Hurricane Summit Proceedings
Monday, February 27 and Tuesday, February 28, 2006

Sponsors
Florida Health Care Association
The John A. Hartford Foundation
The University of South Florida’s Center on Aging
AARP
American Health Care Association
Paragon Rehabilitation
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Executive Summary

Florida Health Care Association sponsored a Nursing Home Hurricane Summit for the Gulf coast states of Florida, Texas, Louisiana, Mississippi, Alabama, and Georgia on February 27/28th in Tallahassee. The John A. Hartford Foundation provided the major funding along with FHCA, American Health Care Association, AARP, the University of South Florida’s Center on Aging and Paragon Rehabilitation. The six states’ representatives provided brief presentations about their respective experiences during the hurricane season of 2005 with participant question/answer sessions following each presentation. Highlights of the lessons learned included:

**Planning and Response – Beginning with Relationships and Agreements:** Relationship building, within the local communities, needs to be initiated before the beginning of the hurricane season. Strengthen local relationships with representatives of power companies and fuel providers and especially with your local Emergency Operations Center. The local infrastructure of power companies, police, fire, and other emergency responders need to be aware of the high acuity level of skilled nursing facilities, including persons on ventilators, dialysis, oxygen, IVs, feeding tubes, etc.

Plan one level above storm category (i.e., if storm is Category 2, plan for a Category 3). Also, evacuate in terms of tens of miles instead of hundreds, to get away from storm surge and not just the wind. Don’t over-evacuate because it’s expensive and hard on residents and staff. Follow the facility hazard mitigation plan and rely on scientific data by keeping in close touch with the local EOC for evacuation decision-making.

**Clinical Preparation:** Work proactively at internal and external disaster drills. Florida Health Care Association (“FHCA”) has a tool in the disaster manual for internal and external disaster management. It was strongly recommended that nursing homes and other long term care facilities/providers work with their local EOC on drills and practice evacuating people on buses and off buses. Practice makes perfect. Communicate with families, especially with a letter, to let them know when you are having evacuation drills and get them involved.

Look at acuities for patients and define all those at risk; regardless of level. Patients on dialysis, tracheotomy care, ventilators, chemotherapy treatment, and persons with diabetes or bed bound have to be carefully assessed before a storm and monitored closely during and after a storm. Have emergency drug kits readily available. Ensure the dialysis treatment is completed right before the storm. Proper food for dialysis and medications are problems when in a disaster setting. Ensure the medications are ordered for the full time period allowed by the state Medicaid agency.

Review the contracts of all vendors and assess their responsibilities pre and post disaster. Some pharmacy services’ contracts were not honored because residents were
evacuated to a different district. The pharmacy in new district could not service either because they did not have patient histories.

**Evacuate or Stay:** Building safety is a critical issue. The facility hazard mitigation plan should assess the ability of the building to withstand a storm at different levels and the potential impact of storm surge, the availability of shutters or if the facility will need plywood, and even how the surrounding drainage works. Work closely with the local EOC staff to determine evacuation decision-making parameters. A well-crafted plan that is followed can alleviate insurance reimbursement problems. Plan for informing residents and families, such as during admission tell them exactly what to expect and when. Look at different options for evacuation, not just one or two facilities. New FEMA maps have redesignated areas to different levels and it would not be prudent to plan to evacuate to those facilities that are in the same designated level evacuation zone. Do not just ask another facility to accept residents, but know the area surrounding the facilities that would be the evacuation referral sites.

Note: The following is a position from a county EOC manager in Florida about evacuation orders: “Evacuations are usually based on storm surge and the evacuation order needs to be based on factual data. We do overestimate the surge, to a degree, in that we try to envision the worst case scenario. We anticipate the storm hitting at high tide at the worst possible angle that causes the maximum surge. Facility administrators who are in evacuation zones need to work with their local EOCs to understand when the evacuation order is made. Facilities in the non-evacuation zones need window protections and their generator needs to be protected, as well as their fuel supply. We need to create some bunkers in the facilities. Too many long term care facilities state in their disaster preparedness plan that they plan to move residents out of their rooms into the corridors to shelter. Why give up these rooms to Mother Nature? This will force these facilities to have to evacuate post-event. Let’s harden these facilities now.”

Some general lessons for planning consideration: 1) at least 7 and preferably 14 days worth of water and ice; 2) generator-powered air conditioning; 3) take care of staff and their family; and 4) maintain a close working relationship with the local emergency operations center.

**Power:** Prioritized grids are based on critical care and infrastructure and have not been redone in a long time. It is key to communicate with the power company so they know who you are and that you have patients who are dependent on power. In 2004, about 80% of generators in the field failed due to poor maintenance, running out of fuel, etc.

“Quick connect” is being encouraged for nursing homes and special needs shelters. Have an engineer assess your needs and know your capacity. Have your documentation ready for your local EOC and ESF-8 systems. Identify the vendors you need to come top off the fuel for your generators. Consider being creative in obtaining fuel. Go to your local EOC and then state EOC, if necessary. Communication is critical in order to get the
supplies you need. Recognize that there may be some resistance to assist private, for-profit providers. Offer to pay for the needed assistance.

Transportation: Know when to evacuate. There are better times than others to evacuate and many have found that nighttime, darkness or early morning are best for patients. It’s the least upsetting and much easier when it is cooler and usually less traffic. Do not transport oxygen patients via bus; use private vehicles. Also consider dividing the patients on buses according to acuity, so the risk is not shared between all the buses.

Nursing homes may be able to contract with local school boards for buses and drivers, even buses with a/c and lifts. Those in Tampa area did not have an issue with the oxygen equipment although some facilities in Florida have learned they are not going to be able to contract with bus companies in 2006 because of liability concerns. It is very important to get local authorities involved when using these resources and discuss safety protocols. If you can organize your transportation by community, then you can share limited resources instead of competing for them.

Resident-centered planning: Consider using a two-arm bracelet identification system to inform about special diets and needs. Make sure to use heavy duty kind and consider affixing to the ankle. This system is also advised when a facility has to evacuate residents for tracking purposes. The medical record information needs to go with the residents being evacuated along with their medications and supplies.
Introduction

The summit began with self introductions and a brief statement of expectations summarized as follows:

- Building partnerships across state lines to learn from one another.
- Identify improved action steps that will help states prepare for 2006’s hurricane season.
- Solidify relationships for resource sharing.
- Learn from the 2005 experiences and how not to repeat mistakes in decision-making.
- Examine ways to better prepare staff, residents, families and the local EOCs.
- Inform participants about insurance premium increases and more exclusions.
- Share the legal ramifications that come from evacuation decisions.
- Share, learn, network and brainstorm how to do better in 2006.
- Get a handle on transportation planning for evacuations.
- Have the world understand that long term care facilities care for very frail.
- Vulnerable and difficult people who need prioritization for services.
- Identify the best model for local, state, and federal levels to work together, especially with evacuation decision-making and post-recovery needs.

The six states’ representatives provided brief presentations about their respective experiences during the hurricane season of 2005 with participant question/answer sessions following each presentation. A highlight of each state’s representative’s comments and the participants’ discussions follows.
2006 Hurricane Summit Participant List

The John A. Hartford Foundation – Amy Berman
US Department of Health and Human Services - Joseph D. Forsha
US Department of Health and Human Services' OIG – Sarah Crarren
Centers for Medicare & Medicaid Services - Margaret P. Sparr
American Health Care Association - Janice Zalen
University of South Florida – Kathy Hyer, Ph.D. and Lisa Brown, Ph.D.
AARP – Charles Milsted and Leslie Spencer

Florida Health Care Association – Bill Phelan, Executive Director
Dion Sena, Florida Health Care Association President
LuMarie Polivka-West, Staff Director of Hurricane Summit
Robin Bleier, RN LHRM FACDONA, RB Health Partners, Inc., FHCA Disaster Committee Chair
Timothy Gregson, FMS Purchasing & Services, FHCA Disaster Committee Co-Chair
Tracy Greene, NHA, Bayshore Pointe Nursing Center, FHCA Disaster Committee Co-Chair
FHCA Staff: Koko Okano, Deborah Afasano, Peggy Rigsby and Zana Raybon
Karen Goldsmith, Goldsmith, Grout & Lewis, P.A., FHCA Legal Counsel
Deborah Charron, Seitin Insurance and Risk Management
Steve Jones, Moore, Stephens & Lovelace, P.A.
Max Hauth, NHA, Hauth Health Care Consultants, Inc.
Cindy Ledford, Delta Health Group

Florida Department of Health – Ray Runo
Michael J. Jacobs, III, MA, and Susan McDevitt, Florida Department of Health staff
Thomas Leto, Hernando County Emergency Management

Florida Agency for Health Care Administration – Molly McKinstry, Long Term Care Chief

Louisiana Nursing Home Association - Joseph A. Donchess, Executive Director
Mark Berger, CPA, and Myron Chatelain, LNHA Staff

Mississippi Health Care Association – Vanessa Henderson Phipps, Executive Director
Craig Robinson, Delta Health Group
Reita Hall, Community Eldercare Services

Texas Health Care Association - Tim Graves, Executive Director
Dorothy Crawford, THCA Staff
Meera Riner, Nexion Health, Inc.

Alabama Nursing Home Association - Louis Cottrell, Executive Director
Katrina G. Magdon and Mike Jordan, ANHA Staff
Bobby Ehlman, USA Healthcare,Inc.
Linda Hoffman, Ball Healthcare Services, Inc.

Georgia Health Care Association – Fred Watson, Executive Director
Stelling Nelson, Ethica Health
Christi Card, UHS-Pruitt Corporation
Florida

An overview of the state’s eight hurricanes within one year crossing two hurricane seasons was provided with key lessons learned from each of the storms. The strong partnership between the nursing home associations, the private, for profit and nonprofit nursing homes and the state agencies, especially the Department of Health and the Office of Emergency Management, as well as the Agency for Health Care Administration, was identified as key to the successful planning and implementation of disaster plans in 2004 and 2005. FHCA has a seat at the statewide EOC prior to and during a hurricane, as well as post recovery. Florida Association of Homes for the Aging is also an involved partner.

Planning and Response – Beginning with Relationships and Agreements: The disaster planning process should be initiated at the end of the previous year’s hurricane season with the disaster preparedness plan reviewed and approved by the local Emergency Operations Center by the spring, before the June 1 hurricane season. Relationship building, within the local communities, needs to be initiated before the beginning of the hurricane season. This is the time to pursue multiple providers for transportation contingencies in case of a possible evacuation and to work with other nursing homes to ensure viable transportation opportunities with any duplication identified. Strengthen local relationships with representatives of power companies and fuel providers.

The local infrastructure of power companies, police, fire, and other emergency responders need to be aware of the high acuity level of skilled nursing facilities, including persons on ventilators, dialysis, oxygen, IVs, feeding tubes, etc. The importance of communication planning was recognized. For example, a facility could ask the local phone company, before the anticipated storm hits, to roll the facility phone number over to a different phone number out of the storm’s path. Use a princess phone in place of complicated phone system to enable communication. Satellite phones and/or ham radios were also recommended.

Be ready for the unexpected, such as power outages for up to two weeks and/or tornados. Be prepared for 14 days – not just 3 days or 7 days. That means 14 days worth of adult briefs, linen, food, and water. Plan for the fuel needs to keep the facility generator operating.

Plan one level above storm category (i.e., if storm is Category 2, plan for a Category 3). Also, evacuate in terms of tens of miles instead of hundreds, to get away from storm surge and not just the wind. Don’t over-evacuate because it’s expensive and hard on residents and staff. Follow the facility hazard mitigation plan and rely on scientific data by keeping in close touch with the local EOC for evacuation decision-making.

Protect facilities. Consider creating bunkers at the facilities. Consider getting grant money to harden facilities (windows protection, roof).

Clinical Preparation: Work proactively at internal and external disaster drills. Florida Health Care Association (“FHCA”) has a tool in their disaster manual for internal and external disaster management. The Joint Commission for the Accreditation of Health Care
Organizations (JCAHCO) requires that drills be six months apart. It was strongly recommended that nursing homes and other long term care facilities/providers work with their local EOC on drills and practice evacuating people on buses and off buses. Practice makes perfect. Communicate with families, especially with a letter, to let them know when you are having evacuation drills and get them involved.

Look at acuities for patients and define all those at risk, regardless of level. Patients on dialysis, tracheotomy care, ventilators, chemotherapy treatment, and persons with diabetes or bed bound have to be carefully assessed before a storm and monitored closely during and after a storm. Have emergency drug kits readily available. Ensure the dialysis treatment is completed right before the storm. Proper food for dialysis and medications are problems when in a disaster setting. Ensure the medications are ordered for the full time period allowed by the state Medicaid agency.

Review the contracts of all vendors and assess their responsibilities pre and post disaster. Some pharmacy services’ contracts were not honored because residents were evacuated to a different district. The pharmacy in new district could not service either because they did not have patient histories.

Florida is working with the Board of Nursing to facilitate reciprocity for staff to go across state lines to assist with disasters. Each state affiliate should work with their respective professional boards to determine the ability to bring in staff across state lines.

EOC: Secure a seat in the emergency operation center at the state and local levels. Working close to a problem brings faster and more successful resolution. The resolution needs to take place at the local level whenever possible. Then have your association follow up to see that it is being worked on. Partnerships between associations and state agencies are vital.

Florida Health Care Association has a seat at the state level EOC and will be training more provider volunteers to work at the local county EOC level. The Florida Department of Health is developing an ESF-8 health and medical template for all counties. It was noted that counties differ in their skills levels and willingness to work with private providers. Nursing home affiliates and providers were encouraged to seek the local relationship and plan on provider representation at the local EOC pre/post a storm.

Florida Health Care Association held a daily 800 number conference call with providers and state government representatives prior and post Hurricane Wilma which worked well in identifying and meeting needs. The nursing homes without power and internet connections use their cell and satellite phones to call in on the daily call.

The following is a summary of the group discussion that followed the Florida presentation:

**Evacuate or Stay:** Building safety is a critical issue. The facility hazard mitigation plan should assess the ability of the building to withstand a storm at different levels and the potential impact of storm surge, the availability of shutters or if the facility will need plywood, and even how the surrounding drainage works. Work closely with the local EOC staff to determine evacuation decision-making parameters. A well-crafted plan that is followed can alleviate insurance reimbursement problems. Plan for informing residents and families, such as during admission tell them exactly what to expect and when. Look at different options
for evacuation, not just one or two facilities. New FEMA maps have redesignated areas to different levels and it would not be prudent to plan to evacuate to those facilities that are in the same designated level evacuation zone. Do not just ask another facility to accept residents, but know the area surrounding the facilities that would be the evacuation referral sites.

Note: The following is a position from a county EOC manager in Florida about evacuation orders:

“Evacuations are usually based on storm surge and the evacuation order needs to be based on factual data. We do overestimate the surge, to a degree, in that we try to envision the worst case scenario. We anticipate the storm hitting at high tide at the worst possible angle that causes the maximum surge. Facility administrators who are in evacuation zones need to work with their local EOCs to understand when the evacuation order is made. Facilities in the non-evacuation zones need window protections and their generator needs to be protected, as well as their fuel supply. We need to create some bunkers in the facilities. Too many long term care facilities state in their disaster preparedness plan that they plan to move residents out of their rooms into the corridors to shelter. Why give up these rooms to Mother Nature? This will force these facilities to have to evacuate post-event. Let’s harden these facilities now.”

Some general lessons for planning consideration:

- at least 7 and preferably 14 days worth of water and ice;
- generator-powered air conditioning;
- take care of staff and their family; and
- maintain a close working relationship with the local emergency operations center

Take care of your staff and their families so they will come in. Have them bring their family, pets or kids, if necessary. Include in the facility planning the possibility of having to provide onsite daycare for children of staff and plan for their food as well.

Post-evacuation happens mostly because of a failure to protect and invest in facilities.

Incident Command Structure: Florida’s Incident Command Structure emphasizes coordination and mutually supportive relationships between federal, state, and local governments and the private sectors. The hurricane response process begins with a pre-storm notification to all health care facilities with a preparation checklist. Daily planning ensues with all of the ESF groups represented. This process of working closely together continues through the recovery period.

Power: Prioritized grids are based on critical care and infrastructure and have not been redone in a long time. It is key to communicate with the power company so they know who
you are and that you have patients who are dependent on power. In 2004, about 80% of generators in the field failed due to poor maintenance, running out of fuel, etc.

“Quick connect” is being encouraged for nursing homes and special needs shelters. Have an engineer assess your needs and know your capacity. Have your documentation ready for your local EOC and ESF-8 systems. Identify the vendors you need to come top off the fuel for your generators. Consider being creative in obtaining fuel. Go to your local EOC and then state EOC, if necessary. Communication is critical in order to get the supplies you need. Recognize that there may be some resistance to assist for profit, private providers. Offer to pay for the needed assistance.

Transportation: Know when to evacuate. There are better times than others to evacuate and many have found that nighttime, darkness or early morning are best for patients. It’s the least upsetting and much easier when it is cooler and usually less traffic. Do not transport oxygen patients via bus; use private vehicles. Also consider dividing the patients on buses according to acuity, so the risk is not shared between all the buses.

Nursing homes may be able to contract with local school boards for buses and drivers, even buses with a/c and lifts. Those in Tampa area did not have an issue with the oxygen equipment although some facilities in Florida have learned they are not going to be able to contract with bus companies in 2006 because of liability concerns. It is very important to get local authorities involved when using these resources and discuss safety protocols.

Also, in Tampa area they used ambulances for those that could not travel by bus and Medicare paid for their transport under certain conditions, such as a mandatory evacuation.

If you can organize your transportation by community, then you can share limited resources instead of competing for them.

Cash: It is important to have large amounts case on hand for a disaster. ATMs and fuel pumps are out of order. You need at least $1,000 a day for a 120-bed nursing home in order to replenish supplies and cover necessary costs in the interim.

Resident-centered planning: Consider using a two-arm bracelet identification system to inform about special diets and needs. Make sure to use heavy duty kind and consider affixing to the ankle. This system is also advised when a facility has to evacuate residents for tracking purposes. The medical record information needs to go with the residents being evacuated along with their medications and supplies.

University of South Florida, Center on Aging’s Survey of Hurricane Season 2004 impact on Florida’s long term care facilities – key points are provided in the following PowerPoint presentation.
University of South Florida

PowerPoint Presentation
Florida Hurricanes’ impact on Nursing Homes

Kathryn Hyer, Ph.D., Florida Policy Exchange Center on Aging, School of Aging Studies, College of Arts and Sciences
Lisa M. Brown, Ph.D. and Jennifer Bond, Ph.D., Department of Aging and Mental Health, Florida Mental Health Institute
LuMarie Polivka-West, MSRP, Florida Health Care Association
John A. Schinka, Ph.D., Department of Psychiatry and Behavioral Medicine

Florida has 670 nursing homes
Florida nursing homes care for 71,000 frail residents
At least 50% of residents have some cognitive impairment (Alzheimer’s disease)
Residents are frail -- require help with dressing, eating, bathing, going to bathroom

Florida hurricanes impact on Nursing Homes

* Florida has 670 nursing homes
* Florida nursing homes care for 71,000 frail residents
* At least 50% of residents have some cognitive impairment (Alzheimer’s disease)
* Residents are frail -- require help with dressing, eating, bathing, going to bathroom

Survey of all Nursing homes, some ALFs and other LTC facilities
Data collected at meetings, mailed surveys
Data collected from October 2004-February 2005
Mailed questionnaires had $5 gift card
USF IRB approval for Study

Florida hurricanes impact on Long-term care

Survey of all Nursing homes, some ALFs and other LTC facilities
Data collected at meetings, mailed surveys
Data collected from October 2004-February 2005
Mailed questionnaires had $5 gift card
USF IRB approval for Study

Florida hurricanes impact on Nursing Homes

* 479 Unique Respondents in dataset
  * 297 -- Nursing homes 44% response rate
  * 125 -- Assisted Living 25% response rate to mailing
  * 57 -- Other --Continuing Care Retirement

* 85% of the survey respondents were affected by hurricane –409 of respondents
  * 262 Nursing homes—39% of all NH
    * 132 beds on average
  * 94 Assisted Living facilities
    * 73 beds on average
  * 53 Other
Hurricane Frances 9-5-04

Had a broad impact zone

Florida hurricanes impact on Long-term care

• Frances and Jeanne had largest impact
  – 75 providers impacted by Frances
  – 74 providers impacted by Jeanne

• Providers sustained multiple storms
  - 21% were impacted by one storm (N=85)
  - 26% were impacted by two storms (N=107)
  - 31% were impacted by three storms (N=128)
  - 20% were impacted by all four storms (N=80)

Hurricanes impact on electrical service

★ 76% of responders lost power at least once during the hurricanes
★ 34.2% lost power in one storm
★ 30% lost power in two storms
★ 10% lost power in three storms
★ 2% lost power in all storms
★ Power loss varied from 1 day to 7 days

Other hurricanes impacts

★ 43% telephone disruptions
★ 27% telephone disruptions once
★ 12% telephone disruptions twice
★ 4% disruptions three times
★ 0.5% disruptions four times
★ 15% experienced problem with water
★ 11% water problems once
★ 3% water problems twice
★ 0.5% water problems three times
Hurricanes impact – evacuation trauma

* 10,058 Elders evacuated across all storms
  * Charlie 4,512 48 facilities
  * Francis 3,180 53 facilities
  * Ivan 460 38 facilities
  * Jeanne 1,920 48 facilities

Power outage impact on Nursing Homes vs. Assisted Living

* 79% NH had generators that worked
* 20% ALFs had generators that worked
* Plans for new generators
  * NHs 14% will upgrade
  * ALFs 20% will purchase; 21% will upgrade

Hurricanes impact on NH & ALFs in Hillsborough

16 NHs responded
  * 2 facilities evacuated residents
  * 6% plan to buy a bigger generator
  * 31% no computer plan
  * 43% transferred patients to hospitals
  * 75% had good relationship with EOC
  * 60% EOC helpful or very helpful

10 ALFs responded Charley, Frances, Jeanne
  * 50% evacuated residents
  * 60% plan to buy a new or bigger generator
  * 40% no plan for computer
  * 57% no or poor relationship with EOC

Further Study

- Impact of hurricanes on staff
- Cost of hurricanes
  - Dollars—Medicaid reimbursement
  - FEMA aid to non-profit NH
  - Deaths of residents or increase in death and morbidity rates
  - Staffing impact—turnover
- Better coordination with FEMA, EOC
- Recognition of fragility of long-term care patients
- Increased litigation?

Florida hurricanes impact on Long-term Care

* Need more capacity to exist without electricity – new and bigger generators
* Need to have 7-day capacity of food, water, ice, oxygen and medicines
* Patient triage:
  * Early dialysis of patients
  * PRN oxygen will need oxygen
  * Industry suppliers store in central area
How many days were family of staff allowed to stay?

Number of Providers allowing Family of Residents in Facility

How many days were families of residents allowed to stay?

Were you able to transfer residents to hospitals?

How helpful was your local EOC?

Would you like to improve your relationship with EOC?
How is your relationship with FHCA or FALA?

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Percent of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Relationship</td>
<td>5</td>
</tr>
<tr>
<td>Poor Relationship</td>
<td>2</td>
</tr>
<tr>
<td>Fair Relationship</td>
<td>7</td>
</tr>
<tr>
<td>Good Relationship</td>
<td>43</td>
</tr>
<tr>
<td>Very Good</td>
<td>43</td>
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</table>

How helpful was FHCA/FALA during the hurricane(s)?

<table>
<thead>
<tr>
<th>Helpfulness</th>
<th>Percent of Providers</th>
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</thead>
<tbody>
<tr>
<td>Not Used</td>
<td>25</td>
</tr>
<tr>
<td>Not Helpful</td>
<td>3</td>
</tr>
<tr>
<td>Somewhat Helpful</td>
<td>14</td>
</tr>
<tr>
<td>Helpful</td>
<td>29</td>
</tr>
<tr>
<td>Very Helpful</td>
<td>5</td>
</tr>
<tr>
<td>No Response</td>
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</tr>
</tbody>
</table>

Relationship with AHCA

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Percent of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Relationship</td>
<td>3</td>
</tr>
<tr>
<td>Poor Relationship</td>
<td>1</td>
</tr>
<tr>
<td>Fair Relationship</td>
<td>15</td>
</tr>
<tr>
<td>Good Relationship</td>
<td>58</td>
</tr>
<tr>
<td>Very Good</td>
<td>25</td>
</tr>
</tbody>
</table>

How helpful was AHCA during the hurricanes?

<table>
<thead>
<tr>
<th>Helpfulness</th>
<th>Percent of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Used</td>
<td>34</td>
</tr>
<tr>
<td>Not Helpful</td>
<td>14</td>
</tr>
<tr>
<td>Somewhat Helpful</td>
<td>16</td>
</tr>
<tr>
<td>Helpful</td>
<td>24</td>
</tr>
<tr>
<td>Very Helpful</td>
<td>11</td>
</tr>
<tr>
<td>No Response</td>
<td>2</td>
</tr>
</tbody>
</table>

Were you surveyed by AHCA?

<table>
<thead>
<tr>
<th>Surveyed</th>
<th>Percent of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>75.1</td>
</tr>
<tr>
<td>Yes—Charley</td>
<td>12.7</td>
</tr>
<tr>
<td>Yes—Frances</td>
<td>8.3</td>
</tr>
<tr>
<td>Yes—Ivan</td>
<td>24</td>
</tr>
<tr>
<td>Yes—Jeanne</td>
<td>1.5</td>
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</tbody>
</table>

How many days after the storm were you surveyed?

<table>
<thead>
<tr>
<th>Hurricane</th>
<th>Number of Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charley</td>
<td>6.0</td>
</tr>
<tr>
<td>Frances</td>
<td>5.5</td>
</tr>
<tr>
<td>Ivan</td>
<td>5.8</td>
</tr>
<tr>
<td>Jeanne</td>
<td>3.9</td>
</tr>
</tbody>
</table>
Were you surveyed by the DOH?

- **Yes--Charley**: 95.4%
- **Yes--Frances**: 3.4%
- **Yes--Ivan**: 1.0%
- **Yes--Jeanne**: 0.2%

How many days after the storm were you surveyed?

- **Charley**: 7.26 days
- **Frances**: 2.95 days
- **Ivan**: 3.95 days
- **Jeanne**: 3.51 days
Florida Health Care Association

PowerPoint Presentation
"The Imperfect Storms... Lessons Learned from Florida's Eight Hurricanes"

Florida Health Care Association Nursing Home Hurricane Summit February 27/28, 2006 Tallahassee, Florida

Florida’s History with Hurricanes
★ 1992 Hurricane Andrew Category 4
★ $26.5 billion and 23 deaths
★ Wind was major destructive force
★ Changed building codes for everyone
★ Strengthened disaster planning for LTC
   – Required plans approved by Emergency Operations Center
   – Evacuations determined by wind and water threat levels
   – Decisions left with administrator

Learning From Florida’s 2004-05 Hurricane Experiences “Welcome to Florida!”

System Lessons
• State Emergency Operations Command – Planning, Response and Recovery
• Relationships with Electric Power, Telephone companies
• Relationships at local level for fuel, support
• Clinical Preparation
• Long Term Care self-support
Good Relationship with Florida Power & Light—Electricity restored

- Resulted in nursing homes being moved to a second tier restoration status
- But many remained without power over a week
- 2005 - Last two nursing homes – 13 days without power – clinical challenges and evacuation decisions questioned by families and regulators because of power outages

Disaster Preparedness= Collaborative Roles & Responsibilities

- Dept. of Health Emergency Operations Center (EOC)
- ESF 8s in Tallahassee and at the local level
- Department of Children & Family Services (DCF)
- Department of Elder Affairs (DOEA)
- Centers of Medicaid/Medicare Services (CMS)
- Agency for Health Care Administration (AHCA) (survey agency)
- University of South Florida Center on Aging/FMHI
- FEMA

Learned the importance of local relationships

- With the power companies
- With the telephone companies
- With the ESF8 representatives
- With the local fire/police and other emergency responders
- With other nursing homes and other health care providers
- With the media

Local

- County Emergency Operations Center:
- Educate your local utility services
- Invite local officials and essential contacts to visit your facility
- Attach faces to the needs of our elderly and frail population…
Evacuate or Stay?
- What does the facility disaster plan say?
- Is there a mandatory evacuation order?
- Has the local EOC sent an advisory?
- Is transportation available for evacuations?
- Are “like” facilities available for receiving?
- Will the acuity levels impact the decision?
- Have residents, families and staff been informed?

Clinical Preparedness
- Timely dialysis
- Medical Supplies – continuous oxygen
- Need to order medications in advance of the hurricane with Medicaid authorization of early orders
- Non Medical Supplies, linens
- Special Diets planned/arranged
- Resident Record Management

Communicating with Families
- Have to get cell phone numbers for families – many out of state
- Provide receiving facilities with the families’ contact information
- Facilities without phone service proved challenging – need to provide a facility cell phone contact to families

Plan...
- Management of our Acuities
  - Defining those at risk = identification/tracking systems
  - Dialysis, Vents, and special needs populations
  - Clinical response to emergent situations
  - Ensure specific information on the types of residents served such as patients with Alzheimer’s Disease

Dealing with Disaster
- Flexibility is Key – need back up plans for disaster plans
- Be ready for the unexpected – ex. tornadoes after the hurricane moves through; generator malfunctions
- Prepare to be an island for 7 days
  - Will supplies last? Will staff be able to travel
  - Are you able to accept Special Needs Shelter (SNS) admissions?

Transportation Arrangements – our Achilles Heel
- In-County Transports
- Out-of-County Transports
- What will it take to transport and evacuate?
- Managing the needs of our residents
- Contracts and other opportunities.....limited transport options for aging population in need
General Lessons Learned

1. Need at least 7 days’ supply of water, ice, and diesel fuel, if possible
2. Generator power of air-conditioning and ice maker desired
3. Educate disaster response personnel on acuity of nursing home residents

FHCA’s Lessons Learned From Hurricanes

- FHCA role in the State Emergency Operations Center is critical
- County EOCs function differently
- FHCA/FAHA staff “hot wire” process between facilities and local ESF8 desks

Role of a State Association

What we did over time:

- Secured a seat in the State Emergency Operations Center
- Daily “meet-me” conference calls with officers, corporate contacts, and vendor reps
- Coordinated daily information sharing via email: Before, during and after disaster

Policy Issues

- Multiple visits by the state – the Attorney General’s Office, the state survey office, the Dept. of Health – who’s in charge?
- Inconsistent federal guidance on payment policy pre/post storms
- Need for resident specific information to move with evacuated residents

- Stafford Act’s shortsightedness
- Community-wide transportation planning for all health care facilities
- Generators are very expensive to purchase and maintain for brief periods of use (quick connect with government owned/stored generators in central locations
- Gas and road access for health facility employees

24
Analysis of the 2004 Hurricane Season

- 2004 was the most intense hurricane season in Florida’s history
- The 2004 hurricanes for Florida resulted in:
  - $60 billion damage-Statewide
  - 117 deaths
  - 9 million people were evacuated across state
  - 8.5 million lost electricity for an extended period
  - Communication breakdown to land lines and cell phone systems
  - 13 hospitals, 16 fire stations, 57 schools destroyed

USF Center on Aging Survey of Long Term Facilities’ 2004 hurricane experiences

- By Kathy Hyer, Ph.D. and Lisa Brown, PhD in coordination with the Florida Health Care Association and Florida Association of Homes and Services for Aged
- Collected data at meetings
- Surveyed nursing homes and assisted living facilities

The Impact 2004 Hurricane Season

- Total Facilities: 114 Hospitals
  - 65 Nursing Homes
  - 85 Assisted Living
  - 29 Home Health Agencies
- Power Outages: 10.2 million customers
- Shelters Opened: 1,049
- People Sheltered: 368,438

Florida Hurricanes’ Impact on Nursing Homes

- 85% of the survey respondents were affected by hurricane – 409 of respondents
- 262 Nursing homes—39% of all NH
  - 132 beds on average
- 94 Assisted Living facilities
  - 73 beds on average
- 53 Other—Continuing Care Retirement Community

Hurricanes’ Financial impact on Nursing Homes

- 259 NHs applied for Interim Rate Request for additional Medicaid money
- 222 For profit
- 37 Not for profit
- Homes requested $14,600,291 for recovery
- Denied/Withdrawn $2,342,318
- Paid $9,598,650 million paid (Avg $52,740/home in daily Medicaid rate)
- Overtime costs, damages, clean up, evacuation expenses
- Payback slow—Jan 05-Jan 06 window on rates—Fl help others in creating Medicaid payback?

Other Hurricanes’ Impacts

- 31% were impacted by three storms
- 76% lost power at least once
- Power loss varied from 1-7 days
- 43% telephone disruptions
- 15% experienced problem with water
2004 Hurricane Season

- Evacuations: 9.5 million
- Meals Served: 12.7 million
- Water Distributed: 17.5 million gallons
- Ice Distributed: 138.0 million pounds
- States Assisting: 40 (Including Alaska)
- Declared Counties: All 67 counties
- Property Damage: 42 billion+

Florida Evacuations of Residents

<table>
<thead>
<tr>
<th>Storm</th>
<th>Facilities</th>
<th>Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charley</td>
<td>48</td>
<td>4,512</td>
</tr>
<tr>
<td>Frances</td>
<td>53</td>
<td>3,180</td>
</tr>
<tr>
<td>Ivan</td>
<td>38</td>
<td>456</td>
</tr>
<tr>
<td>Jeanne</td>
<td>48</td>
<td>1,920</td>
</tr>
<tr>
<td>All</td>
<td>206</td>
<td>10,068</td>
</tr>
</tbody>
</table>

Total Patient Days of evacuation: 40,479

More Lessons Learned:

- Develop state to state relationships
- Identify what members have facilities in other states: This facilitates state to state sharing of supplies, services, and human resources
- Affiliate with your state board of nursing: reciprocity and staffing strategies
- Act as a central repository for provider ideas and offers: housing, employment for displaced workers

February 27/28, 2006 Hurricane Summit in Tallahassee

- Working with the five Gulf Coast states and Georgia for hurricane debriefing on lessons learned and share the best practices in working with the EOC/ESF8 units
- Sharing the difficulties and the successes
- Explore legislative bills
- Goal: Gulf Coast regional planning across state lines for nursing home/health care associations to partner in disaster planning and recovery
Mississippi

Hurricane Ivan: In 2004, Mississippi had to evacuate two nursing homes. There was confusion in communicating with the state and county EOCs over who should evacuate and uncertainty of the sending locations. The Department of Health nurses did not know how to care for nursing home residents and some residents were injured during evacuation. Facilities that stayed in place on the coast lost power but had no major damage.

Mississippi Health Care Association (“MHCA”) acted as liaison between facilities and Mississippi’s Department of Health. MHCA maintained contact with all facilities impacted both before and after the storm to identify needs and resources.

Hurricane Katrina: The major lesson learned was that with a storm this size you will be on your own and for quite a while – at least 7 days. Many people in Mississippi put patient care before their own lives. Employees showed up for work and stayed at the nursing homes. Most homes had more people show up than were scheduled.

Prior to Hurricane Katrina, three nursing homes and one assisted living facility evacuated. After the storm, an additional three nursing homes and an ALF were evacuated. Most residents stayed in state. Two homes were evacuated to Jackson and still lost power. One home requested help with evacuation and it took 36 hours to obtain help and they still had 24 residents remaining when the outer bands hit. Someone finally showed up and got the remaining 24 residents and that home is no longer standing. MHCA posted evacuation information on their website to assist families in determining the location of loved ones.

MHCA was without power and phones for four days. Afterward, they went to a clearinghouse mode to furnish supplies for staff and residents. Also, MHCA assisted with needs for generators, fuel, and power and acted as a liaison with the Dept. of Health. Currently Mississippi still has three nursing homes and one ALF out of commission or nonexistent.

Weaknesses in the System: The weaknesses in communication were at the local emergency management systems level, not the statewide Department of Health level. The problem was that there were breaks in communication between the Department of Health and the emergency management operational side. Respondents noted that it is difficult to “marry an emergency management culture within a health culture.” Florida Department of Health respondents discussed their experiences in having sent 1,400 state employees to help Mississippi after Katrina’s hit and how they used Florida resources to assist Mississippi rather than going through the Mississippi tracking system because of the gaps in reporting/responding.

Power and Transportation: Fuel shortages were a major problem and the state looked to Tennessee for fuel. One supplier stopped at a truck stop and the truckers almost commandeered his diesel. There were many reports of trouble with evacuation transportation and prioritization of power for long term care facilities.
Communication: All communication was lost, even satellite phones. Need training for people with satellite phones.

Security: If people have gone without food, water and power for a week and they know you have drugs and a generator, a long term care facility may become a security risk. There was a shortage of security personnel which put long term care facilities at risk of unwanted entries.

Evacuation: Long term care facilities were not mandated to evacuate and the ones that did evacuate did so to Jackson, Mississippi which was an approximate 200 mile evacuation trip on crowded roads. This resulted in a participant discussion about the need for disaster planning with evacuations within a shorter distance but beyond any surge threat.
The Louisiana Nursing Home Association has a seat at the state Emergency Operations Center where they notify all facilities pre-storm of the anticipated conditions – but they don’t recommend evacuation or shelter in place for that is the responsibility of the administrator or facility owners. The notice to report to the EOC did not come in until less than 48 hours before Katrina hit – this does not provide much time for evacuations. There is a software program called “E Team” at the EOC where needs are recorded and tracked. But communication was so poor after Katrina that the LNHA staff decided to set up their own rescue missions by calling churches for buses and locating other evacuation resources. One state senator drove a bus that he had access to down in the middle of the night to help evacuate a nursing home.

The LNHA also created a web page for family members to track their loved ones who had been evacuated from a nursing home. The Association maintained a list of evacuees and the sites of transfer on the website after obtaining approval that it was not a violation of HIPAA. The website also provided nursing home phone numbers so families could call if they had phone communication.

**Legal:** State Statutes amended after 9/11 provide for prompt and efficient evacuation and rescue of victims and also provide for rapid and orderly start of restoration. Governor of Louisiana has broad authority such as issuing executive order that can last up to 30 days. The Governor may also compel evacuations but there was no mass evacuation order preceding Hurricane Katrina and the decisions were left with the local parishes. But Governor Blanco was right on top of Hurricane Rita with evacuation orders. The powers of parish presidents are essentially the same as that of the Governor in suspending regulatory ordinances and compelling evacuations, etc.

New bills passed right after the hurricanes that impacted long term care facilities: HB5 – creates stricter regulations for building codes, etc. with three years to comply; and HB 107 – gives nursing homes and health care facilities protection of the CONs and licenses during closures due to disaster effects.

**Model Emergency Preparedness:** Louisiana Nursing Home Association (“LNHA”) worked with regulatory agencies in developing. Plan was adopted and all nursing facilities must have plan filed with local OEP (has been in place since about 1992). It is fairly general in scope and details are left up to the facility. Expect some legislation though to tighten up rules.

**Evacuation:** Transportation (buses and high water vehicles) were commandeered by FEMA while evacuation was taking place from nursing home and the residents could not get out for three days (resulted in 6 deaths). Some nursing homes that were evacuated to Lake Charles had to evacuate again. After filling all the nursing homes, we looked to high school gymnasiums and other sites that are not conducive to long-term care. Need to work with EOC on where you plan to go.

Have suggested wrist or arm band identification that contain resident’s vital information (meds, DNR, etc.) for facilities that shelter in place in the event of post-evacuation.
EOC: LNHA is one of two associations with a seat at EOC. Function during pre-storm by notifying facilities of storm status by email or phone call. Then we monitor the facilities and give updates. Post-storm functions include arranging for transportation back to facility if they evacuated. If they sheltered in place, we check on their needs. Had at least 3 people at the bunker immediately after the storm; maybe as many as 5. They worked around the clock at the bunker for 2 months. Remember that some people you counted on from your committee may have to stay at their facilities, so have a deep line up.

Power: LNHA has worked closely with the National Guard and Public Service Commission to get power back on. The Association has accomplished getting long term care facilities prioritized over the last couple of years. They have also had success with getting fuel for generators from the Dept. of Agriculture to facilities. Currently conducting survey to assess generator needs (some had the generator but no electrician). Also looking at larger generators to power an entire facility.

Communication: Had failures with satellite, cell and princess phones. Ham radios worked well though. Obtained cell phone numbers for administrators and DONs, which helped in getting status of facilities.

Transportation: Work on bus contracts. Some facilities had buses but no drivers. Fought agencies to get help; FEMA commandeered buses, fuel, etc. This is a critical area of disaster planning concern.

Security: For civil unrest (a big issue post-Katrina). Big issues were gun fights in the street and buses being carjacked at gun point. Staff had to leave because they were afraid.

Supplies: Have not had problems getting food, pharmaceuticals and other supplies. Have had vendors who stepped up to the plate.

Costs: Katrina, so far, has cost $36 billion and is expected to exceed $80 billion (WTC cost about $8 billion).

Deaths: 1300 total (about 1100 in Louisiana and about 200 in Mississippi).

Status: About 800,000 people displaced and 217,000 homes lost. A lot of nursing homes in the new 100-year flood plain and will not reopen. St. Rita’s is where one nursing home gained fame because its owners were charged with 34 counts of negligent homicide. Many damaged oil rigs in the Gulf.

Aid: Received about $125,000 from AHCA and other states for aid to staff and families.

Special Note: Many lives would have been lost if not for church groups, volunteer firemen, and volunteer organizations. Encourage facilities to develop relationships with these groups in their local area.
Louisiana

PowerPoint Presentation
Louisiana Revised Statutes

- RS 29:721 et seq.
  - Homeland Security and Emergency Assistance and Disaster Act (Amended after 9/11 Terrorist Attack)
- 29:722
  - Prepare for prompt and efficient evacuation, rescue...of victims
  - Provide a setting conducive to the rapid and orderly start of restoration

Louisiana Revised Statutes

- RS 29:724
  - Governor has authority to act to:
    - Issue executive orders
    - Compel evacuations
    - Transfer functions of agencies
    - Commandeer private property
- 29:726
  - Office of Homeland Security and Emergency Preparedness
    - Create a plan
      - Including to cooperate with federal government and any public or private agency in implementing programs for disaster emergency preparation, mitigation, response and recovery.
Special Session Legislation

- **House Bill 5**
  - Authorizes DHH to implement rules creating stricter building codes for health care providers
  - Amended to ensure that the costs would be picked up by the Medicaid Agency
  - Up to three years to comply
  - Any relocations subject to Facility Need Review service area

- **Senate Bill 107**
  - Provides for no loss of license or CON(FNR approval) for facilities closed by storms
  - Give notice of intent to re-open to DHH by 12-31-05
  - Actually re-open by 1-1-08

LNHA Duties at EOC

**Pre-storm:**
- Notify nursing facilities of storm status once Emergency Operations Center (EOC) is activated.
- Track storm; monitor conditions of storm
- Monitor status of facilities (sheltering in place or evacuation); assist facilities with their needs

**Post Storm**
- Monitor status of facilities that have evacuated and sheltered in place for supplies and food.
- E-Team requests
- Coordinate rescue operations, if necessary, with proper rescue agency.
- Coordinate orderly evacuation, if necessary, of facilities which had sheltered in place.
- Maintain a list of evacuees and site of transfer for family and friends.
- Assist operators with the return to their facilities once they are cleared to return. Work with other agencies (National Guard, State Police, Wildlife and Fisheries (water rescue), DHH, LHA, Public Service Commission).
LNHA & EOC

- One of two trade associations that maintains a desk at the State Emergency Operations Center.
- Worked closely with Office of Emergency Preparedness (OEP) since Hurricane Andrew in 1992

Hurricane Katrina

Facts and Information
NOTEWORTHY RECORDS OF THE 2005 ATLANTIC HURRICANE SEASON

Most Numerous
- 27 Named Storms (previous record: 21 in 1933)
- 14 Hurricanes (previous record: 12 in 1969)
- Four major hurricanes hitting the U.S. (previous record: three in 2004)
- Three Category 5 Hurricanes (previous record: two in 1960 and 1961)

Costliest
Hurricane: Katrina (at least $80 billion) (previous record Andrew, $26.5 billion - 1992 dollars)

Deadliest
U.S. Hurricane since 1928: Katrina (at least 1,300)

Strongest
- Strongest hurricane in the Atlantic Basin: Wilma 882 millibars (mb) (previous record: Gilbert at 888 mb)
- Three of the six strongest hurricanes on record:
  - Wilma 882 mb (1st)
  - Rita 897 mb (4th)
  - Katrina 902 mb (6th)

HURRICANE KATRINA

- On August 29, 2005 at 6:10am CDT, Hurricane Katrina made landfall in Plaquemines Parish, Louisiana.
- Katrina was the eleventh named tropical storm, fourth hurricane, and first Category 5 hurricane of the 2005 Atlantic hurricane season (NOAA, 2005).
New Orleans, LA, August 30, 2005 — Aerial photograph of the break in the levee in the 9th ward. Neighborhoods throughout the area remain flooded as a result of Hurricane Katrina.
IMPACT OF STORMS ON LOUISIANA AND MISSISSIPPI

<table>
<thead>
<tr>
<th></th>
<th>LA</th>
<th>MS</th>
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<tbody>
<tr>
<td>Lives Lost</td>
<td>1,071</td>
<td>207</td>
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<tr>
<td>Displaced People</td>
<td>786,372</td>
<td>110,160</td>
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<tr>
<td>Housing Destroyed</td>
<td>217,245</td>
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<td>Households w/o Electricity</td>
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<tr>
<td>K-12 Schools damaged</td>
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<td>263</td>
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<td>K-12 Schools Destroyed</td>
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<td>University Students Lost</td>
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<td>Hospitals Destroyed</td>
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<td>Businesses Destroyed</td>
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<tr>
<td>Decrease In Employment</td>
<td>240,000</td>
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Data from Louisiana Recovery Authority February 2006 Quarterly Report

Hurricane Katrina and Louisiana’s Energy Involvement

Hurricane Katrina’s Effect on Gulf of Mexico Oil Rigs
**Katrina Costs Comparison**

**RELATIVE COST BURDEN ON LOUISIANA CITIZENS DWARFS PREVIOUS DISASTERS**

FEMA cost estimates for recent US disasters (2005$)

<table>
<thead>
<tr>
<th>Disaster</th>
<th>FEMA cost estimate ($ Millions)</th>
<th>Affected population (Millions)</th>
<th>Indexed FEMA cost estimate</th>
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<tbody>
<tr>
<td>Katrina – Louisiana (2005)</td>
<td>$36,200 (36 Billion)</td>
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<tr>
<td>World Trade Center (2001)</td>
<td>$8,140</td>
<td>19.0</td>
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<tr>
<td>Northridge Earthquake (1994)</td>
<td>$9,170</td>
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<td>$308</td>
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<tr>
<td>Hurricane Andrew (1992)</td>
<td>$2,500</td>
<td>12.9</td>
<td>$194</td>
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<tr>
<td>Hurricane Iniki (1992)</td>
<td>$360</td>
<td>1.1</td>
<td>$329</td>
</tr>
<tr>
<td>Loma Prieta Earthquake (1989)</td>
<td>$1,360</td>
<td>23.7</td>
<td>$57</td>
</tr>
</tbody>
</table>

Source: FEMA, US Census 2000, cost estimates adjusted for inflation using CPI
Alabama

Effect of Hurricanes: Different issues – they took in a lot of residents from states directly hit by the hurricanes. Surveyed after Katrina to determine the number of beds and locations for accepting residents from other states. Some problems with residents showing up with a FEMA tag and nothing else – no name, medications, etc. Payment problems because of Medicaid rate differences between states.

Evacuations: During 2004 (Ivan) and 2005 (Dennis and Katrina), it was very limited and most of those decisions came from the facilities themselves. No loss of life or major injury to any residents or staff. Many facilities that did evacuate for Ivan (2004) decided to ride out the 2005 storms.

No written policy on evacuation in Alabama. Done on an individual basis and determined by owner/operator. No written policy on number of days for supplies – unwritten rule is 3 days.

Emergency Preparedness: State regulations call for facilities to have a detailed written plan and procedure to meet all potential emergencies and disasters which include training, review and drills.

Power: Generator requirements are scary (“woefully inadequate”). Must have emergency generator if you have life support. Require automatic battery-powered system which will provide power for 1-1/2 hours.

Communication: Sent contact information for Alabama EM out to facilities prior to storms but were unable to reach EM following storms. Also facilities were provided with the emergency contact information for the Alabama Association staff.

Surveyed facilities after the storms to assess damage and needs and assisted in getting supplies to them and getting them in contact with agencies. Had sister facilities or those in close proximity share services and assist one another.

Damage: Some damage caused by Ivan and Katrina to facilities in southern Alabama. Had roof damage, cosmetic damage, and lots of fallen trees. With flood damage, look out for unwelcome pests (rodents, snakes, etc.) trying to find higher ground when reentering the buildings.

Only two facilities in state are considered to be in a flood prone area.

Issues: After one storm, a facility that had 17 pines trees go through the roof was trying to get chain saws and cut down the trees when the surveyors showed up to inspect the food and water.

Many facility staff had homes destroyed. They continued to work at the facility, but had nowhere to go.

Aid: Set up a fund for Alabama members to contribute for supplies to Louisiana and Mississippi facilities and also for staff so they could get basic necessities for themselves and their families.
Texas

Planning: At the time of the storms, the Texas Health Care Association was well connected with state regulatory agencies but not with emergency management – this has since been corrected. The Association had emergency contact numbers for facilities whereas the state did not and had no way to contact them.

There are 36 nursing homes and about 40 ALFs in the surge zone along the coast in Texas. The Association is working extensively with those facilities to ready them, see where they plan to evacuate to and look at their transportation contracts. All parties are looking at having a 72 hour window for evacuation.

Evacuation: Texas took in about 100 Katrina evacuees but after Rita moved about 3.2 million people. Many people were unnecessarily moved since 11,000 nursing home patients were evacuated from over 100 facilities. But no one knew where Rita was going to hit land. One evacuation was to a junior college that had a nursing school. They were able to utilize nursing beds and some staff.

Communication: Started contacting facilities mostly by email on Wednesday before Hurricane Rita hit on Saturday.

Transportation: This was the biggest issue in preparing for Rita and there is a need for educating emergency response personnel. Some facilities had contracts with transportation providers, some even having already paid money down, that were not fulfilled. Traffic problems and distance precluded round trips. Problems with having elderly people on buses for 10-20 hours so the planning in the future will concentrate on minimizing the transportation distance. Three or four FEMA air lifts occurred with patient information left on the tarmac. Several hundred people were relocated out of state and no one knew who they were. Referenced the possibility of modeling a plan from New York City where they have developed a lane for health care transport and would like to consider that.

Costs: Extraordinary in the sense of overtime, supplies, transportation and facility damage (not patient care cost). Costs of about $2 million, which breaks down to $40,000 - $50,000 per facility (from a survey of about 99 facility respondents). Need to work on Medicaid funding.

Loss/injuries: Estimate 50-60 deaths.

Repatriation: Getting people back. Know who they are, where they came from and who pays for getting them back.
Texas

PowerPoint Presentation
HURRICANES, LONG TERM CARE, AND ASSOCIATION DISASTER RESPONSE

“EXPERIENCE IS WHAT YOU HAVE, RIGHT AFTER YOU NEED IT”
OR
“CHANCE FAVORS THE PREPARED MIND”

FEBRUARY 27-28, 2006

TIM GRAVES, PRESIDENT
TEXAS HEALTH CARE ASSOCIATION

THE CHALLENGE

- Uncertain Hurricane tracks and severity
- 1,000 Katrina Evacuees
- Move 3 million people – Rita
- Move 200,000 pets
- 11,000 nursing home patient re-locations
- Time

THCA ACTIONS

Communication Clearinghouse

- Review of Gulf Coast facilities
- Contact – staff and owners by THCA staff and Board members
- Blast E-mails to membership
- Website updates
- Communications to State, Federal and others
  - DADS
  - Emergency Response
  - CMS (American Health Care Association)
  - FEMA
- Lessons Learned Committee – September 30

ISSUES

- Transportation
  - Knowledge base of Emergency Response Personnel
  - Priority treatment
- Airlifts – Patient Identification
- Extraordinary Costs and the “Stafford Act”

- Repatriation

| Hurricane Rita - Nursing Facility Costs 2005 (Limited Survey) |
|------------------------|----------------|----------------|----------------|---------------|
|                        | Staff          | Supplies       | Transportation | Facility Damage |
| Cost                   | $551,405       | $373,555       | $230,044       | $568,413       | $2,171,012    |

<table>
<thead>
<tr>
<th>Facilities Reopening</th>
</tr>
</thead>
<tbody>
<tr>
<td>69</td>
</tr>
<tr>
<td>63</td>
</tr>
<tr>
<td>45</td>
</tr>
<tr>
<td>25</td>
</tr>
</tbody>
</table>

INITIAL RECOMMENDATIONS

- Focus on “surge zone” – minimize transport distance
- Consider early evacuation of special needs population
- For the major highways, develop a dedicated lane for health care transport vehicles (buses, ambulances, etc.)
- For other road and highways, develop a police escort process for health care transport vehicles
- Be sure DPS troopers and local law enforcement are alerted and available to assist health care transport vehicles
- Develop a system to give health care transport vehicles priority for gasoline refueling if needed
Initial Recommendations (cont’d)

- Develop a system whereby the state can enforce pre-existing transportation contracts in emergency situation; or the state can contract with transportation providers
- Include staff from THCA and other health care associations as on-site participants in the efforts at the State Operations and Emergency Management Center
- Ensure that patient identifying records are transported with the patients

Closing Comments

- “Experience is what you have, right after you need it”
- “Chance favors the prepared mind”
- Given enormity of undertaking, amazing results
- Ongoing Evaluation and Preparation
  - AHLA Conference
  - Gulf State Summit
  - Remember and use pleasant surprises

Founded in 1950, the Texas Health Care Association (THCA) is the largest long term care association in Texas. THCA represents a broad spectrum of long-term care providers and professionals offering long term rehabilitative and specialized health care services. Member facilities, owned by both for-profit and non-profit entities, include nursing facilities, specialized rehabilitation facilities, and assisted living facilities.
Georgia

Regulations: Disaster preparedness regulations were updated in 1984; the latest disaster plan update was about 5 years ago.

Planning: FEMA has new statewide (300-400 page) emergency plan and has only three references to nursing homes in the entire document. No one in the association was contacted for their opinion.

EOC: The association does not have a desk at the EOC and we need to work on this.

Evacuation: Georgia received a total of about 100,000 evacuees. Since that time about 40,000 have applied for Medicaid in Georgia. 327 of the evacuees were admitted to about 30 nursing homes throughout the state – about half from Rita and half from Katrina. There are still 120 evacuated residents remaining in Georgia nursing homes.

Nursing homes serve as special needs shelters because beds area available, staff is trained, and food is in place.

Confusion during receipt of evacuees, as Georgia took in Texas evacuees that had FEMA airlift leave patient information on tarmac. Dobbins AFB personnel performed very well. But in general, nursing home patients were sent to hospitals, and evacuees with only minor ambulatory issues were sent to nursing homes. Mostly a triage problem.

Communication: Gathered up available beds throughout the state and provided that information to Cobb County Dept. of Health, who was coordinating the receiving of patients. There was much miscommunication between the receiving agency and nursing homes. Had problems with patients who were landing in the middle of the night and the state contacting a nursing home at 2:00 am and being told to call back in the morning. In other cases, nursing homes would be expecting patients at 11:00 pm and no one ever showed up.

Transportation: A nightmare. Might have 5 people getting on a 40-person bus because of location or availability of beds. Need to work on having one clearinghouse with a list of beds for quick dispatch.

Power: No requirement for generators in Georgia, but roughly 250 out of 350 facilities have installed emergency power on their own initiative.
National response plan developed by Homeland Security completely leaves out nursing homes. They are now looking at including a nursing home policy since they will be affected by any overflow of patients from hospitals in case of a disaster or terrorist attack.

Who is or should be responsible for evacuation decision-making? Is it a local EOC or parish president decision or should it be the administrator of a health care facility who determines if and when an evacuation occurs? Should this be clearly delineated in a facility’s hazard mitigation analysis of their disaster plan?

It was suggested that local EOCs and providers utilize ham radio operators (ARES – Amateur Radio Emergency Services) in their bunkers. They can communicate worldwide and will pull down their towers in high winds and have them back up as soon as the storm passes.

In developing disaster plans, think worst case scenarios. Resources that are readily available during a Cat 1 are suddenly scarce when it turns into a Cat 4 or 5. The surge zones are critical for disaster planning.

Protect your facility even if you have a contract with a vendor for the contract is not always honored. Water supply or fuel companies may not deliver in the event of a catastrophe, even you have a contract.

There is a debate over whether local authorities should decide the destination for evacuees or if that should be left up to facilities to develop relationships and possibly have multiple locations. Is it too restrictive to require evacuation to a “like” facility?

The Florida Agency for Health Care Administration’s representative provided an overview of the state’s new tracking system that will be on the Agency’s web site. The system will be for health care facilities to report information on available beds, status of generator, contact information for administrative staff, etc.

The second day’s discussion resulted in recommendations and areas of needed focus, as listed in the next section.
Florida Department of Health (DOH)

PowerPoint Presentation
Florida’s Health and Medical Emergency Response System

Ray Runo - ESF 8 Emergency Coordinating Officer
Jon Erwin – ESF 8 Emergency Management & Special Projects Coordinator
Department of Health, Office of Emergency Operations

The State Response

- The State emergency response is based on the principle that all emergencies are local, and we are engaged to provide human and material resources to help impacted communities.

Disasters Impact Communities

- Local Ownership
  - Applies to natural or man-made disasters
  - State and federal officials should offer one-stop shopping in supporting locals

- Coordination
  - Local, state and federal governments need to use the same plan
State of Florida’s Comprehensive Emergency Management Plan (CEMP) Ch. 252 F.S.S.

- Provides guidance to state and local officials regarding responsibilities and procedures
- Supports an integrated and coordinated response (local, state and federal)
- Adopts a functional approach to response: Emergency Support Functions (ESF)

State of Florida’s Initial Response

- Operational Rules:
  - Meet the Needs of the Victim
  - Take Care of the Responders
  - Review Rule Number 1

Craig Fugate: Director of the Division of Emergency Management

Operational Objectives:

- Reestablish Communications with the Impacted Area
- Initiate Search & Rescue
- Address Basic Human Needs & Life Safety
- Restoration of Essential Services
- Begin Recovery Operations

Craig Fugate: Director of the Division of Emergency Management

Disaster Levels

- C: Presidentially Declared Disaster
  - FEMA: a) Mobilizes National & Regional HQ Resources, and
  - b) Responds Primarily From Regional HQs Without Full National Deployment

- B: Ambiguous Zone
  - Has Gubernatorial Declaration, but Unclear Whether it will Obtain Presidential Declaration -Criteria for Decision? -Financing?

- A: State and Local Emergencies
  - Can Occur: With Gubernatorial Declaration
  - Without Gubernatorial Declaration

Requesting Assistance

- Municipality
- Municipality
- Municipality

- County Emergency Operations Center (CEOC)
- State Emergency Operations Center (SEOC)
- Federal Emergency Management Agency (FEMA)
Emergency Service Function 8 (ESF 8)
Health and Medical
Florida’s Strength of Response

ESF 8 Health and Medical Purpose
- The purpose of Florida Emergency Support Function 8 (ESF8) is to coordinate the State’s health and medical resources, capabilities, capacities, and response in an “All Hazards” environment during natural or man-made disasters.
- To develop an integrated and comprehensive statewide ESF 8 health and medical response SYSTEM.

ESF 8 Major Partners
- Department of Health (Lead)
- Agency for Health Care Administration
- Department of Elder Affairs
- Department of Agriculture
- Department of Children & Families
- Florida Hospital Association
- Florida Health Care Association
- Florida Home Health Care Association
- Florida Nursing Association
- Federal Partners

ESF 8 Key Support Partners
- ESF 4 & 9 EMS deployment and SAR
- ESF 5 Information & Planning
- ESF 6 Mass Care
- ESF 7 Resource Support (Logistics)
- ESF 10 Hazmat
- ESF 11 Food & Water
- ESF 13 Military Support
- ESF 14 Media Relations
- ESF 15 Volunteers & Donations
- ESF 16 Law Enforcement

ESF 8 Responsibilities
- Mass Casualty Systems
- Epidemiology/Disease Control
- Immunizations
- Facility Assessments
- Evacuation/Relocation
- Risk Communications
- Nutritional Services
- Statistical Reporting
- Behavioral Health/CISD
- Rapid Impact Assessment/Urban Search & Rescue Teams
- DEET (Bug Spray)
- Renal Facility Support
ESF 8 Responsibilities

- Environmental Health Services
- County Health Dept. Support
- Lab Services
- FEMORS/DMORT
- SanPacs
- Oxygen
- EMS Services
- Hospital Infrastructure/staffing
- Disaster Medical Assessment Teams
- Special Needs Shelters (Equipping & Staffing)
- Pharmaceutical Deployment

Florida Strengths

- Utilize Incident Command System (Unified Command)
- Health and Medical response is predicated on strong relationships.
- Emphasis is on health and medical “systems” which are integrated, interdependent, and focused on the mission.

Florida Strengths

- Focused on support for locals.
- Collaborative planning, training, and exercising with federal, state, county, and private association-agency partners.
- Federal partners are integrated into the management structure.
- Daily unified Incident Action Plans (IAP)
- Focus on continuous planning and analysis

Florida Strengths

- System of continuous improvement.
- Aggressive and on-going communications with facilities.
- Pre-staging resources for deployment.
- Rapid damage assessments.
- Model sheltering and discharge system.
- Transportable to other areas.

ESF 8 Katrina Response

- Area of Operations - lower 6 counties of Mississippi (most severely impacted)
- ESF 8 part of first-in command team and managed ESF 8 system.
- Instrumental in re-establishing the health and medical system.
- Established communications linkages.

ESF 8 Katrina Response

- Conducted damage assessments of over 60 health care facilities (AHCA).
- Provided immunizations for first responders and victims.
- Provided Critical Incident Stress Debriefings
- Established and managed shelters.
- Still providing services to Internally Displaced Persons (IDP’s).
- Worked to establish and implement a system to manage mass fatalities.
- Seamless hand-off to Kentucky.
ESF 8 Katrina Deployments

- 384 ESF 8 personnel deployed (including 140 EMS personnel and 56 Advanced Life Support Units. (with ESF 4&9)
- Three teams of architects, engineers, and industrial hygienists. (AHCA)
- Coordinated VA hospital patients transported out of disaster area to Miami, Tampa, Orlando, and Jacksonville (NDMS)
- 200 SEOC staff to support personnel in the field.
- Acquired and managed health and medical supplies for logistical staging area in Miss.

Inter-State and Federal Health Care Staffing Resources

- The size of last year’s long term event reduced the capacities of local communities to help each other due to the impacted areas.
- ESF 8 deployed over 2,000 health care professionals from the following states:
  - Alabama, Alaska, Arkansas, California, Georgia, Illinois, Iowa, Kentucky, Massachusetts, Michigan, Missouri, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Wisconsin.

Questions?

- Thank you for the opportunity to meet with you.

  - Raymond_Runo@doh.state.fl.us
  - Michael_J_Jacobs@doh.state.fl.us
  - Jon_Erwin@doh.state.fl.us
1. Evacuation - who decides - the state, county or local jurisdiction? Caveats - state authorization if life endangered. State and local coordination - specific plan for Nursing Homes to follow on evacuation order (communication 5 days to within 72 hours). This assumes a requirement for each nursing home to have an operational disaster preparedness plan with identified criteria based on a hazard analysis and risk assessment. What is the knowledge base? Is threat consistent with plans to evacuate? Anticipate a higher level disaster.

2. The facility plan has to be integrated with the local health and medical emergency management plan.

3. Hazard level planning for internal/external resources.
   a) Staffing - where to put them? (Need a place for staff, children, pet room) Concern: Lack of resources for LTC
   b) Communication - Ham radios - establish link to group
   c) Develop relations with volunteer fire departments and faith-based community resources.
   d) Contractual agreements should include information about how they respond in disasters. (Their disaster plan as well.) Mississippi benefited from this relationship with vendors.
   e) Develop a self-sufficiency package (72 hours) of supplies, equipment etc.
   f) All shelters need life safety - quick connect for generators. No upgrade of facility in surge center.

Local plans need to be linked to regional/state resources for evacuation or shelter in place.

4. Transportation - start at the front end in determining responsibility (NDMS) for the triage, transport and destination of evacuees. State level for evacuation - then look at transportation for that evacuation. (Louisiana had success with Hurricane Rita evacuation because state took responsibility). Plans linked to regional/state resources for evacuation or sheltering in place.
   a) Patient tracking and case management to and from the point of evacuation and back.
   b) Universal patient ID system (SSN) contact point of information.

5. If the transport/evacuation hazard risks (flooding & surge) exceed the benefits, nursing homes need to be hardened for staying in place. What resources are available for shutters/wind protection and other hazard mitigation approaches?
6. Nursing homes serve public-funded residents and should have access to the Stafford Act (2000) and the hazard mitigation fund, to also include supplies, equipment and staffing as well as the physical plant.

7. FEMA should work at the direction of the state with the states’ EOC structure. (Unified command system at the direction of the state - unless state has shown a marked inability to protect its citizens). Coordinate Joint Field Office (JFOs), ex. Orlando - disaster recovery - HHS in Tallahassee (joint command at state direction). 10 FEMA and 10 HHS regions - situation dependent and region dependent.

8. Communication - Close contact with local EOC absolutely necessary. Before, during and after the storm - hardware inter-agency staff family/resident contacts challenges - Need to develop the system (HAM radios satellite phones).
   a) Residents, families and staff need to know plans
   b) Have phone rollover to another facility/number - corporate number.
   c) Provide sample letter for family members
   d) Ensure employee preparedness at the point of being hired. Consider a written agreement to ensure understanding of employee responsibilities in times of disasters.
   e) Resident evacuation check list.
   f) Guide for activities to help with new residents, family.

9. Reimbursement
   a) Need for consistent CMS payment policies across disasters with Medicare and Medicaid.
      i. Sending facility (pays sending and sending will reimburse receiving - 30 day guideline)
      ii. Receiving facility - special needs people who were at home who were not Medicare or Medicaid eligible - no payment?
      iii. Need a plan for long term care facilities to accept persons with special needs from shelters - start to apply for Medicaid benefits. Stay within Medicare guidelines - MDS becomes real problem. Can we have presumptive eligibility?
      iv. MDS forms may need to be waived because of disasters. Call state department of health and hospitals - need improved direction from CMS in this area.
   b) Establish a recovery system at the BEGINNING of the disaster (plan, response, recovery).

   Also, Louisiana residents assigned a FEMA number were able to request reimbursement for items lost, such as a wheelchair and other personal items and FEMA paid for the replacement items.

10. Insurance companies are going through an unprecedented crisis - impact on LTC providers (the proceedings will include an advisory from Deb Charron with Seitlin Insurance summarizing her input at the Hurricane Summit.)
11. Staffing:
   a) Plan before, during, after (alpha and beta shifts - including administrative tasks. Have
   b) Based on internal and external disasters drills, staffing assigned to specific areas.
   c) During hiring you need to explain requirements for work during disasters.
   d) Excellent documentation of when people worked. Ensure tracking of costs.
   e) Methodology for staff (salaried) to be reimbursed.
   f) Picture IDs for facility with “essential employee.” Useful when FEMA had curfew
      and limited access on roads to travel to/from work.
   g) Reciprocity agreements across state lines to lend staff.
   h) Payroll delivered in cash.
   i) $1,000/day minimum per facility.
   j) Unemployment comp benefits were extended for 2-3 months and created a problem
      for CNAs and healthcare industry.

12. Essential documentation requirements addressed by state, CMS, HHS.

13. Individual preparedness - before storm hits, give staff time off. Post event - give them
    time to go home and see how things are. If you do this you will keep staff and they will
    attend to residents.

14. Gas stations - develop relationship with local independent/owner. Hook up facilities
    with marinas - pay as you go.

15. Recognize mental health employees’ needs. Compassion fatigue CD. Behavioral health
    needs should be incorporated in plans.

Please add any additional recommendations to the list of recommendations.
Transportation 101 Guide for Disaster Preparedness

April 2006

Plan Ahead

Transportation needs have to be prior planned for residents and staff in the case of a necessary evacuation. It is advised that long term care facilities work with the local Emergency Operations Center in planning for transportation needs. However, every facility needs a transportation agreement(s) that identify any travel restrictions such as distance, county or state lines. Ensure that your transportation agreements include a certificate of insurance.

Ensure your facility has an approved disaster plan with an evacuation plan if necessary.

Include Disaster Readiness as an ongoing topic at your monthly Risk Meeting.

Review Contractual Agreements

Determine if there is adequate bus and emergency vehicle transportation available through contractual agreements and include the contracts as a part of your facility plan.

Know Your Affiliates at EOC

If there is inadequate availability of transportation vehicles in case of a disaster, work through your county EOC to plan accordingly.

Make sure the EOC transportation contact knows who you are and the type of needs anticipated. There has to be a strong working partnership with the local EOC.

Consider inviting the EOC representative to tour your facility and even provide education/information about your disaster plan to the resident council. This attaches faces to your facility.

Align Your Plan

Your facility transportation plan should be aligned with the evacuation status of your facility. If your facility has to evacuate, plan to be out of the facility for at least three days. This means that transportation has to be planned for the relocation of staff as well to continue to care for the residents at the receiving facility.

Create Innovative Transporting Contracts & Strategies

Identify transporting entities: The supply transport is the method by which the supplies will be taken to an out-of-town host facility. Determine if your vendors will assist in this capacity. A signed and current contract is required or an addendum saying that patient and supply transportation is the same.
Have ready in advance a complete list of the: a) Supplies being transported to host site; b) Supplies to be delivered to host site; and, as applicable, c) Supplies host facility will provide.

Check vendor agreements. Vendor agreements are necessary to ensure delivery of emergency supplies, food provisions, nursing equipment and laundry needs to host site. These agreements must be current and must include all supplies that might be needed.

Renew contracts annually with companies that spell out the means of transportation: school buses, private bus companies including church buses, ambulances, and handicapped vans.

If there is the potential for distance travel, plan for different venues such as private bus companies across county lines.

Include in the facility plan the means to transport supplies/beds/staff to the receiving facilities. A facility must not wait to get a U-Haul van on the day of the evacuation.

The facility plan should include an agreement with the local school board on how to have extra buses available for the supplies.

As soon as there is a warning of a storm, reserve the truck(s) in advance. Anticipate going outside your area to access transportation.

Consider moving residents after the sun goes down when environmental temperatures have dropped. This makes it more comfortable for the staff, and reduces the risk of hyperthermia. In addition, transportation is often more accessible later in the day.

**Transportation Readiness & Resident Needs**

**Supplies** - Send resident specific supplies on the buses with the residents. Include an emergency drug kit, hydration and snacks for the residents and staff, satellite phone ($10 a day estimated rental; they only work outside), and at least one cell phone.

Facility’s vehicles are fully fueled and extra fuel available in an approved container.

The staffing for the bus should include at a minimum one nurse and 2-3 CNA’s for every 25 residents. Adjust staffing ratios for acuity.

Some facilities have cross-trained staff in other departments to be CNA’s in an emergency. Identify all your potential resources.

**Residents** - Keep an updated copy of the Resident Roster sample matrix, (HCFA-802) and the Resident Census and Conditions Sheet, (HCFA-672). This will help in the management of acuity and resident specific needs. Each facility needs to identify and plan for special needs residents such as patients on dialysis and oxygen, patients in need of special lifting equipment, etc.

Keep a running list of residents (updated weekly) for their evacuation status. List the following:

- Type of transportation required, recommended transferring and lifting techniques, and aligned staffing. Include a review of who may need oxygen during transport.
- Involve your therapy department in the ongoing provision of lifting, transferring, and transporting training for staff. Involve therapy with the coordination of resident
specific transportation guidelines, and reviews for transferring residents onto buses and other vehicles.

- Identification of any special needs, e.g. insulin for diabetics.
- Have a binder with face sheets that is updated daily of all current residents. Fax the face sheets to the receiving facility if possible. Also, ambulances will need this information for transport.
- Have identification bands for all residents with name, specific requirements such as thickened liquids, etc. Put the family contact name and number on both the face sheet and the identification bands.

Communication Strategies

Notify families of relocation plans for their loved ones.
Provide families or resident representatives with the name and address of the receiving facility.
Provide the contact person’s name and telephone number from the sending facility’s so they can be updated with the latest information on their family member.
Remember that families/resident representatives may need to also evacuate. Obtain current information on where families/resident representatives will be located and contact numbers for them.

It is possible for the phone company to reroute a facility’s telephone number to another number. Note that the receiving facility will not want to have their phone calls doubled with calls from the sending facility family members. Consider an alternative number for this.

Meals, Medications, and Managing the Evacuation

Print off four days of tray tickets before leaving the facility. Move the emergency supplies with the residents or contact the food supplier for adequate foods.
Take all emergency medical and resident related supplies with residents to the receiving facility. (Including documentation systems, assignment sheets, etc.).
Coordinate transporting Medication carts by unit. Try to send the medication/treatment carts on the same bus as resident are from that unit.

If that is not feasible, have the vehicle that is transporting the medication/treatment supplies (for a designated unit); follow the bus with the residents. This helps safeguard that all supplies get to the right location.
Use U-Haul trucks to transport the mattresses and wheel chairs. Make sure all equipment (walkers, chairs, etc.) is labeled with the patient's name and the facility name. Restorative aides should check this on a weekly basis during the hurricane season.

Keep an updated listing of rented equipment such as Hoyer lifts, as well as durable medical equipment provided through Hospice. Decide if rental equipment should be transported.

Try to keep all patients/residents in the same area by med cart distribution.
Coming Home

This is the fun part, but watch out for people scrambling to get back to the buses. Reverse the process now for returning the patients, medication carts, supplies, etc.

Emphasize the need for patience and stress management by staff and residents. Everyone will be tired.

Make sure the Agency for Health Care Administration has approved the facility for a return.

Ensure that food products, power restoration, supplies and medications are available at the sending facility.

Ensure adequate replacement staff, (in all departments) for the return to the facility.

The facility may need to work through the local EOC for the return transportation. Make sure your transportation contracts spell out the return expectations.
Florida Agency for Health Care Administration (AHCA)

PowerPoint Presentation
Agency for Health Care Administration

Emergency Status System
ESS

February 28, 2006

Emergency Status System

- AHCA Internally Developed Application
- Track Emergency Status & Impact for AHCA Regulated Providers
- Pulls Facility Licensure Data from Existing Database - LicenseEase
- Reporting Capabilities for All Data Entered
- 2005 Hurricane Season – Internal Use by AHCA Staff
- 2006 Web Interface – Input from Providers, Associations, and Others
ESS Providers

- Hospitals
- Skilled Nursing Facilities
- Assisted Living Facilities
- In-Patient/Residential Hospice
- Adult Family Care Homes
- Intermediate Care Facilities for the Developmentally Disabled
- Crisis Stabilization Units
- Residential Treatment Facilities
- Transitional Living Facilities
- End Stage Renal Disease Centers

ESS Events & Points of Contact

Events
- Activities Revolve Around “Events” e.g.: Hurricanes
- Different Entries (Options) Based Upon Whether an Event is Open

No Event Open - Pre-Season Information
- Emergency Contact Persons & Contact Numbers
- Utility Account Information
- Existing Generator Information
**ESS Points of Contact**

Open Event (Storm)

- Pre-Storm Information
  - Evacuation Status Including Destination
  - Special Resident Characteristics - Oxygen, Ventilator, Dialysis Dependent
  - Census & Available Beds
- Post-Storm Information
  - Power Status
  - Impact - Structural Damage
  - Evacuation Status - Return to Facility
  - Available Beds
  - Provider Needs and Status of Needs Requests - Equipment, Staff, Supplies (Limited to Internal Users)

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**ESS Online Enhancements**

- Project Completion for 2006 Hurricane Season
- Expeditious TimeLine for Completion
- Utilized Existing Resources
- Incorporated Updated Based Upon 2005 Hurricane Experiences
- Entries of Provider Information by Providers, Provider Affiliates, Association Staff
- Reports from ESS Available for EOC Staff, Associations, Attorney General Staff and State Ombudsman
ESS Accounts Access

Access Depends Upon User Type

- Providers (Single Provider Entries)
- Affiliates (Multiple Provider Entries)
- Associations (All Provider Entries & Reports)
- Other State Agencies Assisting (Reports)
  - Emergency Operations (EOC)
  - Attorney General
  - Long Term Care Ombudsman

ESS Provider Accounts

Allows Entry by Providers

- Emergency Contact Persons and Numbers
- Utility Information
- Generator Information & Status (Fuel)
- Special Resident Characteristics
- Available Beds
- Evacuation Status
**ESS Provider Affiliate Accounts**

- Allows Entry of Provider Information by Affiliates
  - Corporate Contact
  - Other Affiliated Person
- Individual Account for the Affiliate (Person)
- Affiliate Chooses Providers – May Have Multiple
- Provider Must Approve Affiliate as an Authorized Representative

**ESS Association Accounts**

- Access to Provider Information for Provider Type Represented
- Entry of Provider Information
- Reports
  - Provider List
  - Available Beds
ESS Online User Accounts

- Individual Users Receive an Account and Password

- Providers - Receive AHCA Letter and Account – Online Sign Up
  (30 Day Account Pending Written Agreement)
- Affiliates – Online Sign Up, Provider Authorizes (30 Day Account)
- Associations – Online Sign Up, Written Agreement Necessary
- Other State Agencies – Online Sign Up, Written Agreement Necessary

ESS Initial Entry

All Screens are DRAFTS in Development
User Types

All Screens are DRAFTS in Development

User Agreement Entry

All Screens are DRAFTS in Development
ESS User Agreement

All Screens are DRAFTS in Development

Affiliate User Access

All Screens are DRAFTS in Development
Link to Florida AHCA Emergency Resources

All Screens are DRAFTS in Development

Link to Florida Emergency Operations Offices

All Screens are DRAFTS in Development
Affiliate User Access to Provider Information

All Screens are DRAFTS in Development

Affiliate Users – Manage Providers

All Screens are DRAFTS in Development
Partner Users Select from Provider List

All Screens are DRAFTS in Development

Navigation of Provider Information

All Screens are DRAFTS in Development
All Screens are DRAFTS in Development
Emergency Contact Details

All Screens are DRAFTS in Development

Power/Utility Information – No Event Open

All Screens are DRAFTS in Development
Power/Utility Information - Event Open

All Screens are DRAFTS in Development

Generator Information – No Event Open

All Screens are DRAFTS in Development
Generator Details – No Event Open

Generator Details - Event Open

All Screens are DRAFTS in Development
All Screens are DRAFTS in Development
Census/ Available Beds - Hospital

Evacuation Status

All Screens are DRAFTS in Development
All Screens are DRAFTS in Development

Evacuation Destination Selection

Evacuation Destination Details

All Screens are DRAFTS in Development
Return to Evacuation Destination List

Impact List

All Screens are DRAFTS in Development
Impact Details

All Screens are DRAFTS in Development

Impact Severity

All Screens are DRAFTS in Development
ESS Web Reports

All Screens are DRAFTS in Development

All Screens are DRAFTS in Development
All Screens are DRAFTS in Development
All Screens are DRAFTS in Development
ESS Online Next Steps

- BETA Testing – February/ March
- Education & Distribution
- User Account Enrollment
- Encourage Entries of Initial Information (Pre-Season)
Appendix B

ElderIssues LifeLedger System
In Eldercare Knowing the Questions Can be More Valuable than the Answers

When caring for an elderly person, often finding the questions is more important than finding answers. Before we can effectively learn new skills we must learn what we need to know. This is why we have teachers, not just to give answers, but to also give us the questions so that we can better learn the answers.

In the field of eldercare there are few teachers to lead us in becoming effective caregivers. We could go to college to get a social work or nursing degree, but this not practical for the millions of people struggling to care for a loved one.

A new eldercare Web Site is changing that situation by providing a step-by-step process for both new and experienced caregivers. It will lead them to the questions and the answers that will help them to more effective and efficient as well as saving time and money. Most importantly it reduces the stress and helps to balance a caregivers life.

Build a Caregiving Team

Caregivers for the elderly will come into contact with almost every kind of provider of elder services, medical, legal, housing, rehab and on and on. With a few very pleasant exceptions, most will find that the patients and their caregivers have care provided to them or for them, but never with them. When the patient and their caregiver are not an integral part of the care plan and are not engaged with respect for their input; time and money are being wasted while the patient is put into jeopardy. Caring and the desire to help is not the issue with family caregivers, it is having information, knowledge and experience to become an integral member of the team caring for their parent.

Patients and the caregivers cannot be expected to change the system, but there is much that they can do for themselves to help.

1. You must become informed and know where to get the answers to the many questions that arise.
2. You must know and communicate their situation. Ex: Diagnoses, Allergies, End of Life Options, Medications, and much more to the professional providers.
3. You must learn to be a team player and to treat providers as a part of that team, while expecting to be treated by others as the valuable team member that they are.

The LifeLedger provides the step-by-step approach to become an effective member of every caregiving team. It assists in making you the best caregiver you can be.
Will You Be a Caregiver?

The National Council on Aging reports “People do not anticipate caring for a parent. They state ‘We will cross that bridge when we get to it.’ But when adult children suddenly have to cross that bridge, they look frantically for answers and options.” When we are thrust into the caregiver role, it may be when we are not so young ourselves. Many of us join the ranks in our 50’s, 60’s and plus when a parent or spouse may become dependent upon us. No matter how much we hope to avoid this situation, or to put our loved ones into the role of caring for us, we truly have no control. Many plan for the best when they should be hoping for the best, but planning for the worst. An ounce of prevention is worth many pounds of cure when it comes to eldercare.

Learning to be an effective family caregiver is no easy task. We often hear that experience is the best teacher. I contend however, that someone else’s experience is the best teacher. Learning from the mistakes that others have made and the solutions they have developed save us time, money and stress, while increasing the safety and well being of the care receiver.

If we are in a situation where there is a possibility that we may be called upon to be a caregiver or need to be cared for, now is the time to make some preparations. The first step is to learn what the questions are, only then can we start to find the answers. Where can we begin? Communication! Talk with your family about the potential of someone needing care in the future. Admit to each other that the possibility is real and that some thought and preparation could reduce the impact on the family and maximize the independence and self-sufficiency of those who may need the care. To take advantage of others’ experience, the best teacher, speak with friends and neighbors who have walked the walk of caring for an elder. Seek out elder specialists such as Elder-Law Attorneys, Geriatric Care Managers, Financial Planners, etc. to help guide you through the maze. There are books available at your library, magazines such as Today’s Caregiver, and many governmental and non-profit sources as well.

The newest and most prolific source of help and information is the Internet. Today you can find facilities, home health, medical and pharmaceutical data, Caregiver associations and support groups and much more. You can also take advantage of many years of professional Geriatric Care Management experience and knowledge at a newly introduced site specifically developed to assist both new and experienced caregivers. It is the ElderIssues, LifeLedger™. It will lead you step by step through the process and will give you the questions you need to ask as well as the assistance you will need to find the answers. It is fully secure, yet can provide access to emergency personnel when required. Professional service providers can do their best when they have accurate and up to date patient data available. Children who live thousands of miles away can be effective participants in the caregiving process. You can take a free 7 day trial of the LifeLedger™ at www.elderissues.com/demo. If it meets your expectations, you will be asked to purchase an annual subscription for $49.95

Whatever the course of preparation you choose, it will pay off many times over if ever the unthinkable should occur. If you do become a caregiver, don’t be afraid to ask for help. Caregiving is not easy and if you wear yourself out or become ill, there will be 2 people needing care.
A Living Will or Healthcare Surrogate has no value until it can be presented to the medical personnel that are at the point where the care is being provided. It is not enough to say, “I am Mother’s Healthcare Surrogate and she has a Living Will. I don’t have them with me, they must be at her house somewhere.”

There are a number of things you can do to avoid the situation. Have copies with the medical information on the refrigerator for emergency personnel to access. Keep a copy in your glove compartment so it is available if you are not at home, also at work so you can FAX them. You should be sure your physicians are aware of your wishes and should be supplied with copies to be placed in your medical record. The neighbors and other family members, if they have copies they may be able to get it to the medical personnel. You cannot have too many copies. Make extras and share them.

Today’s technology also provides new ways to make advance directives available at anytime and anywhere. They can be posted on an Internet site and the Internet address can be carried in a wallet or purse. Wherever you may be, wherever your Surrogate is located, whenever the documents and contact instructions are needed, they will be waiting and available.

One could make their own site for this purpose or they can utilize a service such as the LifeLedger™ at www.elderissues.com. The LifeLedger™ can also be loaded with other pertinent information that will allow emergency personnel to more effective, and perhaps make the difference between life and death.

You not need to choose an option, you can use them all. The most important thing is to discuss your wishes and provide the documents to those who may be able to get them into the right hands when they are needed.
Like most who have family in Louisiana or Mississippi, I could fill pages with Hurricane Katrina anecdotes; however, I have chosen to share one story that I hope you find interesting as well as applicable to your business.

My mother lives in New Orleans, and on Aug. 28, she moved her furniture to higher ground. She emptied the refrigerator, unplugged power cords, packed a few belongings, closed the shutters, boarded windows and then left town.

She headed to Baton Rouge so that she could easily return home after the storm to assess the damage. But Katrina’s damage was so severe that residents were not allowed to return for several weeks. Instead, she flew to my home in Virginia, and arrived with a week’s worth of clothes, her dog, her medications and a few photographs.

Fortunately, my mother was in good health when the natural disaster hit. Still, the situation stirred within her a number of “what ifs”: What if she hadn’t been healthy? What if she had been injured and needed medical attention? As time passed, her worry deepened: What if she became ill while staying with me? What will happen when her health—both mental and physical—deteriorate?

Perception vs. reality
My mother is a planner. She has appropriate insurance coverage, a living will and a formalized financial plan. That said, I was shocked by the disparity between how well prepared I thought she was for her inevitable health decline and the truth. Yes, she has a well thought-out plan, but after asking her a few questions, I realized that implementing her strategy in an emergency would be extremely difficult. Reality hit me like a ton of bricks.

Our conversation went something like this:

“Mom, do you have a copy of your living will?”

“Yes. It’s in the bank box.”

“Do you keep a list of all your medications?”

“No. I put them in the weekly sorter.” (A plastic container with sections for every day of the week.)

I continued to quiz her.

“Where would I find your Social Security number?”

“My Social Security card is in the bank box.”

“How about your insurance (health, life, long-term care) policy numbers?”

“The policies are all in the bank box.”

As you can probably ascertain, getting to her safety deposit box during the evacuation was not possible for several reasons. For one, Aug. 28 fell on a Sunday, when banks are closed, and for another, banking services were unavailable for months after Katrina.

As a result of this experience with my mother, I discovered that I didn’t have an aging family member’s important documents on hand, or the names and contact information of her insurance agent or doctors.

Advantages outweigh cost
The harshness of Hurricane Katrina has extended beyond ruined homes and flooded cities. For me, it has identified a void in the system my mother—and probably many fellow Americans—use to protect documentation that is vital to their safety and well-being.

It is clear to me that clients must have more than one copy of their papers, and clients’ loved ones must be able to easily access these when necessary.

The Association of Health Insurance Advisors has recently partnered with LifeLedger to offer a service that fills this void. AHIA members can provide their clients with access to a secure, online system that stores personal documents, and financial and medical information.

LifeLedger helps seniors maintain maximum independence and peace of mind, knowing their records are safe, and family and caregivers can quickly obtain the records with a click from just about anywhere in the world.

The LifeLedger Personal Health Record (PHR) service is $9.95 a month. To learn more, call AHIA at 703-770-8200 or visit the LifeLedger link at www.ahia.net.

I’m pleased to report that my mother is back in New Orleans. Her Social Security card, insurance policies and living will remain in the bank box. I’m comforted however, in knowing that she now has a PHR. Should the unexpected happen—again, I can get my hands on her records in seconds.
Appendix C

External and Internal Disaster Drill Form
EXTERNAL and INTERNAL DISASTER DRILL FORM

Please check one: External Drill ______ Internal Drill ______

FACILITY NAME: DATE: TIME:

National Fire Protection Association Chapter 11 Health Care Emergency Preparedness 11-5.3.9 Drills: Each organizational entity shall implement one or more specific responses of the emergency preparedness plan at least semi-annually. Experiences show the importance of drills to rehearse the implementation of all elements of a specific response including the entity’s role in the community, space management, staff management, and patient management activities. The rehearsal of an emergency preparedness plan should be as realistic a test of that plan as possible. Preparation for the rehearsal should involve the following: training, walk through familiarizations, and discussions after the walk-through to resolve questions or problems.

Date of disaster in-service prior to the drill ___/___/___

I. Describe the incident created for the drill or note if a “real event” is serving as the drill requirement.

II. List outside community resources requested to participate in the drill

[ ] fire department [ ] water company [ ] phone company
[ ] police department [ ] electric company [ ] sewer company
[ ] bomb squad [ ] EOC [ ] hospice
[ ] County EMS [ ] dialysis [ ] other ________

III. Facility Response to the incident

Number of Employees present: __________ Length of Drill: __________

Did the Employees follow the Policies and Protocols? [ ] yes [ ] no If no, please list date of follow-up in-service and attach facility action plan to quality assurance committee and process. Date of follow-up in-service ___/___/___.

Narrative response to include evacuation of residents down stairs, to other parts of the facility, and or out of the facility:
IV. Provide a narrative description of the role of outside community resources who participated in drill (include names and contact information).

Narrative Response:

V. Outside Agency Notification:

[ ] AHCA  [ ] DOH  [ ] DOEA
[ ] DCF  [ ] VA  [ ] insurance provider
[ ] EOC  [ ] other  [ ] other

Additional comments:

VI. List Key Staff Participation:

VII. Signature of Person responsible for drill:

___________________________________________ , _______________
Name                                                                                  Title

___________________________________________ , _______________
Name                                                                                  Title

Remember to advise your local fire department and facility alarm system company **BEFORE** your drill to avoid false alarm.