GERIATRIC EMERGENCY PREPAREDNESS AND RESPONSE (GEPR) WEBINAR SERIES SESSION THREE
THE CONTINUUM OF CARE, OPERATIONAL PREPAREDNESS AND EMERGENCY RESPONSE (COPER) PROGRAM: A STATE MODEL

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Northeastern Maine Regional Resource Center

Kathy Knight, RN, BSN, CHEC

Kathy is the director of the Northeastern Maine Regional Resource Center (NE-MARC) at Eastern Maine Medical Center (EMMC). She is the Director of Education and Training for the EMMC Regional Resource Center. She has worked in partnership with Maine Health Council, Maine Emergency Management Association, and the Maine Office of Emergency Management and Security to develop local, regional, and state-wide Medical, Behavioral, and Public Health Emergency Preparedness and Response Plans for the state of Maine. She facilitates annual emergency preparedness and response training sessions for all Maine healthcare organizations and facilities. She is actively engaged in a statewide volunteer network of community health care professionals who respond to incidents in their community. She works to build collaborative relationships with the state, county, and local emergency management and health agencies. Kathy has been awarded numerous leadership and achievement awards by local, regional, and state-wide health and emergency management agencies.

Kathy worked 21 years as EMMC’s Emergency Department Executive Director, where she was a key leader in developing plans and procedures to respond to a variety of crises. She was instrumental in the development of the Hospital’s Emergency Operations Plan, the first formalized written plan of its kind developed for a Maine hospital.

Kathy obtained her Bachelor of Science in Nursing from the University of Maine at Orono, her Master of Science in Nursing from the University of Southern Maine, and has completed post-graduate training in Emergency Management and Community Health in Emergencies through the Harvard School of Public Health.

Judith A. Metcalf, APRN, BC, MS

Judith A. Metcalf is Principle Investigator and Director of the University of New England Maine Geriatric Education Center. Ms. Metcalf has her Bachelors in Nursing from Salem State College, Salem, Massachusetts, her Masters from Boston University and her Post-Masters Adult Nurse Practitioner Certification in Primary Health Care Nursing from Simmons College Boston.

Ms. Metcalf has directed the programs of the UNE-MGEC since 2003. Focus areas include evidence based practice and quality of care in team training for emergency department health professionals, geriatric health literacy collaborative team training, Living Well – Living Well model for home-based care, and Advanced Care Planning workshops and long term care and assisted living communities. UNE-MGEC is also one of the 14 HHS-funded GECs that are members of the Geriatric Emergency Preparedness Region (GEP). Her position as Director of the UNE-Maine GEC is complemented by her involvement in the UNE MHCAP as a nurse practitioner providing primary care to older adults in residential, assisted living, rehabilitation and long term care settings.

She serves on several national and statewide committees and boards and is a current Board Member of the National Association of Geriatric Education Centers (NAGEC) and the National Association of Geriatric Education (NAGE).
“Continuum of Care, Operational Preparedness and Emergency Response (CCOPER) Program: A State Model”

Kathy Knight, RN, BSN, CHERC
Director, Northeastern Maine Regional Resource Center; EMHS Center for Emergency Preparedness, and Northeastern Maine Medical Reserve Corps; Eastern Maine Healthcare Systems (EMHS), Brewer, Maine

Funding and Support Provided by MeCDC

Judith A. Metcalf, APRN, BC, MS
Director, UNE Maine Geriatric Education Center Center for Community and Public Health, University of New England, Portland Maine

Background

UNE Maine Geriatric Education Center & Continuum of Care Operational Preparedness and Emergency Response (CCOPER) collaboration

Overview

- Background
- Purpose
- Scope
- Partnerships
- Structure
- Deliverables
- Challenges and Barriers
- Strategies for Success
- Purchases
- Evaluation
- Lessons Learned
Background: 2009 Survey of EMHS LTC and Home Health Care Organizations

- Surveyed EMHS organizations in 3 counties:
  - Aroostook
  - Hancock
  - Penobscot
- 8 LTC facilities
- Eastern Maine Home Care

Service Area Statistics

- **Northeastern Maine Region (8 Counties):**
  - Total population of 438,000
  - Nearly 67,000 (15.2%) are older than 65 years of age.
  - 54 LTC facilities
  - 15 Home Health Care Agencies
  - 19 hospital service areas

Survey Results

- Very few organizations had engaged in “All Hazards” emergency response preparedness (ERP) planning
- Only 50% had developed a response plan for specific emergencies
- Majority of Emergency Response Plans (ERPs) were untested
- 75% did not have staff training programs for emergency preparedness
- Majority of ERPs were incomplete
LTC Planning Gaps

- **Five Major Planning Gaps Identified:**
  - Coordination between local, regional and state emergency management partners, long term care services and home health.
  - Establishment of decision-making criteria and guidelines for resident evacuation.
  - Development of effective communications systems.
  - Established resident tracking and case management systems.
  - Development and refinement of an all-hazards disaster preparedness plan.

Continuum of Care Operational Preparedness and Emergency Response (CCOPER) Grant

**APPLICANT**

Eastern Maine Healthcare Systems (EMHS)

**EXECUTIVE CHAMPION**

Senator Susan Collins
Lisa Harvey-McPherson, RN, MBA, MPPM; EMHS VP Continuum of Care

Introduction to CCOPER Grant

- **Continuum of Care Operational Preparedness and Emergency Response (CCOPER) Grant**
  - 12 month program
    - Originally intended as a 3 year project
    - Funded for year of October 1, 2010 to September 30, 2011
  - **Focus Areas:**
    - Long Term Care Facilities
    - Home Health Care Agencies
    - Hospice Agencies
Purpose

- Detailed regional assessment of continuum of care readiness
- Development of tools (plans, exercises, training, etc.) for long term care, residential care, assisted living and home health care organizations to ensure the provision of comprehensive and coordinated all-hazards emergency response.
- Incorporate home care, hospice and long term care facilities into the Regional Resource Center Region III healthcare coalition.
- Development of a planning model capable of readily being duplicated in other rural areas in Maine and nationally.

Scope

GEOGRAPHIC
- Aroostook County
- Penobscot County
- Piscataquis County
- Washington County
- Hancock County
- Knox County
- Waldo County
- Somerset County
- Kennebec County

TARGET ORGANIZATIONS
- Long Term Care Facilities
- Home Health Care Agencies
- Hospice
- Residential Care

Other Partners

- Maine Centers for Disease Control and Prevention (MeCDC)
- Maine Emergency Management Agency (MEMA)
- Maine Health Care Association (MHCA)
- Maine Primary Care Association (MPCA)
- Office Senator Olympia Snow
- Office Senator Susan Collins
- Regional Resource Centers (RRC’s)
- Agencies on Aging
- American Red Cross
- Maine EMS
- Fire
- Law Enforcement
- University of New England, Maine Geriatric Education Center (UNE MGEC)
- Home Care Alliance of Maine
- EMHS
CCOPER Structure

- CDC Grant Oversight
- EMHS Executive Leadership
- Steering Committee
- CCOPER Collaborative Regional Healthcare Coalitions

Test Organizations

- Purpose of "Test Organizations"
  - Organizations that work closely with the CCOPER Team to trial and troubleshoot end products prior to release
- LTCF
  - (1) Large Organization
  - (1) Small Organization
- Home Health Care/Hospice
  - (1) Large Organization
  - (1) Small Organization
CCOPER Program Deliverables

1. Mitigation
   - Regional Assessment
   - All-Hazards HVA
   - 96 Hour Analysis
   - MOU's
   - Equipment Purchases
   - HSEEP Compliant Exercise Program

2. Preparedness
   - All-Hazards Emergency Management Plan Template
   - Training Program
   - Demobilization Plan
   - Recovery Plan
   - Program Evaluation

3. Response

4. Recovery

Committing to the Process

- Each participating organization was asked to sign a charter to signify their “intent to participate”
- “Stars” assigned to completed tasks to instigate competition.
All Hazards Approach

- Hazards Planning focuses on developing capacities and capabilities that are critical to preparedness for a wide variety of emergencies or disasters.
- Emergency Plans to address adequate response systems to a variety of hazards
  - Natural Hazards
  - Technological Hazards (fire, hazardous materials event, etc.)
  - Human Hazards (terrorism, hostage taking, bombings, etc.)
  - Hazardous Materials (chemical, radiological, etc.)

Emergency Management Cycle

- Phase of the Emergency Management Cycle
  - Mitigation/Prevention
  - Preparedness
  - Response
  - Recovery

Incident Command Structure

- Standardized method of organizing response
- Defines responsibilities and reporting channels
- Uses common terminology
- Flexible and scalable
Preparedness, A Moving Target

Regional Needs Assessment

- **Purpose:**
  - Assess current levels of preparedness
  - Identify gaps in planning

- **Response Rate:**
  - LTCF: 75% (107 questions)
  - HHC: 100% (70 questions)
Facility Size and Proximity To Acute Care Facility

Long Term Care Facility Size

- 40% of participants < 40 beds
- 34% of participants 40-80 beds
- 15% of participants 80-120 beds
- 7% of participants 120-160 beds
- 3% of participants 160-180 beds

Summary of Findings-Regional Assessment

- Geographically Diverse (Rural and Urban)
- Variations in Financial Structure (Private, Non-Profit, For-Profit)
- Variations in Organizational Size (Small, Large)
- Dissimilar levels of preparedness

Summary of Findings-Regional Assessment

- < 65% budget for emergency management planning and response.
- 52% have EMP reviewed by local, regional or state officials
- 58% of organizational plans included coordination or response with local, regional and state officials.
Summary of Findings- Regional Assessment

Most organization’s Emergency Management Plan:
- Includes a basic evacuation plan as required by CMS, but focus on shelter-in-place.
- Does not address triage of casualties or quarantine.
- Does not have established Memorandum of Understandings (MOU) with vendors/organizations to provide services, equipment, space, supplies.
- Do not include collaboration and planning with other responding agencies (ARC, NE-MRRC, hospitals, etc.)

Evacuation plans for long term care facilities (LTCF) are, in general:
- Poorly constructed
- Limited in scope
- Do not encompass realistic instructions or plans for complete evacuation of the facility

Most healthcare organizations are encouraged to “shelter in place” resulting in unrealistic evacuation plans

Many LTCF emergency management plans do not address:
- “Surge Capacity”: ability to care for large numbers of casualties above and beyond normal census
- “Surge Capability”: caring for victims with unusual or highly specialized medical needs in adverse situations.

Potential influx:
- Palliative care
- Temporary care of rehab/nursing home patient
- Early discharges and placement of LTC patients
Prioritization of Needs

#1: Staff training in emergency response procedures
#2: Evacuation and ACS Planning
#3: Exercise Planning and Conduct
#4: Development of MOU's
#5: Communication Redundancy (Technology)

Challenges and Barriers

- Shortened Planning Time Period
- Organizational Financial Restrictions
- Organizational Staffing Shortages
- Incentivizing Targeted Partners
- Large, Geographically Diverse Territory
- Regulatory Limitations on Needed Surge Response
- Meeting Needs of Home Health Agencies

Challenges and Barriers (Cont.)

- Limited Public Safety Participation
- Limited EMA Participation
- Lack of Leadership Commitment and "Buy In"
- Lack of Understanding Regarding "Value Added" By Program Participation
Strategies for Success: Incentivizing Participants

- Positive Incentives (The Carrot):
  - Identify "value added" as a result of program participation.
  - Limit time commitment for unproductive activities (travel)
  - Providing a completed product at the "finish line"
  - Diminish/limit staff obligations

- Potential Negative Ramifications of Non-Participation (The Stick):
  - Identify legal and regulatory consequence of "Failure to Prepare"

Positive Incentives (The Carrot)

- Financial “Value Added”
  - FREE... EMP plan template
  - FREE... Consultation
  - FREE... Training
  - FREE... HVA Template and Assistance

Positive Incentives (The Carrot)

- Conservation of Staffing “Value Added”:
  - Networking
  - Collaboration with Response Partners
  - Limitation of Travel
  - High intensity, monthly meeting
Preparedness and Networking

“The middle of a disaster is **NOT** the time to exchange business cards”

Senator Susan Collins
R-Maine

Limitation of Travel

- Maximum 1 hour driving time (50 miles) between organization and meeting location.
- Grouping response partners
- Allow partner to attend session in another region if unable to attend scheduled offering in their region.

Meeting Locations

- Participating Organization

Regional Trainings

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<th>Sub-region</th>
<th>March</th>
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High Intensity, Monthly Planning Meetings

- 5 hour monthly meetings
- Work within response group
- Provided template and associated training
- Personalize template between meetings

Potential Negative Ramifications (The Stick)

- Lack of compliance with legal and regulatory requirements.
- “Failure to Prepare” civil litigation and associated fines.
- Increased mortality/morbidity of patient population in response where organization is unprepared.

Legal and Regulatory Compliance (The Stick)

<table>
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<th>Regulation/Act</th>
<th>Date Enacted</th>
<th>Description</th>
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<tr>
<td>Medicare &amp; Medicaid</td>
<td>Federal law requires Medicare and Medicaid-certified facilities have written plans and procedures to meet all potential emergencies and provide training to employees in emergency procedures.</td>
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<td>Stafford Act (1988)</td>
<td>Establishes broad mandate to protect the general public and vulnerable populations, enables the President to declare an emergency or major disaster, empowers the President to issue regulations to govern the provision of federal assistance for a major disaster.</td>
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<tr>
<td>Pandemic All-Hazards Preparedness Act</td>
<td>Added a provision entitled “at-risk individuals” to the Public Health Service Act. Provision defines senior citizens as having special needs in the event of a public health emergency.</td>
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<tr>
<td>Older Americans Act (1992)</td>
<td>1982 created a new chapter on abuse, neglect and exploitation prevention. 2002 new language addressing elder mistreatment and “self-neglect” and “elder justice.” Elders are increasingly susceptible to abuse during a disaster where resources in a nursing home and community may be stretched thin.</td>
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Legal and Regulatory Compliance (The Stick)

<table>
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<th>Regulation/Law</th>
<th>Description</th>
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<tr>
<td>Social Security Act</td>
<td>• Establishes requirements for nursing homes which participate in the Medicare and Medicaid programs</td>
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<td>• Protects health, safety, welfare, and rights of residents</td>
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<td>• Certified nursing homes are required to have:</td>
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<tr>
<td></td>
<td>1. Detailed written plans and procedures to meet all potential emergencies and disasters and</td>
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<td></td>
<td>2. Must have adequate training for employees in emergency procedures</td>
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<tr>
<td>Tort Claims</td>
<td>• Filing negligence claims is a logical cause for action especially in nursing home cases where there is a violation of duty of care and damages</td>
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<td>• “Negligence” is defined as “conduct that falls below the standard of care established by law for the protection of others against unreasonable risk of harm”</td>
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<td>• EXAMPLE: a nursing home may be found liable when the long-term care facility fails to protect the residents or fails to give them proper medication</td>
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Negative Outcomes In A Real-World Response

- Recent large scale disasters demonstrated LTCF’s either deviated from or worked beyond their emergency plans during the event.
- Problems included:
  - Transportation contracts not honored
  - Complicated medication needs
  - Host facilities unavailable or inadequately prepared
  - Inadequate staffing
  - Insufficient food and water
  - Difficult re-entry to facilities
  - Increased mortality and morbidity among residents of nursing homes and assisted living facilities is associated with evacuation during a disaster.

Failure to Prepare!

- Multiple acute care and long term care organization criminal and civil charges.
- Future legislation anticipated to address “failure to prepare”
- Organizations that have not properly prepared and experience negative outcome will be held liable.
Leadership Support

- Leadership must be made aware of the legal and moral consequences of inadequate emergency response planning.
- Organizational leadership must make a commitment to support emergency response planning and training efforts.

Purchases: EOC Kits

- Each regularly participating agency that signed the Charter/Intent to Participate received an EOC Kit.
- EOC Kit Contents:
  - ICS Quick Guides (ICS Structure, Workplace Violence, Public Health Emergencies)
  - Midland Weather Alert Radio
  - Midland Emergency Crank Radio
  - HAMM Radio
  - HAM Radio License Manual
  - Yellow Medical Bracelets
  - ICS Vests (5 per organization)
  - Scanner
  - Flashlights
  - Tote

CCOPER Program Evaluation Process

- Focus:
  - Organizational Mitigation and Preparedness including status of written plans
  - Status of MOUs
  - Degree of integration with traditional emergency response organizations
  - Satisfaction with program and products
CCOPER Program Evaluation

CCOPER Project Final Evaluation

Will you use the tools from the CCOPER Project to develop an EOP?

Yes
No

Will the templates and other resources be worth your development costs?

Yes
No

Does the HVA (Hazard Vulnerability Analysis) scenario fit your organization?

Yes
No

Will the communications management principles be effective?

Yes
No

Are you more confident in your preparedness after completing the CCOPER training?

Yes
No

Relevancy and Value of Subject Matter

Overall Approval Rating: 4.1

How would you rate the overall quality of the CCOPER Project?

Excellent
Very Good
Good
Fair
Poor

How would you rate the quality of the templates and other resources?

Excellent
Very Good
Good
Fair
Poor

CCOPER Program Overall Satisfaction Scores

How would you rate the overall value of the CCOPER Program?

Excellent
Very Good
Good
Fair
Poor
Lessons Learned

- Participants require ongoing assistance with implementation of tools acquired through the CCOPER Grant.
- Justification is required to attain LTCF/AL integration with the broader regional healthcare coalition.
- Organizations whose executive leadership viewed EP as a priority accomplished more and engaged more fully in preparedness process.

Questions

- We now have some time to answer your questions. If you have any questions, please use the “Chat” feature located on the right side of your screen. Please send your chat to everyone if possible.
- After the Q and A, we would like to ask each of the participants to answer the short evaluation questionnaire.

Q & A
Final Question
Thank You for Participating!

Reminder: Please complete our short survey.
We appreciate your feedback.

NOTE: Continuing Education Participants must complete a final survey in order to receive CE/CME credit.