LONG TERM CARE PREPAREDNESS

Base Plan with Appendixes and Annexes

Updated November 2016

MDH Minnesota Department *of* Health

WEST CENTRAL MINNESOTA HEALTHCARE PREPAREDNESS COALITION · WCMHPC

Metro **Health & Medical** Preparedness Coalition

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Southwest Healthcare Preparedness Coalition

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2   INTRODUCTION

The Minnesota Long Term Care (LTC) Preparedness Toolkit was developed to assist with emergency preparedness planning for this specialized health care population. LTC facilities, as they are referred to in the toolkit, include nursing homes, skilled nursing facilities, and assisted living facilities.

Members of the Minnesota Department of Health, Care Providers of Minnesota, Aging Services of Minnesota, and regional representation from the Health Care Preparedness Program developed this tool to assist LTC facilities in emergency preparedness. Latest revisions to this toolkit took place in the fall of 2016 with additional input from individuals representing LTC facilities. The primary focus of the revision is the updated CMS emergency preparedness requirements which were released September 2016 with the implementation beginning in November 2017.

See Appendix A for CMS Emergency Preparedness Checklist for Effective Healthcare Facility Planning

This toolkit can be used by LTC facility owners, administrators, and staff. Information includes: sample templates, forms, and suggested resources to develop and/or enhance facility emergency preparedness plans within LTC throughout the state of Minnesota. It should not be viewed as a static document but one that provides a foundation for an All Hazards approach to preparedness, planning, and response activities.

It is recommended that not one person at any facility be charged in preparing this plan. Rather, it is suggested that an internal committee be formed from various disciplines within the facility to work on this plan. This toolkit serves as a base template that can be customized to the needs of each facility. The tools in this document are important items you will need to address prior to an event occurring.

3   OVERVIEW OF ALL HAZARDS APPROACH TO PLANNING

Recent events such as Hurricane Sandy, the Red River floods of 2009 and other events have stressed all types of health care facilities and shown that better planning is needed. Because different types of events present different challenges to health care entities, an all hazards approach to planning is proven to be most efficient and most beneficial. An all hazards response plan must be based on the hazards that are most likely to affect a facility and it is important in directing how a response may unfold and what the correct response actions would be. In order to identify the most likely hazards, a hazard vulnerability analysis should be completed (see section 3 for more information on the Hazard Vulnerability Analysis info).

3.1   ALL HAZARDS

Hazards may be thought of as extreme events. Hazard vulnerability analysis is often based on an "all hazards approach." This means that one begins with a list of all possible disasters, regardless of their likelihood, geographic impact, or potential outcome. The list may be the result of a committee brainstorming session, research, or other methodology, and should be as comprehensive as possible.

It may be helpful to divide the potential hazards into categories to focus the thought process. Typical

categories may include natural hazards, technological hazards, and human events. These are certainly not requirements, and should not be considered to be constraining. There is overlap between the categories as well. For example, a transportation accident may be considered to be a technological hazard rather than a human event.

Once the complete hazards listing is developed, look at it critically for items that might be appropriately grouped together as one hazard category. Organize the list into categories.

Finally, a prioritization process should be undertaken to determine the course of emergency planning. The realistic factors of time and money play a role in decisions of preparedness, and facilities must choose to apply their limited resources where they will have the most impact. To work toward this end, each identified hazard will be evaluated for its probability of occurrence, risk to the organization, and the organization's current level of preparedness.

3.2 PROBABILITY

Disasters, by nature, are not predictable. Still, familiarity with the geographic area and research will identify those for which the facility must be most prepared. It is important to consider both expected occurrences as well as unlikely scenarios.

Regularly occurring natural disasters are typically well known within a community. The community will often be able to provide data that include hundred-year flood plains, weather information for the locale, etc. The weather bureau may also be able to provide input. In addition, community emergency planning agencies may have already done a community-based hazard vulnerability analysis. This may not provide a complete solution, but it will provide a start.

Nursing homes and long term care facilities have become increasingly dependent on technology to provide their normal services. As a result, a failure of a given technological system can put a facility into an internal state of disaster. Beyond the walls of a facility itself, technology in the community can fail or lead to an incident creating victims in need of medical care or otherwise affecting the health care facility. External transportation failures can lead to unavailability of supplies, which can also be disastrous. In order to determine the probability of these events, examine the internal technology in the facility and the availability of backup systems to compensate for failure. Service records and system failure reports can be used to evaluate the likelihood that these incidents may occur. Types of industry in the community should also be considered in this assessment for a technological disaster with broad community impact.

Establishing the probability of occurrence of these events is only part objective and statistical—the remainder can best be considered intuitive or highly subjective. Each hazard should be evaluated in terms that will reflect its likelihood. The tool presented in this document, for example, uses the qualitative terms of *high, medium, low,* or *no probability of occurrence*. A factor may be used, but is not required, to quantitatively assess the probability.

3.3 RISK

Risk is the potential impact that any given hazard may have on the organization. Risk must be analyzed to include a variety of factors, which may include, but are not limited to the following:

- Threat to human life
- Threat to health and safety
- Property damage
- Systems failure
- Economic loss
- Loss of community trust/goodwill
- Legal ramifications

The threat to human life and the lesser threat to health and safety are considered to be so significant that they are given separate consideration on the hazard vulnerability analysis document. Consider each possible disaster scenario to determine if either of these human impact threats is a factor.

The remaining three categories on the analysis tool classify risk factors as to their disruption to the organization in high, moderate, or low classification. From the bulleted list above, property damage, systems failure, economic loss, loss of community trust, and legal ramifications are all considered together to determine the level of risk.

Property damage in a disaster situation may be a factor more often than not, although the degree of damage may vary. Seismic activity may virtually destroy a building, or render it uninhabitable. In the most severe scenario of this type, the property damage will also include equipment and supplies within the facility. Other hazards may impact only a portion of the building, for example, flooding only in the basement. Perhaps severe weather resulted only in a few broken windows.

Systems failure may have been the cause of the emergency in the first place. A major utility failure may require backup equipment or service that is significantly less convenient, or may not be sustainable for a lengthy time. Even though an alternate system is available, the failure will typically cause a facility to implement emergency plans. Systems failure, however, is not necessarily an isolated occurrence. It can be the result of another hazard, such as flooding damage to an emergency generator.

In any disaster, economic loss is a possibility that deserves consideration. If a facility cannot provide services because of disaster, revenue will be affected. It may result from damage to the physical plant or equipment, inability to access the facility due to transportation or crowd control issues, or a negative public relations impact. Long term care entities are businesses like any other, and economic disruptions can be managed for only a limited time. Each hazard must be analyzed for its adverse financial impact.

An issue of loss of goodwill has the potential for legal ramifications in the aftermath of a disaster. If errors were made in the management of the emergency, if lives were lost or injuries occurred, the facility could face legal action. It is advisable to consult risk management and/or the facilities legal counsel if questions exist in this area.

3.4 PREPAREDNESS

Finally, an evaluation of the organization's current level of preparedness to manage any given disaster should be undertaken. This process should involve the input of community agencies. The health care facility will not be responding to an emergency in a vacuum, and there may be community resources to support the facility.

Long term care facilities have done disaster planning for many years and are well prepared to manage many types of emergencies. However, the scope of current emergency planning has expanded and the typical organization will find at least some hazards from the all-hazards list for which improvements are needed. The current status of emergency plans and the training status of staff members to respond to any given hazard is a factor to consider in evaluating preparedness.

The health care organization may carry insurance to compensate for losses suffered because of some emergencies. Backup systems may also be thought of as insurance protecting against certain occurrences. The availability of insurance coverage or backup systems should be factored into the determination of the current preparedness status.

The hazard vulnerability analysis tool in this document evaluates the organization's preparedness level as good, fair, or poor. An alternative way of approaching this issue is to evaluate each hazard based on the amount of improvement needed, for example, slight, moderate, or major. Both systems will yield similar results.

Planners within the organization should evaluate this section critically and realistically. Failure to do so may result in a false sense of security, which may result in an increased impact on some of the risk factors discussed above. Appropriate evaluation of preparedness will direct the organization's effort and resources earmarked for emergency management.

4 PLAIN LANGUAGE

Utilization of plain language decreases staff confusion and ensures transparency for residents and visitors. The linked toolkit offers suggestions for how to utilize plain language in emergency overhead paging.

Minnesota Hospital Association. (2011). *Plan Language Emergency Overhead Paging.* St. Paul, MN. https://www.mnhospitals.org/Portals/0/Documents/ptsafety/overhead-paging-toolkit-2011.pdf

Emergency Situation	Emergency Code
Severe Weather	**Weather Alert + Descriptor**
• **Thunderstorm Watch**	Weather Alert + Thunderstorm Watch
• **Thunderstorm Warning**	Weather Alert + Thunderstorm Warning (+ Lockdown/Shelter-in-Place/Evacuate)
• **Tornado Watch**	Weather Alert + Tornado Watch
• **Tornado Warning**	Weather Alert + Tornado Warning (+ Lockdown/Shelter-in-Place/Evacuate)
Security Alert	**Security Alert + Descriptor + Location**
• **Active Shooter**	Security Alert + Active Shooter + Location (+ Lockdown/Shelter-in-Place/Evacuate)
• **Bomb Threat**	Security Alert + Suspicious Device/Bomb Threat (+ Lockdown/Shelter-in-Place/Evacuate)
• **Civil Disturbance**	Security Alert + Civil Disturbance + Location (+ Lockdown/Shelter-in-Place/Evacuate)
• **Missing Person/ Elopement**	Missing Person + Descriptor + Location (+ Lockdown, as applicable)
• **Threat of Violence**	Security Alert + Threat of Violence + Location (+ Lockdown/Shelter-in-Place/Evacuate)
Emergency Alert	**Emergency Alert + Descriptor + Location**
• **Electric Power Outage**	Emergency Alert + Electric Power Outage + Location (+ Lockdown/Shelter-in-Place/Evacuate)
• **Fire**	Emergency Alert + Fire Alarm + Location (+ Lockdown/Shelter-in-Place/Evacuate)
• **Flood**	Emergency Alert + Flood + Location (+ Lockdown/Shelter-in-Place/Evacuate)
• **Hazardous Material**	Emergency Alert + Hazardous Material + Location (+ Lockdown/Shelter-in-Place/Evacuate)
• **Natural Gas Leak**	Emergency Alert + Natural Gas Leak + Location (+ Lockdown/Shelter-in-Place/Evacuate)
• **Evacuation**	Emergency Alert + Mandatory Evacuation + Descriptor + Location (+ Lockdown/ Move to Staging/Assembly Areas)
• **Medical Emergency**	Emergency Alert + Nurse Stat + Location
• **Shelter in Place**	Emergency Alert + Shelter in Place + Descriptor + Location (+ Lockdown/ Move to Staging/Assembly Areas)
(https://www.mnhospitals.org/Portals/0/Documents/ptsafety/overhead-paging-toolkit-2011.pdf)	

5   HAZARD VULNERABILITY ANALYSIS TOOL

The *hazard vulnerability analysis tool* is simply that -- a tool. It is provided as a resource and a starting point for organizations to evaluate their vulnerability to hazards. It may be modified or changed in any way that is appropriate for individual facility use.

This document uses a quantitative method to evaluate vulnerability, which is also not required. The facility may find a qualitative method equally as effective.

Using this tool, each potential hazard is evaluated as described above and scored as appropriate in the areas of probability, risk, and preparedness. The factors are then multiplied to give an overall total score for each hazard. Note that a hazard with no probability of occurrence for a given organization is scored as zero and will automatically result in a zero for the total score.

Listing the hazards in descending order of the total scores will prioritize the hazards in need of the facility's attention and resources for emergency planning. It is recommended that each organization evaluate this final prioritization and determine a score below which no action is necessary. The focus will then be on the hazards of higher priority. Establishing a cutoff value, however, does introduce risk to the organization for those hazards falling below. The facility has determined that there is some probability and risk of the event occurring, and has chosen to exclude it from the planning process. It must be noted that the acceptance of all risk is at the discretion of the organization.

5.1 HAZARD VULNERABILITY ANALYSIS
INSTRUCTIONS:

Evaluate every potential event in each of the three categories of probability, risk, and preparedness. Add additional events as necessary.

Issues to consider for probability include, but are not limited to:
1. Known risk
2. Historical data
3. Manufacturer/vendor statistics

Issues to consider for risk include, but are not limited to:
1. Threat to life and/or health
2. Disruption of services
3. Damage/failure possibilities
4. Loss of community trust
5. Financial impact
6. Legal issues

Issues to consider for preparedness include, but are not limited to:
1. Status of current plans
2. Training status
3. Insurance
4. Availability of back-up systems
5. Community resources

Multiply the ratings for each event in the area of probability, risk and preparedness. The total values, in descending order, will represent the events most in need of organization focus and resources for emergency planning. Determine a value below which no action is necessary. Acceptance of risk is at the discretion of the organization.

Facilities are to review and update their HVA annually.

5.2 SAMPLE HVA TOOL

Note: an electronic HVA can also be accessed through your regional health care coalition. The electronic version looks like

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interruption of services*	*Preplanning*	*Time, effectiveness, resources*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Tornado								0%
Severe Thunderstorm								0%
Snow Fall								0%
Blizzard								0%
Ice Storm								0%
Temperature Extremes								0%
Proximity to Airport								
Proximity to Train Tracks								
Proximity to MOA								
Proximity to Downtown								
Drought								0%
Flood, External								0%
Wild Fire								0%
Landslide								0%
Dam Inundation								0%
Volcano								0%
Epidemic								0%
AVERAGE SCORE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

See Appendix B for HVA.

6 EMERGENCY OPERATIONS PLAN TOOL

The following tools serve as specific components that will allow your organization to plan and prepare to meet the needs of both your residents and staff in the event of an incident. Each tool will be preceded by a descriptor of the tool and instructions where necessary. These tools when taken as a whole are the basis of an Emergency Operations Plan (EOP).

Once the EOP has been developed, it is also the role of the team to be sure that this plan is shared with appropriate staff and that internal training is conducted. This training should be incorporated into regularly scheduled trainings as staff changes do occur and keeping current on any material requires periodic review.

For an EOP to maintain viability and usefulness, it needs to be updated on a scheduled basis. As each facility grows and changes, the EOP also needs to be modified to reflect those changes. Once these tools are completed, your EOP will be well on the way to serving each facility's need to care for staff and residents.

6.1 INCIDENT COMMAND SYSTEM

In any emergency response, it is critical that clear lines of authority (chain of command) exist within the facility. This ensures that there is timely and efficient decision-making and communication. It is important to define a chain of command, designate a facility incident commander, and clarify their authority and decision-making ability. This is an important aspect of the disaster plan.

Disaster planning needs to start at the top of the organization. Bring the leaders of the organization into the planning process from the very beginning to identify and agree upon the best course of action for the health care facility, its residents and staff. Organization leaders should discuss the financial and clinical implications of the various proposed response strategies. This may include items such as closing to new admissions or agreeing to be a "surge" or overflow setting for the local hospital. Medical and administrative priorities need to match, and your facility's leadership team needs to be clear about its role and authority.

Incident Command Systems (ICS) can be used at organizations both large and small — it can even be used by just one person. If you have a small organization, the same person may fill multiple spots on the ICS organizational chart. Assure through practice and exercise that one designated person is not disproportionately overburdened with her or his roles in an emergency. It is recommended that, at a minimum, frontline staff obtain the basics of ICS by taking ICS 100, ICS 200, and ICS 700. These courses and more can be found at: https://www.fema.gov/training-0

6.2 BENEFITS OF UTILIZING INCIDENT COMMAND IN HEALTH CARE

Common terminology/clear text
The use of common terminology provides for a clear message and sharing of information. It avoids the use of codes, slang, or discipline specific verbiage that may not be clearly understood by all planning and response partners. Common terminology helps to define the organizational

structure: as an example, the identification of sections, section chiefs, and branch directors. Another key benefit of common terminology is the ability to share resources in the response, such as personnel to oversee incident management or operations. By using consistent terminology, the opportunity to develop memorandums or agreements to share personnel is enhanced.

Modular organization
The ICS structure begins from the top and expands as needed by the event. Positions within the structure are activated as dictated by the incident size or complexity. As complexity increases, the ICS organization expands. Only those functions or positions necessary for an incident are activated. This will be clearly demonstrated in subsequent sections that detail the incident management team along with their roles and responsibilities.

Management by objectives
The Incident Commander initiates the response and sets the overall command and control objectives. The mission of the response is defined for all members of the response team through a clear understanding of the organization's policy and direction. This includes an assessment of the incident from the current situation to projected impacts. To meet the overall mission, or command objectives, individual sections will establish incident objectives as well as the strategies to achieve these objectives through clear tactics. Because emergency response is not "business as usual," clearly defined objectives will allow staff to focus on the roles in the response, avoiding duplication of efforts or omission of critical actions.

Incident Action Planning
The development of objectives is documented in the Incident Action Plan (IAP). A written plan provides personnel with direction for taking actions based on the objectives identified in the IAP and reflects the overall strategy for incident management while providing measurable strategic operations for the operational period. To ease this process, ICS forms are designed and developed for nursing homes and are contained within the California Nursing Home ICS guidebook (http://cahfdisasterprep.com/NHICS/GuidebookTools.aspx).

Manageable span of control
A key concept in ICS is maintaining a span of control that is both effective and manageable. Because emergency events are not business as usual situations, the span of control for operations that are not routine should be kept at an effective number. Within ICS, the optimum span of control is one supervisor to five reporting personnel. If the number falls outside these ratios, the incident management team should be expanded or consolidated.

Pre-designated incident locations/facilities
In the planning stages, planners should determine the location of their response and coordination sites, including the coordination and command sites. Within ICS, sites are identified for both scene and regional coordination, such as helicopter landing zones, staging areas, command posts, and emergency operations centers. Planners within the nursing home or long-term care facility should identify sites for ICS management, staging areas for receipt of supplies and equipment, evacuation sites if the infrastructure is unsafe, and so on.

Resource management
Resources are assets that are used in the response. Examples include personnel, equipment, food, communications, supplies, vehicles, etc. When making requests for assistance from other health care facilities, local emergency management, regional health care coalitions and other state partners have a clear picture of current and needed resources. This level of awareness allows those providing the support to provide the necessary assets through a clear understanding of current capability.

Integrated communications
There are three elements within integrated communications: modes, plans and networks. The modes include the hardware systems that transfer information, such as radios, cell phones, and pagers. Plans are developed in advance and outline how to best use the available modes through a clear and concise communication policy and procedure (for example, determining who can use radios and what information should be communicated). Networks are identified within the jurisdiction and will determine the procedures and processes for transferring information internally and externally.

Common command structure
The ICS provides for a common command structure that identifies core principles for an efficient chain of command. *Unity of Command* dictates that each person within the response structure reports to only one supervisor. A *single command* exists when a single agency or discipline responds to an event; for example, the fire service at a warehouse fire is commanded by a fire captain or chief. When multiple agencies or disciplines are working together at a scene, there is a *unified command* structure that allows for coordination in response actions. For nursing homes, this may occur when the facility is the scene of the incident, such as a fire. The nursing home administration and the fire command work together in a unified command structure.

6.3   BASIC ICS JOB ACTION OVERVIEW

The organization chart is the base to ICS and is utilized when a response to any incident is necessary. Specific personnel placed in the various roles are determinant on the skills and position with the organization.

- **Incident Commander**: Leads the response, appoints section leaders, approves plans and key actions (CEO, administrator, Director of Nursing (DON), nursing supervisor.)
- **Operations Section**: Handles key actions including first aid, search and rescue, fire suppression, securing the site (DON, Department supervisors, nursing supervisor, direct care staff.)
- **Planning Section**: Gathers information, thinks ahead, makes and revises action plans and keeps all team members informed and communicating. (Safety committee, Continuity of operations planning team, etc.)
- **Logistics Section**: Finds, distributes, and stores all necessary resources (maintenance supervisor, purchasing, human resources director)
- **Finance Section:** Tracks all expenses, claims, activities, and personnel time and is the record keeper for the incident (controller, accounts department, payroll.)

- **Public Information Officer**: Provides reliable information to staff, visitors and families, the news media and concerned others as approved by the Incident Commander. (Social Worker, Administration Personnel)
- **Safety Officer**: Ensures safety of staff, residents, and visitors; monitors and corrects hazardous conditions. Has authority to halt any operation that poses immediate threat to life and health.
- **Liaison Officer**: Serves as the primary point of contact for supporting agencies assisting the facility. (Social Worker, Administration Personnel)

Example Organization chart:
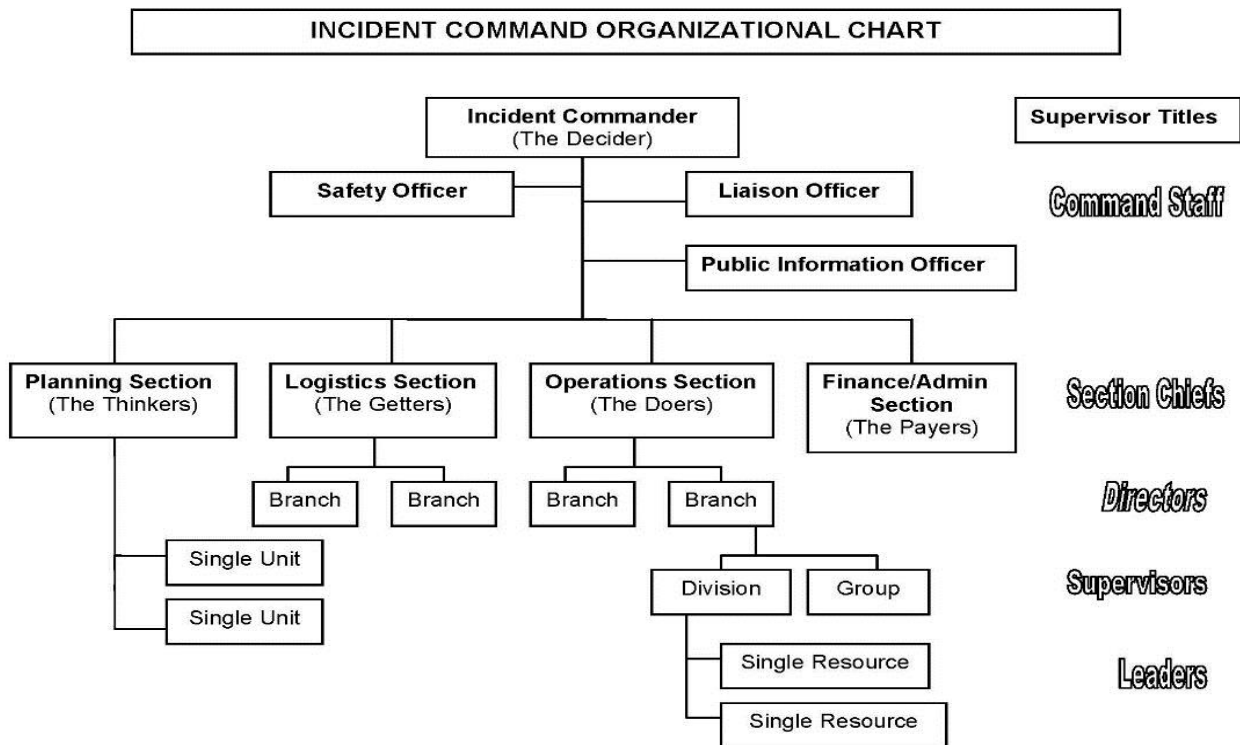
Depending on the size of the facility, one person may occupy multiple positions **within the section.** You do not need to activate all positions – only activate what you need for the incident. This is your basic Incident Command. If part of a larger system i.e.: health organization, you will need to know where your ICS fits within that organization's structure.

See Appendix C for Organization Chart/Job Action Sheets

An online version of the Heath Care Incident Command system (HICS) specifically designed with the Long Term Care facility in mind is located at http://www.smrrc.org/hics.htm.

The following chart is a list of persons that can be used to fill a role in the Organization Chart:

Incident Command Position	Facility role
Incident Commander	Administrator/CEO
Medical Director/Specialist	Medical Director/Nurse Consultant
Public Information Officer	Administrator/Media Relations
Liaison Officer	Community specialist/assistant administrator
Safety Officer	Maintenance
Operations Section Chief	Director of Nursing/Nursing Supervisor
Resident Services Branch Director	Director of Staff Development
Nursing Unit Leader	Nursing supervisor/Charge Nurse
Admit/Transfer & Discharge Unit Leader	Nursing supervisor/Charge Nurse/Admissions
Infrastructure Branch Director	Housekeeping supervisor
Dietary Unit Leader	Dietary supervisor
Environmental Unit Leader	Housekeeping
Physical Plant/Security leader	Maintenance
Planning Section Chief	Assistant administrator
Situation Unit Leader	Admissions
Documentation Unit leader	Medical Records
Logistics Section Chief	Chief Finance Officer/Assistant Administrator
Services Branch Director	Accounts manager
Communications Unit Leader	Maintenance
IT/IS Unit Leader	IT/IS staff
Supply Unit Leader	Purchasing
Staffing/Scheduling Unit Leader	Human Resources/Staffing
Transportation Unit Leader	Maintenance/Activity staff/Rehab
Finance/Admin Section Chief	Chief Finance Officer/Accounting
Time Unit Leader	Payroll/billing
Claims Unit Leader	Risk Manager/Quality manager

7 ORGANIZATION INFORMATION / CONTACT INFORMATION

For an EOP to be functional, it is dependent on current and accurate information. Key to any response is the ability to know who to notify and how to get in touch with these personnel. For this reason, having current and accurate organizational information along with current information regarding key staff is essential. An effective response cannot occur without personnel. The following information needs to be maintained and updated periodically so timely communications and response can occur. The following information is broken out into three separate areas:

1. **Organizational Information:** contains the contact information for facility ownership and leadership.
2. **Emergency Contact Roster-Internal:** contains the contact information for supervisors/leaders within the organization.
3. **External Contact Information-External:** contains emergency contacts, contractors, and outside support services

See Appendix D for Contact lists

8 FACILITY- SPECIFIC INFORMATION

This information is made up of the location and characteristics of the facility and the people associated with it. As with any response, it is important to understand the physical features of a facility in order to maintain safety and efficiency. It is also important to understand the occupancy and certain specific information regarding the occupants. The facility-specific information provides descriptions of the facility and some baseline information regarding staff and residents. The information contained should be reviewed and updated annually.

See Appendix E for Facility Specific Information

9 DECISION MAKING

During an unplanned event knowing what needs to be done to ensure the safety of the residents as well as the staff can be extremely stressful. The facility should have a clearly delineated decision making tree.

9.1 SAMPLE DECISION MAKING TREE

Emergency Decision Tree
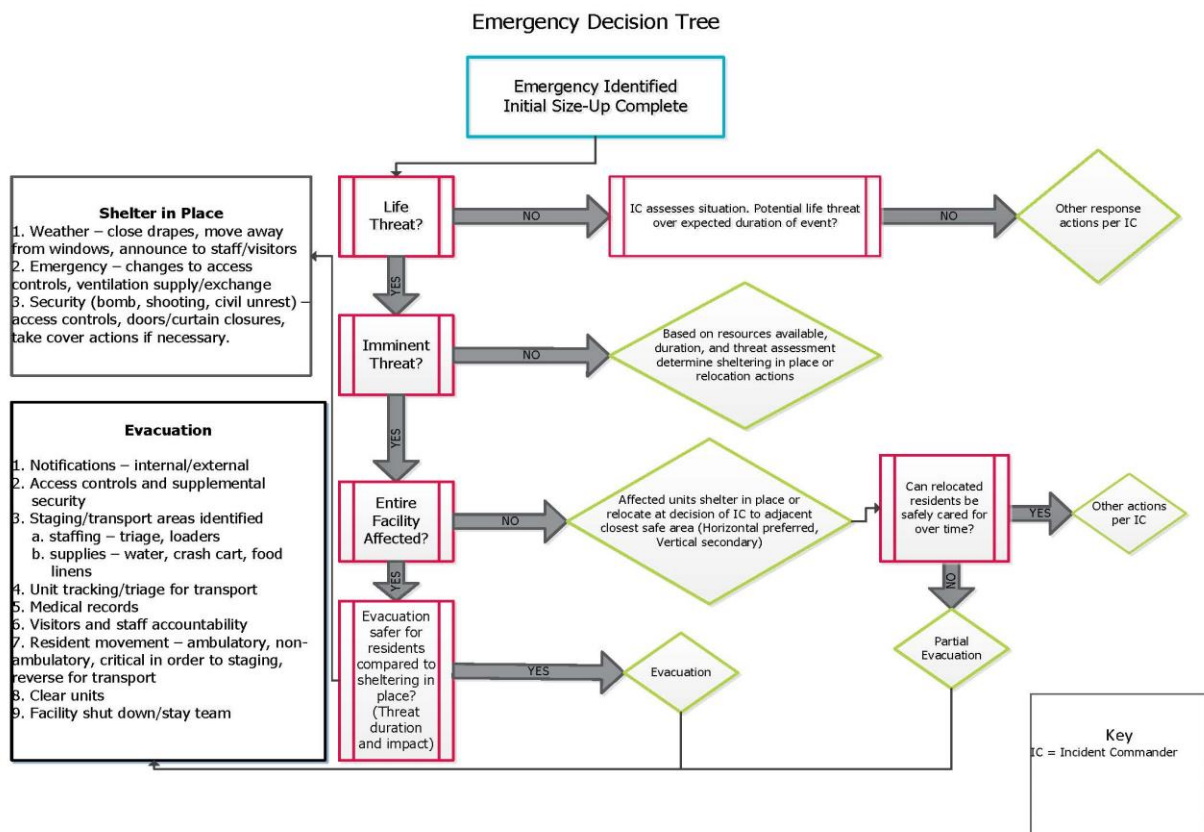
10 HIPAA IN EMERGENT SITUATIONS

During emergent situations, the decision to share private patient/resident health care information is difficult. To ensure that there is continuity of care there may be situations where it is necessary to waive HIPAA.

See Appendix F for HIPAA Waiver toolkit.

AT A GLANCE – May I disclose protected health information for public health emergency preparedness purposes?

(From the perspective of the source of the information)

Disclosure to a Public Health Authority

START

Am I a covered entity? §160.103 — NO → The Privacy Rule does not apply to non-HIPAA covered entities → Disclosures can be made without regard to the Privacy Rule

YES

Is the intended recipient a public health authority (PHA)? §164.501 — YES → Is the PHA authorized by law to collect or receive information for the purpose of preventing or controlling:
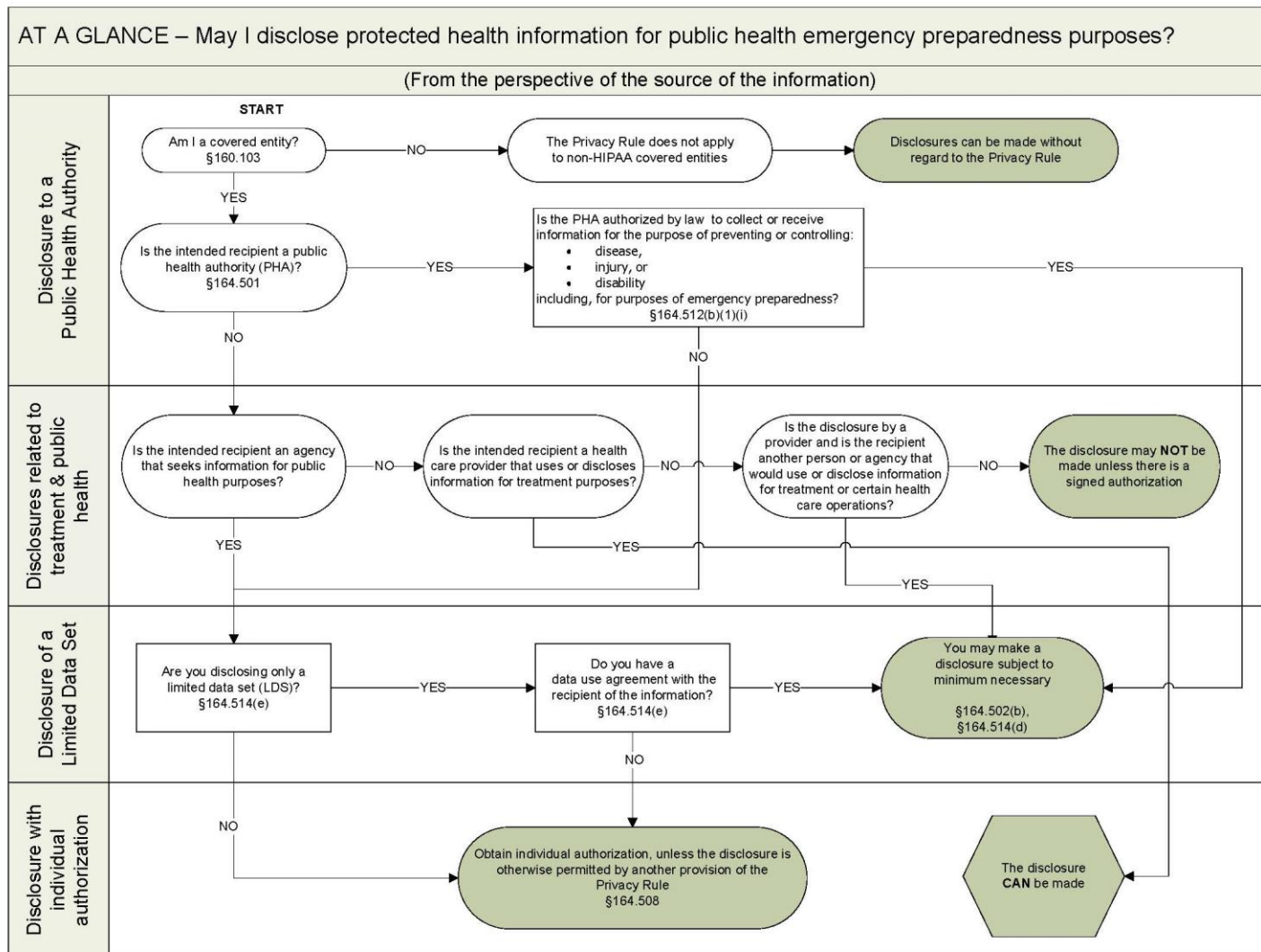- disease,
- injury, or
- disability

including, for purposes of emergency preparedness? §164.512(b)(1)(i) — YES →

NO

NO

Disclosures related to treatment & public health

Is the intended recipient an agency that seeks information for public health purposes? — NO → Is the intended recipient a health care provider that uses or discloses information for treatment purposes? — NO → Is the disclosure by a provider and is the recipient another person or agency that would use or disclose information for treatment or certain health care operations? — NO → The disclosure may **NOT** be made unless there is a signed authorization

YES

YES

YES

Disclosure of a Limited Data Set

Are you disclosing only a limited data set (LDS)? §164.514(e) — YES → Do you have a data use agreement with the recipient of the information? §164.514(e) — YES → You may make a disclosure subject to minimum necessary

§164.502(b), §164.514(d)

NO

NO

Disclosure with individual authorization

Obtain individual authorization, unless the disclosure is otherwise permitted by another provision of the Privacy Rule §164.508

The disclosure **CAN** be made

11 ETHICAL GUIDELINES

The Institute of Medicine's *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations* offers a useful framework which fundamentally relies on the principle of justice.

Ethical Values:

- Fairness – who receives what and at what point
- Professional Duty – do no harm, do not abandon
- Stewardship – allocating scarce resources; utilitarianism

Ethical Process Elements:

- Transparency – communication to stakeholders
- Consistency – nondiscrimination
- Proportionality – elevating response during emergency
- Accountability – acting upon duty to respond

During an emergency, the following events require incorporation of sound ethical considerations:

1. Triaging – There are two phases of triage: reactive and proactive. Reactive triaging occurs when there is no notice of a disaster such as an explosion or tornado. Triaging must occur "in the moment." Proactive triage would be the prioritization of which resident to evacuate first prior to an impending crisis.
2. Allocation of Resources - Workforce members should know what resources are available during a crisis, where supplies are stored, and have the tools needed to determine how scarce resources will be issued.
3. Workforce members should be prepared to adjust their standards of care during an emergency. Considerations include ensuring individuals are trained to provide care normally outside of their professional practice.

12 EVACUATION PLAN

While evacuation is typically not preferred, there may be times when this option is safest for the residents and staff. Due to the varied abilities of nursing home residents, evacuation can be a daunting task without appropriate consideration and planning ahead of time. Prior planning regarding how residents will be transported, who will provide the transportation, what specialty types of vehicles will be needed and where they will come from all need to be prearranged in order to maximize the safety of residents and staff. Evacuation planning also includes determining what supplies, food, water, medications, and other physical items will be needed in order to maintain safety. Pre-determined locations should be identified where residents can be taken that will adequately meet their needs. Identifying pre-determined locations and having discussions ahead of time will ensure a smooth transition. Two sample memoranda are provided to serve as templates (See Appendix I). Additionally, it should be noted that having an evacuation agreement with more than one facility would be appropriate. Traditionally, facilities often choose the closest like facility with which to partner. However, a second facility some distance away may be prudent in the event that the closest facility may be similarly affected and unable to handle the transfer request.

The following pages are specifically dedicated to looking at evacuation needs. If additional evacuation and shelter-in-place planning resources are desired, please refer to the Minnesota Department of Health website.

12.1 TRANSPORTATION PLAN

The transportation plan should describe how the residents will be transported to the sheltering facilities. It should include as an attachment any contracts or Memorandums of Agreement with transportation companies, churches or ambulance services, or other transportation modality. The transportation plan should include:

a. The number and types of vehicles required.
b. How the vehicles will be obtained.
c. Who will provide the drivers.
d. Medical support to be provided for the patient or resident during transportation. The following support needs should be considered:
1. Residents who are independent in ambulation.
2. Residents who require assistance with ambulation.
3. Residents who are non-ambulatory.
4. Residents with cognitive impairments.
5. Residents with equipment/prosthetics (equipment/prosthetics should accompany residents and should be securely stored in the designated mode of transportation).
e. Estimation of the time to prepare residents for transportation.
f. Estimation of the time for the facility to prepare for evacuation.
g. Estimation of time for the patient or resident to reach the sheltering facility.
h. Detailed route to be taken to each sheltering facility if possible.
i. Description of what items must be sent with the patient or resident such as:
1. The patient's medical record, which contains medications the patient is taking, dosage, frequency of medication administration, special diets, special care, etc.
2. A three-day supply of medications (if possible).
3. Special medical supplies the patient may need.
4. Other items such as clothing, incontinence diapers, etc.
j. The medical records should be provided to the receiving facility and remain with the receiving facility until the patient or resident is transferred back to the sending facility or to another facility.
k. Records should be maintained of which residents are transported to which facilities.

12.2 EVACUATION DESTINATION INFORMATION

The Sheltering Plan should describe where the residents will be transported. The receiving facility should be appropriate for the level of care required for the residents being evacuated. The plan should include as an attachment any contract, memorandum of agreement, or transfer agreement the facility has with a receiving facility. The following should also be included in the plan:

a. Sleeping plan
b. Feeding plan
c. Medication plan
d. Accommodations for relocated staff
e. Number of relocated residents that can be accommodated at each receiving facility

12.3 Staffing Plan

The Staffing Plan should include how the relocated residents will be cared for at the sheltering facility as well as the number and type of staff that is needed at the evacuating facility to help evacuate the residents. The Staffing Plan should include:

    a. Description of how care will be provided to relocated residents

    b. Identification of number and type of staff needed to evacuate the facility and to accompany residents to the sheltering facility

    c. Plan for relocating facility staff

    d. A contingency plan if facility staff cannot make it into the shelter due to their own family's needs.

12.4 ATTACHMENTS AND DOCUMENTS

The following documents should be included as attachments to the Evacuation Plan:

    a. Sheltering agreements between the facility and the receiving facility (must be update annually)

    b. Transportation agreements between the facility and ambulance companies, bus services, churches, etc. (must be updated annually)

    c. Documentation of any coordination between law enforcement, fire departments, etc.

See Appendix G for Evacuation plans, checklists and transportation agreements.

13 SHELTERING IN PLACE

In certain situations, such as a tornado or chemical incident, your facility may be better off to stay and shelter in place. The facility needs to plan for sheltering in place. In an emergency, your facility may be without telephone or other communications, electric power, or water and sewer service for several days. The facility must be able to exist on its own for at least 72 hours without outside assistance. Your plan should include provisions for resident care (monitoring of medical conditions), facility safety and security, food, water, medications, contact with first responders (fire, police, EMS, etc.), public health, transportation, staff, lighting, temperature control, waste disposal, and medical supplies.

The sheltering in place plan is not to be specific to the event requiring sheltering, instead, the plan should contain the following:

- Plan in place describing how three days of non-perishable meals are kept on hand for residents and staff. The Plan should include special dietary requirements.
- Plan in place describing how 72 hours of potable water is stored and available to residents and staff.
- Plan in place identifying 72 hours of necessary medications that are stored at the facility and how necessary temperature control and security requirements will be met.
- Plan in place to identify staff that will care for the residents during the event including any transportation needs that the staff might have and how the facility will meet those needs.

- Plan in place for an alternative power source, such as an onsite generator, and describe how 72 hours of fuel will be maintained and stored. Alternate power source plan provides for necessary testing of the generator.
- Plan in place describing how the facility will dispose of or store waste and biological waste until normal waste removal is restored.
- Emergency Communications Plan in place, such as for cell phones, hand held radios, pager, satellite phone, laptop computer for instant messaging, HAM radio, etc.
- Adequate planning considerations given to the needs of residents, such as dialysis patients.
- Adequate planning considerations given to residents on oxygen.
- Adequate planning considerations given to residents using durable medical equipment such as masks, nasal cannulas, colostomy equipment, g-tube, etc.

See Appendix H for Facility Shelter in Place plan, Supply and Equipment lists, and checklists.

14 MEMORANDUMS OF UNDERSTANDING

Health care facilities should consider memorandums of understanding (MOUs) with organizations that can provide them resources and services during emergencies and disasters. MOUs are established between hospitals, other health care providers and/or emergency response agencies to identify their agreements to collaborate, communicate, respond and support one another during a disaster or other public health emergency. Understandings regarding the incident command structure, patient and resource management, processes and policies in place for requesting and sharing of staff, equipment and consumable resources, as well as payment, are generally addressed in a local mutual aid MOU.

MOUs help facilities demonstrate and document compliance with Joint Commission and State and Federal expectations for collaborative planning and disaster response. MOUs are also a documentation asset when seeking federal reimbursement through FEMA after a disaster.

MOUs are also used by facilities to document agreements with other organizations and agencies to provide transportation, consumables (e.g., water, food), equipment, personnel and many other resources and services that may be needed during a disaster event. These MOUs help to document a facility's ability to respond and to sustain operations.

Examples include MOUs with:

- Local hospitals for patient transfer, supplies, equipment, pharmaceuticals, and personnel.
- Local nurse registry agencies, temporary agencies, and security personnel providers.
- Other local health care providers including clinics and long term care facilities for personnel, supplies, equipment, and transportation.
- Vendors and suppliers for health care and non-health care resources, including linen and fuel.
- County government for services including transportation and security; for supplies; and for assistance in managing the treatment and transportation of staff and patients.
- Third party payors to suspend lag time for payments

See Appendix I for MOU templates

15 RECOVERY PLAN

Disaster and crisis planning are primarily focused on preparing and responding, however, another critical component is the recovery phase. At this point the worst of the immediate and acute crisis has passed, and a facility can focus on returning to standard operations. From a facilities standpoint, recovery often means taking a look at the infrastructure of the facility and making determinations if the facility is still operable and capable of taking care of the residents. Recovery should be coordinated with others such as local emergency management, financial personnel, public health, food delivery services, utilities, etc. In other words, recovery involves taking a complete look not just at the physical structure, but also those types of needs that support the safe and effective operation of your facility.

See Appendix J for consideration checklists for re-opening

16 STAFF CARE PLAN

During a crisis or disaster, additional help is often needed. One way to assist in making it easier for staff to stay at or report in to work, is to have a staff care plan. A staff care plan includes pre-determined arrangements for staff members' family and loved ones. Having this information available allows staff to feel comforted that arrangements are made for their loved ones and often increases the likelihood that staff will remain at or report in to work.

See Appendix K for Staff Care Plan documentation

17 EXERCISE, EVALUATION AND IMPROVEMENT PLANNING

For any plan to be useful, it needs to be tested periodically to determine if it works or if weaknesses appear once the plan is tested. Unless the plan is tested routinely, it is not truly a functional piece of work, which is the goal of having an emergency operations plan. Finding out during a crisis that the plan has real weaknesses is not the time to face that kind of risk. For this reason, there should be an exercise plan which includes both an evaluation piece and improvement planning. CMS requires facilities have a training program that involves:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

See Appendix L for Exercise, Evaluation, and Improvement planning checklist

18 REGIONAL RESOURCES AND SUPPORT AGENCIES

The following map will indicate which region the health care facility is located in:

September, 2004

See Appendix M for the color coded Regional Contact information

19 LIST OF APPENDIXES

19.1.14.12   Loss of telephone service policy

19.1.14.13   Missing person policy

19.1.14.14   Severe weather policy

19.1.14.15   Water shortage policy

19.1.14.16   Winter storm safety policy

19.1.14.17   Workplace Violence/Hostile event

The attachments contained within the Appendixes and Annexes are considered templates. To make the documents facility specific, facilities will need to adapt the templates.

Appendixes and Annexes are maintained in a separate file source.

20 ACRONYMS

AAC	After Action Conference
AAR	After Action Report
ADM	Alternate Dispensing Method
AHLS	Advanced Hazmat Life Support
AII	Airborne Infectious Isolation
ALS	Advanced Life Support
APR	Air Purifying Respirator
ARC	American Red Cross or Agency Review Committee
ASPR	Assistant Secretary for Preparedness and Response
BH	Behavioral Health
BHP	Behavioral Health Provider
BHPP	Bioterrorism Hospital Preparedness Program (discontinued - see HSPP)
BLS	Basic Life Support
BT	Bioterrorism
C/E	Controller & Evaluation Handbook
CAT	Chemical Assessment Team
CBHH	Community Behavioral Health Hospitals
CBRNE	Chemical, Biological, Radiological, Nuclear and Explosive
CDC	Centers for Disease Control
CGMO	Chief Grants Management Officer
CILS	Local Centers for Independent Living
CIP	Critical Infrastructure Protection
CMIST	Communication, Medical, Independence, Supervision, Transportation
COOP	Continuity of Operations Plan
CAP	Corrective Action Program

CPH	County Public Health
CST	Civil Support Team
DAB	Departmental Appeals Board
DBERT	Disaster Behavioral Early Response Team
DDS	Design and Development System
Decon	Decontamination
DEM	Department of Emergency Management
DHHS	Department of Health and Human Services
DHS	Department of Human Services or Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DOC	Department Operations Center
DOT	Department of Transportation
DPS	Department of Public Safety
ECC	Emergency Coordination Center
ED	Emergency Department
EEG	Exercise Evaluation Guide
EH	Environmental Health
EM	Emergency Management
EMI	Emergency Management Institute
EMP	Emergency Management Plan/Program
EMS	Emergency Medical Services
EMSRB	Emergency Medical Services Regulatory Board
EOC	Emergency Operations Center or Environment of Care
EOP	Emergency Operations Plan
EP	Emergency Preparedness
EPA	Environmental Protection Agency
Epi	Epidemiologist

EPR	Emergency Preparedness & Response	
EPs	Element of Performances	
ERG	Emergency Response Guidebook	
ERS	Emergency Response System	
ERU	Emergency Response Unit	
ESAR-VHP	Emergency System for the Advanced Registration of Volunteer Health Professionals	
ESF	Emergency Support Functions	
ExPlan	Exercise Plan	
FCC	Federal Coordinating Center	
FCO	Federal Coordinating Officer	
FE	Functional Exercise	
FLOP	Finance, Logistics, Operations, Planning	
FPC	Final Planning Conference	
FSE	Full-Scale Exercise	
GETS	Government Emergency Telecommunications Service	
GIS	Geographic Information System	
GMO	Grants Management Officer	
GPMRC	Global Patient Movement Requirements Center	
FEMA	Federal Emergency Management Agency	
HAM	Slang for Amateur Radio Operator	
HAN	Health Alert Network	
HAZMAT	Hazardous Materials Management	
HC	Health Care	
HCC	Hospital Command Center	
HCF	Health Care Facility	
HICS	Hospital Incident Command System	
HERT	Hospital Emergency Response Training	
HFP	Healthcare Financial Partnership	

HHS	Health and Human Services	
HPICM	Health Policy Information Compliance Monitoring	
HPP	Hospital Preparedness Program	
HRSA	Healthcare Resources & Services Administration (Grant dollars)	
HRTS	Hospital Resource Tracking System	
HSEEP	Homeland Security Exercise & Evaluation Program	
HSEM	Homeland Security & Emergency Management	
HSPD	Homeland Security Presidential Directive	
HSPP	Healthcare System Preparedness Program	
HVA	Hazard Vulnerability Analysis	
HVAC	Heating, Ventilation & Air Conditioning	
IAC	Incident Advisory Council	
IAP	Incident Action Plan	
IC	Incident Command or Infection Control	
ICP	Incident Command Post	
ICS	Incident Command System	
ICU	Intensive Care Unit	
IDDA	Intra-Departmental Delegation of Authority	
IDEPC	Infectious Disease Epidemiology, Prevention and Control	
IMT	Incident Management Team	
IMS	Incident Management System	
IP	Improvement Plan	
IPC	Initial Planning Conference	
IPG	Incident Planning Guide	
IRG	Incident Response Guide	
IT	Information Technology	
ITV	Interactive Television	
JAS	Job Action Sheets	

JCAHO	(acronym no longer in use) The Joint Commission
JFO	Joint Field Office
JIC	Joint Information Center
JIS	Joint Information System
JOC	Joint Operations Center
JPIC	Joint Public Information Center
LEPC	Local Emergency Planning Committees
LHD	Local Health Department
LMS	Learning Management System
LPH	Local (county) Pubic Health
LRN	Laboratory Response Network
LTC	Long-term Care
MAC	Multi-Agency Coordination Center
MCHP	Minnesota Council of Health Plans
MCI	Mass Casualty Incidents
MDH	Minnesota Department of Health
MDS	Mass Dispensing Site
MERET	Minnesota Emergency Readiness Education & Training
MHA	Minnesota Hospital Association
MIMS	Minnesota Incident Management System
MLS	Minnesota Laboratory System
MN Trac	Minnesota system for Tracking Resources, Alerts & Communication
MMRS	Metropolitan Medical Response System
MOS	Measure of Success
MOU	Memo of Understanding
MPC	Mid-term Planning Conference
MRC	Medical Reserve Corps
MRCC	Medical Resource Control Center

MSCC	Medical Surge Capacity and Capability
MSEL	Master Scenario Events List
NBHPP	National Bioterrorism Hospital Preparedness Program
NDMS	National Disaster Medical Management System
NEXS	National Exercise System
NFPA	National Fire Protection Association
NGO	Nongovernmental Organization
NIC	NIMS Integration Center
NIEHS	National Institute of Environmental Health Sciences
NIIMS	National Interagency Incident Management System
NIMS	National Incident Management System
NIOSH	National Institute for Occupational Safety and Health
NoA	Notice of Award
NOC	National Operations Center
NRF	National Response Framework
NRP	National Response Plan (Obsolete)
ODP	Office of Domestic Preparedness
OEP	Office of Emergency Preparedness
OPHS	Office of Public Health and Science
OSCF	Off Site Care Facility
OSHA	Occupational Safety and Health Administration
PAPRs	Powered Air Purifying Respirators
PHEP	Public Health Emergency Preparedness
PCC	Patient Care Coordination
PEMS	Postal Emergency Management System
PFA	Psychological First Aid
PH	Public Health
PHIN	Public Health Information Network

PHL	Public Health Laboratory
PHNC	Public Health Nurse Consultant
PHPC	Public Health Preparedness Consultant
PICEs	Potential Injury Creating Events
PIO	Public Information Officer
PIS	Public Information System
POC	Project Officer
POC	Point of Contact
PPE	Personal Protective Equipment
PPR	Periodic Performance Review
PSA	Primary Service Area
PSAP	Public Safety Answering Point
PSAT	Patient Surveillance and Tracking
RBHC	Regional Behavioral Health Coordinator
RCC	Regional Coordinating Center
RCW	Regional Cache Warehouse
RDN	Regional Distribution Node
RFID	Radio Frequency Identification
RHRC	Regional Hospital Resource Center
RHPC	Regional Healthcare Preparedness Coordinator
ROC	Regional Operations Center
RPC	Regional Program Coordinator
RRCC	Regional Response Coordination Center
RSS	Receipt Storage & Staging Sites (part of SNS)
RTAC	Regional Trauma Advisory Committee
RTC	Regional Treatment Center
SAM	SNS Asset Management System
SC MN	South Central Minnesota (15 county area)

SEOC	State Emergency Operations Center
Sit Man	Situation Manual
SMART	Simple, Measurable, Achievable, Realistic and Task Oriented
SNS	Strategic National Stockpile
SOG	Standard Operating Guidelines
SOP	Standard Operating Procedure
T & EPW	Training & Exercise Plan Workshop
TCL	Target Capabilities List
TSP	Telecommunications Service Priority
TTX	Tabletop Exercise
UASI	Urban Area Security Initiative
UICC	Unified Incident Command Center
UMN	University of Minnesota
UTL	Universal Task List
VAMC	Veterans Administration Medical Center
VMAT	Veterinary Medical Assistance Team
VMI	Vendor Managed Inventory (part of SNS program)
VOAD	Voluntary Organizations Active in Disaster
VoIP	Voice over Internet Protocol
WC	Wheelchair
WMD	Weapons of Mass Destruction
WPS	Wireless Priority Service