An effective Command Center should be large enough to accommodate the leadership team, have phone and internet access as well as a means to communicate with their triage/intake or holding area(s).

- **Resident Tracking Confusion:** Stronger communication between the LTC Coordinating Centers and DSFs must be made to ensure a smooth resident placement process. When two facilities are being evacuated, a challenge can be ensuring the LTC Coordinating Centers and the two DSFs are not calling the same RAFs. During this year's exercises, as members were entering their emergency status online, both the LTC Coordinating Centers and DSFs were calling the same RAFs, which caused confusion at many levels. In addition, by exercise design, there were several simulated "waves" of evacuated residents. The first was a generic wave of evacuated residents that was sent to all RAFs within the region via constant contact e-mail. Not all of the facilities received this wave, most likely due to lack of current e-mail addresses in the system, or their e-mail server blocking the e-mail. The second wave of evacuated residents came from the identified DSFs from within the region for that days exercise. Only RAFs selected by either the DSF or the LTC Coordinating Center received the second wave of evacuated residents. This inherently caused confusion amongst the RAFs as to the exact number of residents they would be receiving and from which DSFs. The exercise mechanics behind how the evacuated residents are "sent" from the DSFs to the RAFs will need to be explored and further refined in next year's exercises to avoid this level of confusion and also to promote cleaner resident tracking.

# ANALYSIS OF CORE CAPABILITIES

Aligning exercise objectives and capabilities provides a consistent classification for evaluation that transcends individual exercises to support preparedness reporting and trend analysis.

The following section provides an overview of the performance related to each exercise objective and associated capability, highlighting strengths and areas for improvement.

## Capability 1: Healthcare Systems Preparedness

**HSP Capability 1:** Healthcare Systems Preparedness
Function 1: Develop, refine or sustain Healthcare Coalitions

**HSP Capability 1:** Healthcare Systems Preparedness
Function 7: Coordinate with planning for at-risk individuals and those with special medical needs

### Associated Objectives:

- Demonstrate the ability of the LTC Coordinating Center responders to match evacuating residents with appropriate bed types at RAFs using the categories of care found within the LTC-MAP in a timely and effective manner.

### Strengths

The capability level can be attributed to the following strengths:

**Strength 1: Standing Up the Plan.** LTC-MAP members are notified of a plan activation by the Everbridge electronic notification system and an email notification from the LTC-MAP system. The Everbridge system is managed by each of the Regional Communications Centers. The Everbridge electronic notification system and the LTC-MAP system worked well with no technical issues reported.

**Strength 2: Clinical Placement.** Throughout the exercises, the responders at the LTC Coordinating Centers utilized the tools and reports within the LTC-MAP website to identify the proper receiving facilities based on resident mobility, clinical diagnosis and identified RAFs Categories of Care.

### Areas for Improvement

**Area for Improvement 1: Incident Action Plan.** DSFs struggled to create an Incident Action Plan (IAP) during the initial phases of the exercise.

**Reference:** DSF Controllers / Onsite Evaluators

**Analysis:** Developing and documenting a formal Incident Action Plan (IAP) is a critical step in any incident response. Typically accomplished by the Incident Command Team, the IAP drives the decision making and actions for any operational period. Having this

plan "front and center" throughout a disaster (e.g., displayed on a whiteboard, ICS form or other method, see photo below) will keep the team on track and focused. RPA has provided a guide to assist you in developing your IAP (*see Appendix G, Nursing Home Incident Command System (NHICS) Incident Action Briefing (Form 201)*. We recommend that this tool become part of your Emergency Operations Plan and Command Center tool kit, as it can assist you in the development and documentation of your Incident Action Plan, thereby keeping your team on task in managing the event.

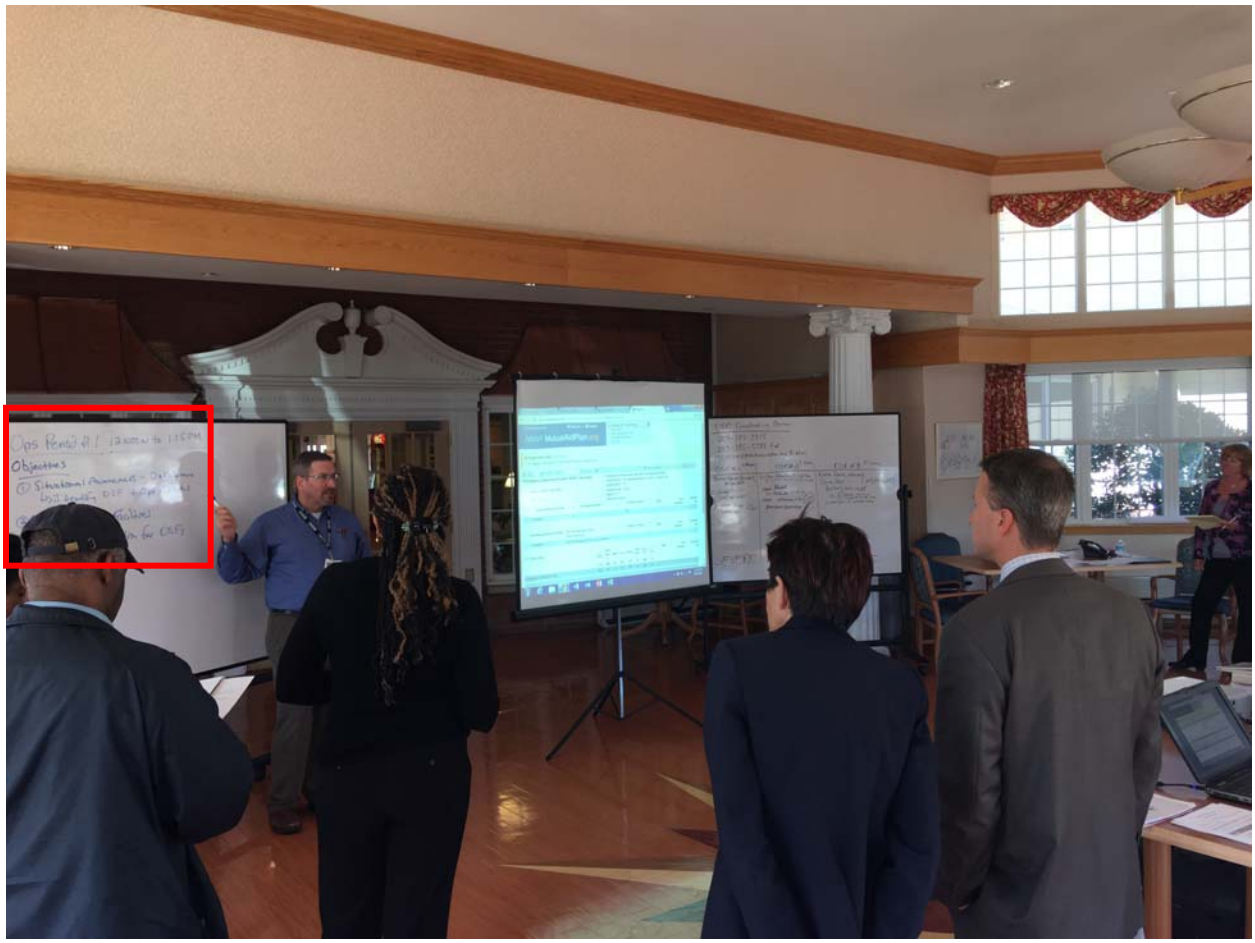


**Photo: LTC Coordinating Center – Lord Chamberlain Nursing and Rehabilitation Center, Region 1**

**Area for Improvement 2: Use of the Incident Command System by plan members.** Not all plan members were comfortable with using a formal or informal incident command system structure.

**Reference:** DSF Controllers / Onsite Evaluators

**Analysis:** Evaluators, community partners and plan members themselves, noted a lack of familiarity and comfort using a formal or informal Incident Command System (ICS). The DSFs and LTC Coordinating Centers all needed prompting by the controllers to establish Incident Action Plans (IAPs) to assist in managing the incident. The California Association of Health Facilities has developed the Nursing Home Incident Command System (NHICS) program. Members need to adopt an Incident Command Structure consistent with that used in their local community. The NHICS follows the basic

framework outlined in the National Incident Management System (NIMS) and is consistent with most community Incident Command Systems. The NHICS program, charts, Job Action Sheets, Forms and instructional tools are all available online at the California Association of Health Facilities (CAHF) website at https://www.cahfdisasterprep.com/nhics.

## Capability 3: Emergency Operations Coordination

**HSP Capability 1:** Emergency Operations Coordination
Function 3: Support healthcare response efforts through coordination of resources

### Associated Objectives:

- Demonstrate effective response and evacuation coordination by LTC Coordinating Centers and RAF personnel through the use of ICS.

### Strengths

The capability level can be attributed to the following strengths:

**Strength 1: Incident Command Vests.** It was noted that some plan members have purchased and properly implemented Incident Command System Vests. The vest position titles mirror the facility's Incident Command System and are an effective way to designate positions, provide a common operating picture of who is assigned to which position, and make staff readily identifiable to internal and external responders.

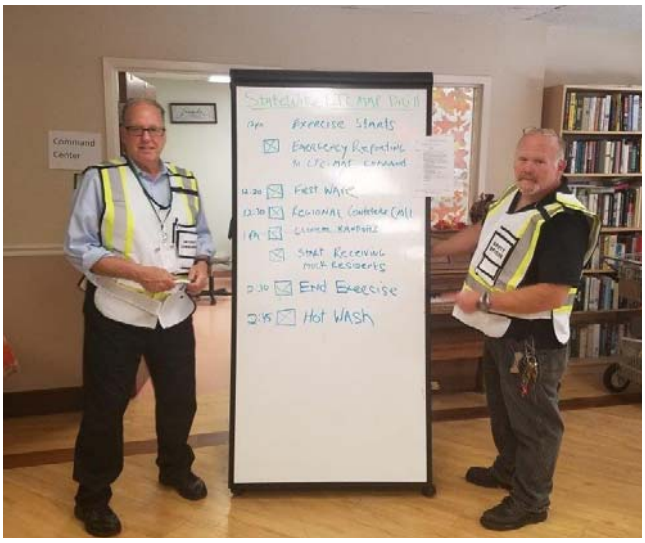



**Photo: Command Center – Maefair Health Care Center, Region 1**

**Strength 2: Key Contacts have been consistently updated.** In previous years, several LTC-MAP members expressed concern that they did not receive the Everbridge electronic notification system messages. Over the past year we have focused efforts during the Annual Education Conferences and with our Regional Steering Committees to drive improvements at the facility level in maintaining and updating contact information. Overall, there was a noticeable decrease in the number of members not receiving the Everbridge notifications.

## Areas for Improvement

**Area for Improvement 1:** **Holding Area Setup**. DSFs lacked the knowledge and tools to effectively operationalize an internal holding area.

**Reference:** DSF Controllers

**Analysis:** A component of a quality Full Building Evacuation (FBE) Plan is to establish a Holding Area. The objective of a Holding Area is to stage residents who have been brought from the clinical units and await transportation from the facility. In order for this area to be successful, it needs to be clinically staffed, have medical supplies available and a system in place to track when residents enter and leave the holding area. As there are multiple functions that need to take place within the Holding Area, and several DSFs struggled to manage this area, a checklist was developed to support Holding Area operations (see Appendix F).

**Area for Improvement 2:** **Communication to evacuated residents/families.** Ongoing communication must occur with residents and families after evacuation has occurred.

**Reference:** DSF Controllers

**Analysis:** During an evacuation, DSF Command Centers focus on the safety of the residents and getting them to a RAF quickly and safely. After the residents have been moved, leadership should consider sending their own nurses/staff out to the RAFs as soon as possible to re-establish communication and care to the evacuated resident(s). Each DSF Command Center should have a list of what RAFs the residents were sent to and start assigning nurses to conduct visits. During the exercises the DSFs did not have a clear plan on when and who would contact families and inform them of the current situation and where their family member would be transferred to. RPA developed a Holding Area Checklist to provide guidance to the leadership staff in the Holding Area (see Appendix F).

**Area for Improvement 3:** **GIS Maps for the LTC Coordinating Centers**

**Reference:** LTC Coordinating Centers Controller

**Analysis:** There were multiple occasions when the LTC Coordinating Center responders were trying to place residents from the DSF to the closet RAF. In addition, deployment of resources, such as available transportation, is better enabled with a poster sized map where the LTC Coordinating Center responders are able to identify the sending/loaning facilities and their proximity to the DSFs. In some cases there are closer facilities in neighboring regions than a farther distance from within the same region. Having a map that details all the healthcare facilities in the region, their facility types and the location of the LTC Coordinating Centers would be very helpful.

### Capability 6: Information Sharing: HSP Capability 6: Information Sharing

Function 1: Provide healthcare situational awareness that contributes to the incident common operating picture (includes resident tracking).

**PHP Capability 6:** Information Sharing

Function 2: Develop, refine, and sustain redundant, interoperable communication systems.

### Associated Objectives:

- Identify the number of LTC-MAP members that provided Emergency Reporting within 30 minutes, by the end of the exercise or did not complete it at all.
- Ensure RAFs receive clinical hand-offs from the DSF, on their actual mock residents who are being evacuated.
- Ensure Plan Members provide ongoing information and situational reports to the LTC Coordinating Centers as their internal situation escalates.
- All plan members to develop and submit a press statement on their actions as it pertains to the exercise.
- Ensure ongoing communication capability throughout the disaster (exercise) by employing redundant systems (e.g., landline telephone, cellular telephone, text, e-mail / scanning, fax, other 2-way communications, and the LTC-MAP website).
- All plan members will coordinate a response to social media being inappropriately used by staff.
- All plan members to complete a Transportation Evacuation Survey and post in their facility data on the LTC-MAP website.
- All plan members to complete a facility based After Action Report & Improvement Plan utilizing the template provided by the Russell Phillips & Associates.
- As part of this AAR a Facility Participation Report was completed for each region (see Appendix C).

### Strengths

The capability level can be attributed to the following strengths:

**Strength 1: Social Media.** Many LTC-MAP members have policies on social media and cell phone usage while working within the facility or community. Members took proactive approaches to handle staff posting on social media sites. These policies and responses were sent to RPA during the exercises and are noted in Appendix C.

**Strength 2: Clinical Handoff.** Several RAFs mentioned that the DSF nursing staff did a great job explaining the resident's emergency evacuation form over the phone. This enabled each RAF to prepare for how to care for the incoming residents as well as how to better prepare the staff and the building for their arrival.

**Strength 3: Family Involvement.** Many plan members informed residents and families of the exercise they were participating in. This was a chance for resident and families to see how the facility or community would handle such an event. We commend the LTC-MAP members who had families onsite during the exercise to observe first hand. CMS

requirements specify that facilities must have a communication plan on how facilities will communicate with families before, during and after a disaster. This provided a good opportunity to develop these plans and detail how those communications will take place and by what means.

## Areas for Improvement

The following areas require improvement to achieve the full capability level:

**Area for Improvement 1: Media Press Statements.**

**Reference:** RAF Inject Responses

**Analysis:** When responding to a disaster, inevitably the media is going to show up looking for information. In some cases, RAFs gave too much information to the media which could be damaging to the DSF, residents or their families. In other cases, RAFs either provided little information or no information at all. Members should have a Press Statement template that could be easily filled out to help capture appropriate information pertaining to the disaster. In addition, the template could be used by the Public Information Officer (PIO) as part of the Incident Command System team to work with media to benefit the DSFs and RAFs (see Appendix E).

**Area for Improvement 2: Command Center Layout.** Proper setup was lacking in DSF member's Command Centers.

**Reference:** Hotwash Conference Call / DSF Controllers

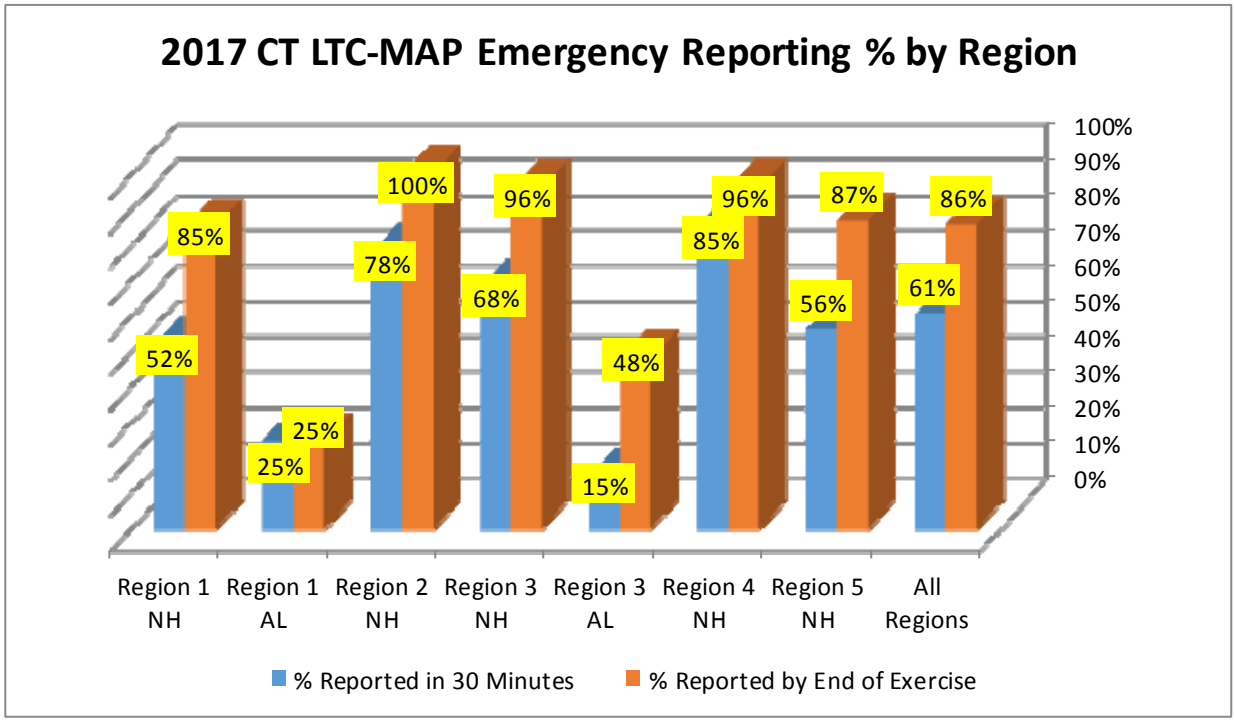
**Analysis:** Command Centers help the leadership stay on task and focus on ensuring the disaster runs smoothly. Phone calls, resident placement decisions, resident tracking, and overall management of the emergency is conducted from the command centers. Members should have a checklist of items regarding how to setup and operate their internal command center and thresholds for when to activate them, as part of their internal Emergency Operations Plan (EOP) or Disaster Plan.

**Photo: Apple Rehab Saybrook, Region 2**

**Area for Improvement 3: LTC-MAP Member Emergency Reporting.**

**Reference:** Hotwash Conference Calls / LTC Coordinating Centers Controllers

**Analysis:** When disasters occur, it is important to capture critical information pertaining to facility operational issues, open beds, available transportation and other various resources within the affected and neighboring regions. The established emergency reporting benchmarks were within the first 30 minutes, within 2.5 hours (the exercise time frame) or no report. See Appendix C for the detailed facility compliance by region. Many of the non-reporting facilities were Assisted Living (AL) Facilities. See graph below for the compliance by region and facility type.




**Area for Improvement 4: Transportation Evacuation Survey:**

**Reference:** LTC Coordinating Centers Controllers, DSFs Controllers

**Analysis:** All the selected DSFs completed a Transportation Evacuation Survey. As this is such an important planning tool for all of the LTC-MAP members, community, regional and state partners, the completion of a Transportation Evacuation Survey was an established benchmark all LTC-MAP members. For regional compliance, see Appendix C. For instructions on how to complete the facility Transportation Evacuation Survey, see Appendix H.

**Area for Improvement 5: Communications Strategies – "Closing the Loop":**

**Reference:** LTC Coordinating Centers Controllers, RAFs EEGs, DSF Controllers

**Analysis:** Accountability of all relocated residents is paramount in an evacuation situation. The primary method for "Closing the Loop" between the DSFs, RAFs and the LTC Coordinating Centers was fax technology, by exercise design. An option that was tested in this year's exercise was scanning / e-mailing to the LTC Coordinating Center. Many of the RAFs experienced difficulty in sending the Influx Logs via fax due to overall call volume and busy signals. Scanning of the Influx Logs and sending via E-Mail went through one hundred percent of the time. Further exploration of the e-mail address to use for the CT LTC-MAP and who amongst the responder teams would have access to it will occur in 2018. Additional approaches may include depositing pdf attachments to the incoming e-mails to a specific location where they may be retrieved from the web based management system.

## Capability 10: Medical Surge

**PHP Capability 10:** Medical Surge

Function 1: The Healthcare Coalition assists with the coordination of the healthcare organization response during incidents that require medical surge
Function 3: Assist healthcare organizations with surge capacity and capability
Function 5: Provide assistance to healthcare organizations regarding evacuation and shelter in place operations

### Associated Objectives

- LTC Coordinating Center coordinate the requests of equipment from the DSFs and RAFs with the assistance of the Healthcare Coalitions and plan members
- DSFs prepare and coordinate the evacuation of their residents, using an Incident Command system, coordination with their local authorities and establishing an efficient holding / evacuation area. Communicate with RAFs as appropriate.
- Ensure that RAFs can surge to accept influxes of evacuating residents by LTC Coordinating Center responders facilitating resource requests and resident tracking, as needed.
- Ensure that RAFs properly implement their influx of resident's plans, including establishing an influx /surge area, utilizing the plan tools to document the arrival of resident.

### Strengths

The capability level can be attributed to the following strengths:

**Strength 1: New Charts.** Upon receiving the mock residents, many of the RAFs created a new chart for each resident. This proved to be beneficial to the RAFs as it made it easier for them to place the resident into a room and immediately start a Care Plan.


**Photo: Orchard Grove Specialty Care Center, Region 4**

**Strength 2: Staff Call Backs.** It was noted that many of the RAFs had their off-shift leadership staff involved in the exercise. We commend these facilities, as most disasters occur during this time frame. In addition, several facilities are using traditional phone tree call systems while others are using web based electronic notification systems for reaching off-duty staff for recall during a disaster response. As expected, the use of the electronic notification systems achieved a higher and quicker rate of staff response.

**Strength 3: CT DPH Surge Waiver.** Each day of the exercise a Resident Accepting Facility as selected to contact the Connecticut Department of Public Health, Facility Licensing and Investigations Section to simulate the waiver signoff and approval process. Every selected RAF was able to successfully reach the CT DPH-FLIS Section Chief and execute the signed surge waiver in a timely fashion. This is a critical component to the surge process as it authorizes the 10% surge above the RAFs licensed beds.

### Area for Improvement

The following area requires improvement to achieve the full capability level:

**Area for Improvement 1: Categories of Care identified in the LTC-MAP website**

**Reference:** LTC Coordinating Centers Controllers

**Analysis:** There were multiple occasions where the LTC Coordinating Centers were trying to place residents and when cross checking the Categories of Care between the DSF and RAF it was noted the potential RAF did not have their the Categories of Care complete. See Appendix I for a quick reference guide on updating the facility's Categories of Care. In one case, the LTC Coordinating Center was looking to place residents on "vents" as indicated by the DSF. The LTC Coordinating Center responder was unfamiliar with the differentiation of vents vs. BiPAP or CPAP. Fortunately, the LTC Coordinating Center was able to solicit the assistance of the facility's Director of Nursing to clarify the specific Category of Care and bed type needed by the DSF.

# CONCLUSION

There were many strengths identified in these exercises by both plan members and the LTC Coordinating Centers.

Every year we educate, drill and exercise to ensure all LTC-MAP members are aware of how to handle an internal or external disaster that may or may not require resident relocation. With that comes challenges to not only to a DSF but also RAFs regarding managing staff, residents, families and media, all while maintaining a safe environment and continuity of care for residents.

This year, we noticed a stronger presence of community partner involvement, both in the planning phase as well as during the exercises in their Command Centers. Local emergency managers, local health directors, emergency medical services directors and regional healthcare coalition partners participated across all regions during the exercises. Many plan members took advantage of the exercises to reach out to their local community partners to begin building good working relationships.

Many plan members utilized the Nursing Home Incident Command system in some form (e.g., wearing vests, establishing positions within the Incident Command System, using the various forms). Standardizing the forms, reporting and overall goals and objectives has made each year a learning experience for all members who actively participate.

We also continue to see areas of potential improvement. All LTC-MAP partners will continue to work together toward the goal of getting all members to complete their emergency reporting in a timely manner. Along with reporting compliance, the LTC-MAP will continue to focus on resident tracking and consistent communication between DSF(s) and the LTC Coordinating Centers. We understand that during disasters there are many challenges and requests the DSF(s) and LTC Coordinating Centers encounter. Through the use of a designated Point of Contact from the LTC Coordinating Center and regular briefings with the DSFs, the responder teams are able to stay on task, accomplish established operational period objectives and respond accordingly to the various resource requests from the DSF(s).

We will continue to build off of each year's exercises with the goal of strengthening member knowledge and their confidence level in effectively managing a disaster. Disasters can happen at any time, and members must remain in a constant state of readiness.