DEPARTMENT OF HEALTH

Long Term Care Preparedness Toolkit

Base Plan

To establish common terms, this toolkit uses “Long Term Care (LTC) facility/agency” to include nursing homes, skilled nursing facilities (SNF), assisted living facilities (ALF), assisted living (AL) licensed group homes, intermediate care facility for individuals with intellectual disabilities (ICF/IID), home care agencies, and hospice.

In Partnership with the MDH and the following Regional Coalitions, and State Associations.

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Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

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Introduction

The Minnesota Long Term Care (LTC) Preparedness Toolkit is designed to assist with emergency preparedness planning for this specialized health care population. LTC facilities/agencies, as they are referred to in the toolkit, include nursing homes, skilled nursing facilities (SNF), assisted living facilities (ALF), assisted living (AL) licensed group homes, intermediate care facility for individuals with intellectual disabilities (ICF/IID), home care agencies, and hospice.

Members of the Minnesota Department of Health, Care Providers of Minnesota, LeadingAge of Minnesota, Minnesota Home Care Association, Minnesota Network of Hospice & Palliative Care, and regional representation from the Health Care Preparedness Program developed this tool to assist LTC facilities in emergency preparedness. Latest revisions to this toolkit took place in the Fall of 2022 with additional input from individuals representing LTC facilities/agencies. The CMS emergency preparedness interpretive guidance was released and implemented in April 2021.

CMS Appendix Z resources:

- **Appendix Z-QSO-21-15-ALL Appendix Z (https://www.cms.gov/sites/default/files/2021-04/som107ap_z_emergprep.pdf)**
- **A.1 CMS Emergency Preparedness Checklist**
- **A.2 ASPR TRACIE CMS Provider Type Definitions**
- **A.3 Table Requirements by Provider Type**
- **A.4 CMS Releases Updated Emergency Preparedness Guidance**

CMS/MDH Appendix Z Resources:

- **A.5 MDH Crosswalk**
- **A.6.1-supplemental doc**
- **A.6.2 resident plan**

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

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

Plain Language

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

Minnesota Hospital Association (2011). Plain Language Emergency Overhead Paging Toolkit (https://www.mnhospitals.org/Portals/0/Documents/ptsafety/overhead-paging-toolkit-2011.pdf)

Continuity of Operations Plan (COOP)

A Continuity of Operations Plan (COOP) will document how the facility or agency will perform essential operations during an emergency or long-term disruption, which might last days or weeks. The plan will identify mission critical functions, departmental communication methods, and alternate personnel, systems, and locations. Each facility or agency needs a COOP to ensure they can respond effectively to a variety of situations.

The COOP is designed to coordinate department/work area strategies to ensure continuity of operations. The plan takes an all-hazards approach that addresses natural, manmade, and technological hazards. Implementation of a department/work area's continuity plan will be based on the needs of the incident and resources available. The COOP should include succession planning for continuity purposes. A COOP does not replace a facility/agency emergency operations plan.

Succession Planning: delegation of authority/order of succession during an emergency.

Overview of All-Hazards Approach to Planning

Recent events, including COVID-19, floods, tornados, winter storms, and other events have stressed all types of LTC facilities/agencies and shown that better planning is needed. Because different types of events present different challenges to LTC facilities/agency's, an all-hazards approach to planning is proven to be most effective and most beneficial. An all-hazards response plan must be based on the hazards that are most likely to affect a facility/agency and is important in directing how a response may unfold and what actions would need to be taken. To identify the most likely hazards, a hazard vulnerability analysis should be completed (see **Appendix B** for more information on the Hazard Vulnerability Analysis).

All-Hazards

Hazards may be thought of as extreme events. A Hazard Vulnerability Analysis (HVA) is often based on an "all-hazards approach." This means a facility/agency begins with a list of all possible disasters, regardless of their likelihood, geographic impact, or potential outcome. The list may be the result of a committee brainstorming session, research, or other methodology, and should be as comprehensive as possible.

It is helpful to divide the potential hazards into categories to focus discussion and planning. Typical categories may include natural hazards, technological hazards, and human events. These are certainly not requirements and should not be considered constraining. There is

overlap between the categories as well. For example, a transportation accident may be a technological hazard rather than a human event.

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

Finally, prioritize hazards to guide the emergency planning process. The realistic factors of time and money play a role in decisions of preparedness, and facilities must choose to apply their limited resources where they will have the most impact. To aid prioritization, each identified hazard is evaluated for its probability of occurrence, risk to the organization, and the organization's current level of preparedness.

Hazard Vulnerability Analysis and Tool

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

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

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

It is recommended that each facility/agency evaluate the prioritization and determine the minimum score in which no action is necessary. List hazards in descending order based on the total score, this will prioritize the hazards in need of the facilities/agency's attention and resources for emergency planning. The focus will then be on the hazards of higher priority. The minimum score determined that there is some probability and risk of the event occurring, but the facility/agency has decided to exclude it from the planning process. It must be noted that the acceptance of all risk is at the discretion of the facility/ agency.

*To obtain a regional HVA contact your Regional Healthcare Preparedness Coordinator (RHPC) or to identify who your county emergency manger is see Appendix N *

*See Appendix B for the process to develop your own Hazard Vulnerability Analysis (HVA) and Tool *

Sample HVA Tool

Note: an electronic HVA can also be accessed through your regional health care coalition. Below is a screenshot of what the electronic HVA looks like and how changes in Probability, Impact and Response change the Risk.

Alert Type	PROBABILITY	ALERTS	ACTIVATIONS	SEVERITY = (MAGNITUDE - MITGATION)						RISK
				HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur			Possibility of death or injury	Physical losses and damages	Interuption of services	Preplanning	Time, effectiveness, resources	Community/Mutual Aid staff and supplies	* Relative threat
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	Number of Alerts	Number of Activations	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 =High 2 = Moderate 3 = Low	0 - 100%
Active Shooter	1	0	0	1	1	1	1	1	1	7%
Act of Terrorism	2	0	0	2	2	2	2	2	2	27%
Air Quality Issue	3	0	0	3	3	3	3	3	3	60%
Bomb Threat										
Building Move	1	0	0	2	2	2	3	3	3	17%
Chemical Exposure, External	2	0	0	3	3	3	1	1	1	27%
Chemical Exposure, Internal	3	0	0	1	1	1	2	2	2	30%
Chemical Spill										
Child Abduction	1	0	0	3	3	3	1	1	1	13%
Civil Unrest / Protesting	2	0	0	1	1	1	2	2	2	20%
Communication / Telephony Failure	3	0	0	2	2	2	3	3	3	50%
Dam Failure										
Drought										
Earthquake										
Epidemic										
Evacuation										

See Appendix B for more information on the Hazard Vulnerability Analysis and Tool

Emergency Operations Plan

The following sections serve as specific components that will allow your facility/agency to plan and prepare to meet the needs of both residents and staff in the event of an incident. Each section will offer a description of the concept, and instructions. When combined, these sections are the basis of an Emergency Operations Plan (EOP).

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

For an EOP to maintain viability and usefulness, it needs to be updated on a scheduled basis. As each facility grows and changes, the EOP also needs to be modified to reflect those changes. After including every section below, your EOP will be well on the way to serving each facility's/agency's need to care for staff and residents.

Communications

A communication plan for both internal and external communication is important to get the correct message to the right people at the right time. A plan should set out goals, strategies, communication activities, and timeframes to help facilitate communications.

See Appendix C for more information to help LTC facilities communicate with each other.

Incident Command System

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

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

Incident Command Systems (ICS) can be used at facilities/agency's both large and small — it can even be used by just one person. If you have a small facility/agency, the same person may fill multiple spots on the ICS organizational chart. Assure through practice and exercise that one designated person is not disproportionately overburdened with their roles in an emergency.

It is recommended that, at a minimum the roles of: Incident Commander, Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance Section Chief (also referred to as command staff) obtain the basics of ICS by taking ICS 100, ICS 200, and ICS 700. These courses and more can be found at: Federal Emergency Management Agency Training Website (https://training.fema.gov/is/crslist.aspx?lang=en&page=1) .

Here is a video link to give all staff a brief overview of the ICS structure, and here is a video link that depicts a scenario showing the importance of being prepared.

Basic ICS Job Action Overview

The organization chart describes the ICS chain of command and defines key response areas. Specific personnel placed in the various roles are determined on the skills and position with the facility/agency. Below are suggested positions for ICS roles.

Incident Commander: Leads the response, appoints section leaders, approves plans and key actions (CEO, Administrator, Director, Director of Nursing (DON), Nursing Supervisor.)

Finance Section: Tracks all expenses, claims, activities, and personnel time and is the record keeper for the incident (controller, accounts department, payroll.)

Logistics Section: Finds, distributes, and stores all necessary resources (maintenance supervisor, purchasing, human resources director)

Operations Section: Handles key actions including first aid, search and rescue, fire suppression, securing the site (DON, Department supervisors, nursing supervisor, direct care staff.)

Planning Section: Gathers information, thinks ahead, makes and revises action plans and keeps all team members informed and communicating. (Safety committee, Continuity of operations planning team, etc.)

Depending on the size of the incident and capability of the facility/agency, one person may occupy multiple positions within the section. You do not need to activate all positions – only activate what you need for the incident. This is your basic Incident Command. If part of a larger system, you will need to know where your ICS fits within that facilities/agency's structure.

See Appendix D for ICS operations, templates, Job Action Sheets, and the NICS Incident Action Plan. Appendix D also has specific ICS structures for different incidents, to lend an idea to specific duties during a response.

Additional resources: California Disaster Preparedness Program (https://www.cahfdisasterprep.com/nhics)

Facility/Agency Information and Contact Information

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

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

See Appendix C for Contact lists

Building Specific Information

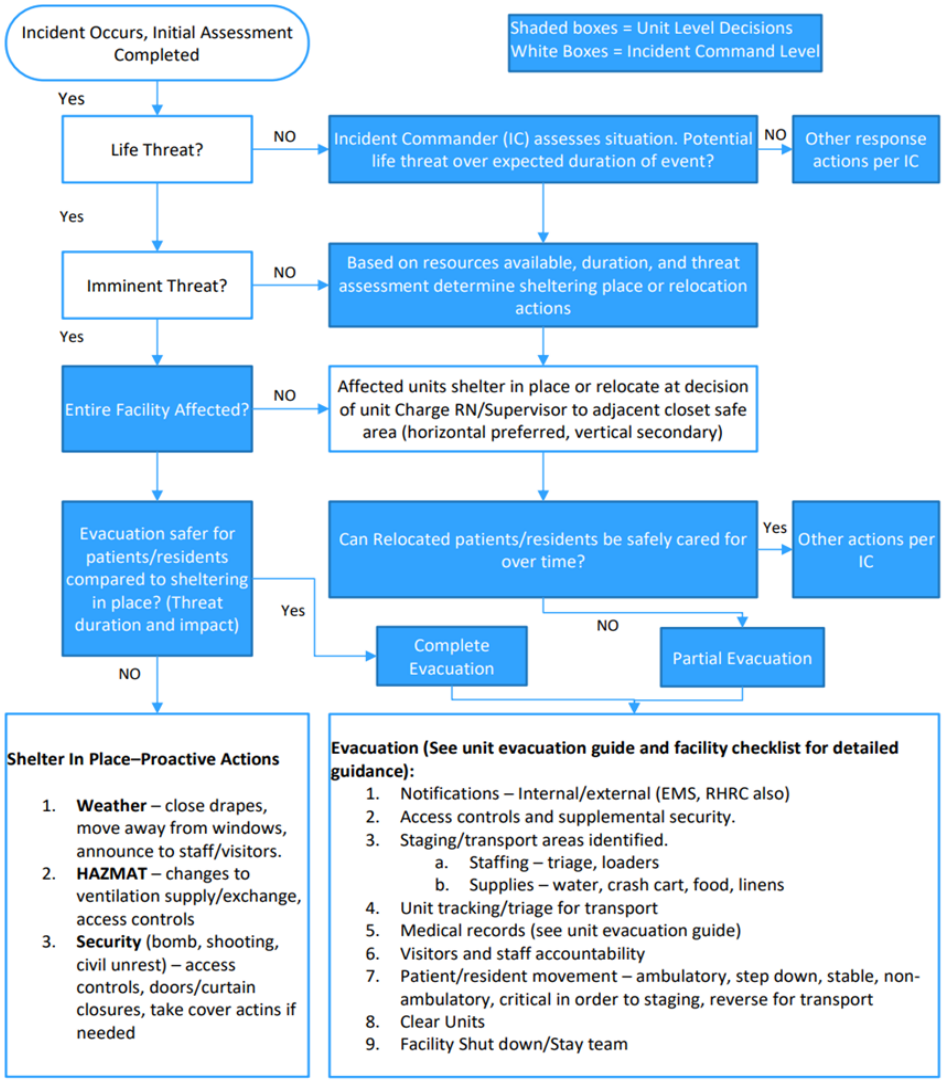
This information is made up of the location and characteristics of the facility/agency and the people associated with it. As with any response, it is important to understand the physical features of a facility/agency to maintain safety and efficiency. It is also important to understand the occupancy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

See Appendix E/C for Facility/Agency Specific Information

Decision Making

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

Sample Decision Making Tree

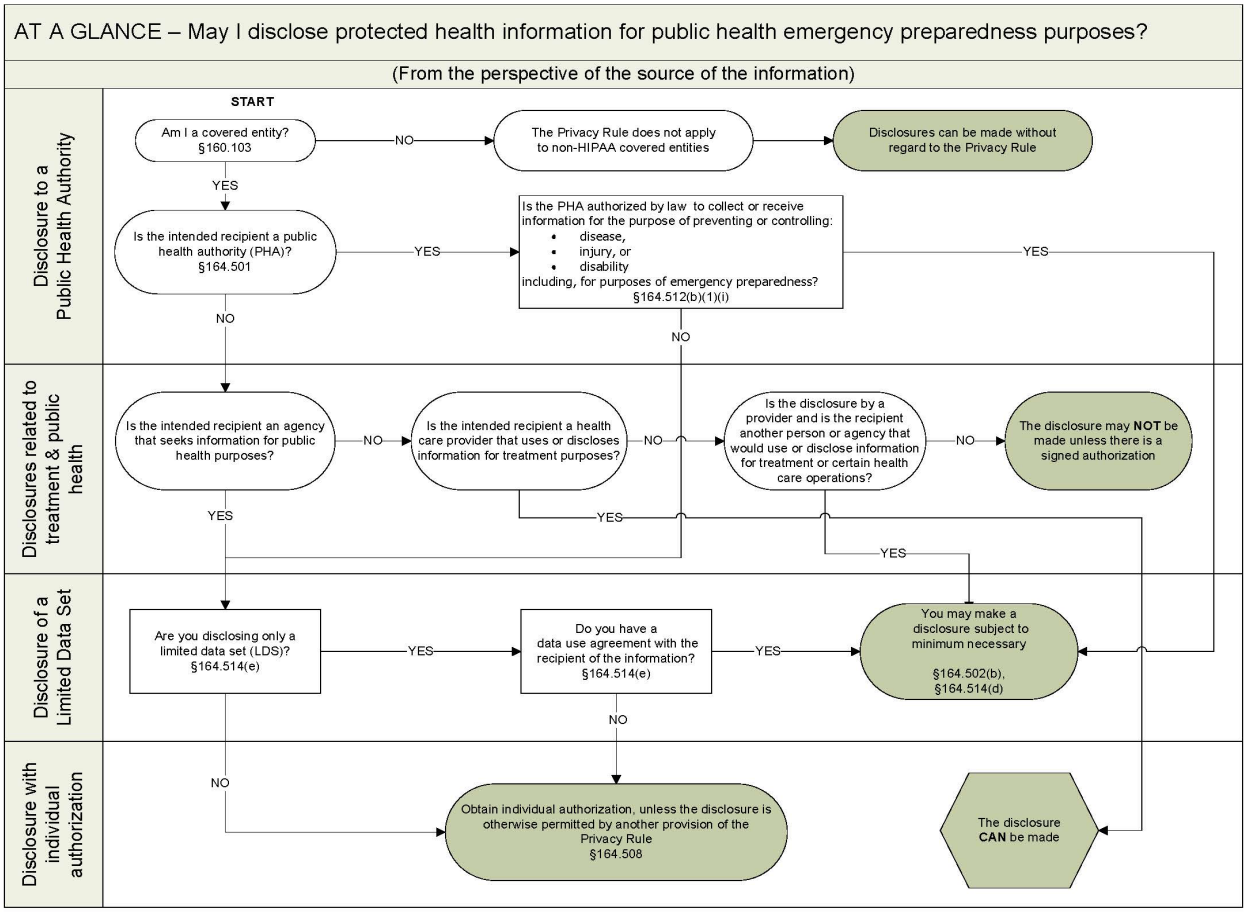


Source: Emergency Sheltering, Relocation, and Evacuation for Health Care Facilities. (https://www.health.state.mn.us/communities/ep/surge/sheltering/index.html)

HIPAA/1135Waivers in Emergent Situations

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

See Appendix G for HIPAA Wavier Toolkit



Source: [hhs.gov (https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/emergencyprepdisclose.pdf)](https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/emergencyprepdisclose.pdf)

1135 Waivers

When a disaster or emergency is declared under the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to their regular authorities.

For example, under section 1135 of the Social Security Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure:

1. sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods
2. providers who give such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse)

Examples of these 1135 waivers or modifications include:

- Conditions of participation or other certification requirements
- Program participation and similar requirements
- Preapproval requirements
- Requirements that physicians and other health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – state law governs whether a non-Federal provider is authorized to provide services in the state without state licensure)
- Emergency Medical Treatment and Labor Act (EMTALA)
- Stark self-referral sanctions
- Performance deadlines and timetables may be adjusted (but not waived).
- Limitations on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers

These waivers under section 1135 of the Social Security Act typically end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.

Information Curtesy of CMS website: 1135 Waivers | CMS (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers)
Resources:

1. 1135 Waiver at a Glance (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/1135-Waivers-At-A-Glance.pdf)
2. 1135 Waivers (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/CMS-Presentation-1135-Waivers.pdf)
3. AUTHORITY TO WAIVE REQUIREMENTS DURING NATIONAL EMERGENCIES (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/1135-Waivers-Authority.pdf)

Ethical Guidelines

The Institute of Medicine's Guidance for establishing Crisis Standards of Care for use in disaster situations offers a useful framework which fundamentally relies on the principle of justice.

Ethical Values:

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

Ethical Process Elements:

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

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

1. Triage: workforce members should be prepared to prioritize which residents to evacuate first prior to or during a crisis
2. Allocation of Resources: workforce members should know what resources are available during a crisis, where supplies are stored, and have the tools needed to determine how scarce resources will be issued
3. Standards of Care: workforce members should be prepared to adjust their standards of care during an emergency. Considerations include ensuring individuals are trained to provide care normally outside of their professional practice

Here is the Link to the Minnesota Department of Health's Crisis Standards of Care page.
Ethical Considerations for Crisis Standards of Care- Minnesota Dept. of Health (https://www.health.state.mn.us/communities/ep/surge/crisis/ethical.html)

Infection Prevention and Control:

Infection prevention and control is required to prevent the transmission of communicable diseases in all health care settings. Infection prevention and control demands a basic understanding of the epidemiology of diseases; risk factors that increase patient susceptibility to infection; and the practices, procedures and treatments that may result in infections.

The risk of acquiring a healthcare-associated infection is related to the mode of transmission of the infectious agent (e.g. CDI, SSI, CRE, MRSA, etc.), the type of patient-care activity or procedure being performed and the underlying patient's host defenses. Healthcare workers should be vaccinated against preventable diseases such as hepatitis B. Personnel at risk for exposure to tuberculosis should be screened per recommendations.

When an infection outbreak affects a broad population in the United States, the Centers for Disease Control and Prevention (CDC), is responsible for making specific recommendations for infection control measures in different circumstances and settings.

- MDH Infection Prevention and Control (https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/index.html))
- COVID-19 PPE and Source Control Grids (4/7/22) – This document was developed to help facilities identify what level of PPE was needed bases on community transmission level. https://www.health.state.mn.us/diseases/coronavirus/hcp/ppegrid.pdf

Crisis Staffing

Maintaining adequate staffing is essential to provide a safe environment for residents and staff. Facilities should be prepared for varying levels of staffing shortages, have contingency staffing plans in place, and ensure resident safety.

Health care facilities may need to implement crisis-level staffing strategies and the identification of conventual, contingency and crisis staffing. It is up to the facility/agency to determine their staffing level.

Conventional: This phase includes activation of the facility's normal day-to-day protocols to fill staffing gaps, including utilizing on-call staff, and leveraging resources from facility partners. The quality of care provided to the residents is the highest practicable level of care to meet the needs of the residents.

Contingency: This phase occurs when local resources are exhausted. It may include canceling events or activities to balance workloads; readjusting facility schedules to allow for maximization of in-house staff; adding incentives or bonuses for staff who take on additional shifts; bringing on additional staff from outside of the facility (i.e., supplemental staff); and using volunteers to serve nonclinical roles to assist with critical daily tasks.

Crisis: This phase occurs when there is significant staffing shortages and consists of implementing large-scale changes to the way the facility provides care and conducts business. Activities include leveraging statewide and federal resources. Staff must consider altered standards and do the best they can with the resources available.

See MDH Long-term Care Contingency Staffing Plan (Template) and training webinar for additional information. Long-Term Care Emergency Preparedness (https://www.health.state.mn.us/communities/ep/ltc/index.html)

Volunteers

Use of volunteers can be part of day-to-day operations or part of an emergency. In either case they need to be properly trained for their assigned job.

Local volunteers

Minnesota Responds/Medical Reserve Corp is a partnership that integrates and engages local, regional, and statewide volunteer programs to strengthen public health and health care, reduce vulnerability, build resilience, and improve preparedness, response, and recovery capabilities. Each Community Health Board in Minnesota has a Minnesota Responds program. MNResponds: FAQ (https://www.mnresponds.org/faq.php)

All requests need to go through proper channels which **MAY** include the county Emergency Operation Center and the State Emergency Operation Center.
Workers Comp and tort claim defense and indemnification are covered by the jurisdiction that maintains the volunteers unless the volunteers are responding at the request of the commissioner of health then they are covered by the state. Sec. 12.22 MN Statutes (https://www.revisor.mn.gov/statutes/cite/12.22)

Liability insurance is covered by the requesting jurisdiction/facility.

State volunteers

This may happen depending on the situation like COVID-19 when the MN National Guard was activated. Below was the consideration used during COVID-19.

Each situation will be different, and the consideration may change.

Prior to consideration for National Guard support, the facility must have exhausted the resources available as outlined in the LTC Progression guidelines which includes having:

- Exhausted all internal staffing options, including payment of incentives, cross training of positions, etc.
- Explored potential assistance from related facilities.
- Attempted to obtain assistance from Supplemental Nursing Agencies and have contracts in place with multiple agencies.
- Attempted to obtain assistance from Public Health Agencies.
- Activated any Emergency Staffing MOU's (Memorandums of Understanding) and Memorandums of Agreement (MOA) which have been outlined in the facility Emergency Plan.
- Contacted their trade associations for assistance.
- Contacted their assigned Regional Healthcare Coalition for assistance.
- Contacted their county emergency managers.

If all areas have been exhausted, and the application for assistance meets the criteria as assessed by the LTC Response Team Crisis Manager, National Guard assistance may be an option.

Sheltering in Place

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

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

- Plan in place describing how three days of non-perishable meals are kept on hand for residents and staff. The Plan should include special dietary requirements.
- Plan in place describing how 72 hours of potable water is stored and available to residents and staff
- Plan in place identifying 72 hours of necessary medications that are stored at the facility and how necessary temperature control and security requirements will be met.
- Plan in place to identify staff that will care for the residents during the event including any transportation needs that the staff might have and how the facility will meet those needs
- Plan in place for an alternative power source, such as an on-site generator, and describe how 72 hours of fuel will be maintained and stored. Alternate power source plan provides for necessary testing of the generator
- Plan in place describing how the facility will dispose of or store waste and biological waste until normal waste removal is restored
- Emergency Communications Plan in place, such as for cell phones, handheld radios, pager, satellite phone, laptop computer for instant messaging, runners, etc
- Planning considerations given to the needs of residents, such as dialysis residents
- Planning considerations given to residents on oxygen
- Planning considerations given to residents using durable medical equipment such as masks, nasal cannulas, colostomy equipment, g-tube, etc

See Appendix H for Facility Shelter in Place checklists and Response Items.

Evacuation

While evacuation is typically not preferred, there may be times when this option is safest for the residents and staff. Due to the varied abilities of residents, evacuation can be a daunting task without appropriate consideration and planning. Prior planning regarding how residents will be transported, who will provide the transportation, what specialty types of vehicles will be needed and where they will come from all need to be prearranged to maximize the safety of residents and staff. Evacuation planning also includes determining what supplies, food, water, medications, and other physical items will be needed to maintain safety. Pre-determined locations should be identified and have an MOU created where residents can be taken that will

adequately meet their needs. Identifying pre-determined locations and having discussions ahead of time will ensure a smooth transition. Sample memoranda are provided to serve as templates (**See Appendix K**). Additionally, it should be noted that having an evacuation agreement with more than one facility would be appropriate. Traditionally, facilities often choose the closest like facility with which to partner. However, a second facility some distance away may be prudent if the closest facility may be similarly affected and unable to handle the transfer request.

The following pages are specifically dedicated to looking at evacuation needs. If additional evacuation and shelter-in-place planning resources are desired, please refer to the Health Care Sheltering, Relocation, and Evacuation (https://www.health.state.mn.us/communities/ep/surge/sheltering/index.html)

See appendix I for Evacuation Checklists.

Evacuation Transportation

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

1. The number and types of vehicles required
2. How the vehicles will be obtained
3. Who will provide the drivers
4. Medical support to be provided for the resident during transportation. The following support needs should be considered:
    a. Residents who are independent in ambulation
    b. Residents who require assistance with ambulation
    c. Residents who are non-ambulatory
    d. Residents with cognitive impairments
    e. Residents with equipment/prosthetics (equipment/prosthetics should accompany residents and should be securely stored in the designated mode of transportation)
5. Estimation of the time to prepare residents for transportation
6. Estimation of the time for the facility to prepare for evacuation
7. Estimation of time for the resident to reach the sheltering facility
8. Detailed route to be taken to each sheltering facility if possible
9. Description of what items must be sent with the resident such as:
    a. The resident's medical record, which contains the medications being taken by the resident, dosage, frequency of medication administration, special diets, special care, etc
    b. A three-day supply of medications (if possible)
    c. Special medical supplies the resident may need
    d. Other items such as clothing, incontinence products, etc

10. The medical records should be provided to the receiving facility and remain with the receiving facility until the resident is transferred back to the sending facility or to another facility
11. Records should be maintained of which residents are transported to which facilities

See Appendix J for Evacuation Transportation

Evacuation Destination Information

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

- Sleeping plan
- Feeding plan
- Medication plan
- Accommodations for relocated staff
- Number of relocated residents that can be accommodated at each receiving facility

Evacuation Staffing

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

- Description of how care will be provided to relocated residents
- Identification of number and type of staff needed to evacuate the facility and to accompany residents to the sheltering facility
- Plan for relocating facility staff
- A contingency plan if facility staff cannot make it into the shelter due to their own family's needs

Memorandums of Understanding

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

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

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

Examples include MOUs with:

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

See Appendix K for MOU templates

Attachments and Documents

The following documents should be included as attachments to the Evacuation Plan, reviewed and updates annually:

1. Sheltering agreements/MOUs between the facility and the receiving facility
2. Transportation agreements/MOUs between the facility and ambulance companies, bus services, churches, etc
3. Documentation of any coordination between law enforcement, fire departments, emergency manager, etc

See Appendix I/J for evacuation plans, checklists, and transportation agreements.

Recovery

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

also those types of needs that support the safe and effective operation of your facility/agency, staff, and residents. Recovery is a fluid situation which may last months to years.

See Appendix L for consideration checklists for re-opening

Staff Care

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

- Main family preparedness page: Disasters and Emergencies (https://www.ready.gov/be-informed)
- How to build a household emergency kit: Build a Kit (https://www.ready.gov/kit)
- How to write a household plan: Make a Plan (https://www.ready.gov/plan)
- Fillable emergency communication card that folds to fit in the wallet: Make a Plan Form (https://www.ready.gov/sites/default/files/2021-10/family-communication-plan_fillable-card.pdf)
- Individuals with Disabilities: Individuals with Disabilities (https://www.ready.gov/disability)
- Pets and Animals: Pets (https://www.ready.gov/pets)
- Seniors: Seniors (https://www.ready.gov/seniors)
- Do1Thing-Emergency Preparedness for Individuals and Businesses: https://www.do1thing.com/
- MN Council on Disability:- Emergency Plan for People with Disabilities (https://www.disability.state.mn.us/technical-assistance/emergency-preparedness/emergency-plan-for-people-with-disabilities/)
- Red Cross - Prepare For Emergencies (https://www.redcross.org/get-help/how-to-prepare-for-emergencies.html)

Behavioral Health

During an emergency it is important to consider behavioral health concerns. Behavioral health includes the emotions and behaviors that affect your overall well-being. Behavioral health is sometimes called mental health and often includes substance use. Just like physical health, behavioral health has trained providers who can help you much like a physical health care provider.

- WellnessMN (https://wellnessmn.org/)
- Disaster Behavioral Health and Emergency Preparedness (https://www.health.state.mn.us/communities/ep/behavioral/index.html)

- Regional Behavioral Health Coordinators (RBHC) (https://www.health.state.mn.us/communities/ep/behavioral/rbhc.html)
- home | Workplace Health Promotion | CDC

Exercise, Evaluation, and Improvement Planning

For any plan to be useful, it needs to be tested periodically to identify gaps in the plan and areas for improvement. Unless the plan is tested routinely, it is not truly a functional piece of work, which is the goal of having an emergency operations plan. All disaster plans fail in some capacity during a real-world incident. Regular preparedness exercises and training can help the facility/agency to adapt the plan during an incident. For this reason, there should be an exercise plan which includes both an evaluation piece, improvement planning, and trainings

The Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Requirements state that LTC facilities/agencies must offer training on emergency procedures at least once annually and must complete at least two exercises annually: one full-scale exercise that is community or facility based and one additional exercise of the facility's choice. See link for requirements: CMS Emergency Preparedness Requirements by Provider Type.

See Appendix M for Exercise, Evaluation, and Improvement Planning Checklist

Recovery can take months to years and is part of the cycle for emergency preparedness.

Basic Exercise Requirements by facility/agency type per CMS Appendix Z:

Facility Type	Community based exercise every two years or Individual facility based functional exercise	Addition exercise opposite one above. May be a second full-scale exercise, mock disaster drill or tabletop exercise or workshop.	Documentation of exercise, AAR
SNF/ALF	Annual Full-scale exercise	Annual additional exercise	X

Facility Type	Community based exercise every two years or Individual facility based functional exercise	Addition exercise opposite one above. May be a second full-scale exercise, mock disaster drill or tabletop exercise or workshop.	Documentation of exercise, AAR
AL Group Homes – ICF/IID	Annual Full-scale exercise	Annual additional exercise	X
Home Care	X	X	X
Hospice inpatient	Annual Full-scale exercise	Annual additional exercise	
Hospice outpatient	X	X	X

Variability in Requirements

For inpatient providers:

(inpatient hospice facilities, PRTFs, hospitals, LTC facilities*, ICFs/IID, and CAHs): The types of acceptable testing exercises are expanded. Inpatient providers can choose one of the two annually required testing exercises to be an exercise of their choice, which may include one community-based full-scale exercise (if available), an individual facility-based functional exercise, a mock disaster drill, or a tabletop exercise or workshop that includes a group discussion led by a facilitator.

*NOTE: For LTC facilities, while the types of acceptable testing exercises was expanded, LTC facilities must continue to conduct their exercises on an annual basis.

Facilities must conduct exercises to test the emergency plan, which for LTC facilities also includes unannounced staff drills using the emergency procedures.

For outpatient providers:

(ASCs, freestanding/home-based hospice, PACE, HHAs, CORFs, Organizations (which include Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services), CMHCs, OPOs, RHCs, FQHCs, and ESRD facilities): Facilities are required to only conduct one testing exercise on an annual basis, which may be either one community-based full-scale exercise, if available, or an individual facility-based functional exercise. The opposite years (every other year opposite of the full-scale exercises), these providers may choose the testing exercise of their choice, which can include either another full-scale, individual facility-based, a mock disaster drill (using mock patients), tabletop exercise or workshop which includes a facilitator.

Regional Resources and Support Agencies

The following map will assist LTC facilities/agencies in determining to which region they belong.

See Appendix N for links to regional and coalition specific contact information.

List of Appendixes and Annexes

Appendix/Annex	Description
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Appendix A.2	CMS Rule by Provider Type Definitions
Appendix A.3	Table Requirements by Providers
Appendix A.4	CMS Updated Emergency Preparedness Guideline
Appendix A.5	MDH Crosswalk
Appendix A.6.1	Supplemental Document for Group Homes, Hospice, and Home Care
Appendix A.6.2	Resident Emergency Preparedness Information
Appendix B	Hazard Vulnerability Analysis and Tool
Appendix C.1	Communications
Appendix C.2	External and Internal Contact Roster Excel Spreadsheet
Appendix D.1	Incident Command System (ICS) Organization Chart
Appendix D.2	HCIS Incident Action Plan
Appendix D.3	ICS Guide – Digging Deeper
Appendix D.4	Extra Job Action Sheets
Appendix E	Facility/Agency Contact Lists
Appendix F	Building Specific Information
Appendix G	HIPAA Waiver Toolkit
Appendix H	Facility Shelter in Place Checklists and Recovery Items
Appendix I	Evacuation Checklists
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Appendix K	MOU Templates
Appendix L	Recovery Checklists
Appendix M.1	Exercise, Evaluation, and Improvement Planning Checklist and AAR/IP
Appendix M.2	AAR-IP Short Template
Appendix M.3	AAR-IP Medium Template
Appendix M.4	CMS AAR Template
Appendix N	Regional Contacts and Important Resources
Annex A	Emergency Notification of Administrator
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Appendix/Annex	Description
Annex E	Electrical Power Outage
Annex F	Apartment Evacuation
Annex G	Fire Guidance
Annex H	Severe Weather
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Annex K	Missing Resident
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Annex N	Active Shooter
Annex O	Radiological

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

Acronyms

Acronym	Description
AAR	After Action Report
AL	Assisted Living
ALF	Assisted Living Facility
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CFLOP	Command, Finance Logistic, Operations, Planning
CMS	Centers for Medicare & Medicaid Services
COOP	Continuity of Operations Plan
CSC	Crisis Standards for Care
DOC	Department Operations Center
DON	Director of Nursing
EM	Emergency Management
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment and Labor Act
EOC	Emergency Operations Center
EOP	Emergency Operations Plan

Acronym	Description
FEMA	Federal Emergency Management Agency
HAI	Healthcare Associated Infections
HHS	Health and Human Services
HICS	Hospital Incident Command System
HPP	Hospital Preparedness Program or Health Care Preparedness Program
HIPAA	Health Insurance Portability and Accountability Act
HHS	Health and Human Services
HSEEP	Homeland Security Exercise & Evaluation Program
HSEM	Homeland Security & Emergency Management
HVA	Hazard Vulnerability Analysis
HVAC	Heating, Ventilation & Air Conditioning
IAP	Incident Action Plan
IC	Incident Command or Infection Control
ICAR	Infection Control Assessment and Response Program
ICF/IID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
ICS	Incident Command System
IMS	Incident Management System
IP	Improvement Plan
IT	Information Technology
JAS	Job Action Sheets
LTC	Long-term Care
MDH	Minnesota Department of Health
MHA	Minnesota Hospital Association
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
NFPA	National Fire Protection Association
NICS	Nursing Home Incident Command System
OSHA	Occupational Safety and Health Administration
PFA	Psychological First Aid
PHPC	Public Health Preparedness Consultant
PIO	Public Information Officer
POC	Point of Contact

Acronym	Description
PPE	Personal Protective Equipment
RHPC	Regional Healthcare Preparedness Coordinator
SNF	Skilled Nursing Facility