
PROMISING PRACTICES IN STATE SURVEY AGENCIES

Issue Brief: Emergency Preparedness Practices in State Survey Agencies and Provider Associations

Introduction

The critical need for effective emergency preparedness planning across public and private entities has received greater recognition in the aftermath of the September 11 attacks in 2001, Hurricane Katrina in 2005, and numerous other recent disasters across the nation. Considerable resources continue to be invested to identify successes and failures from recent experience and to improve the nation's ability to prepare for, respond, and recover from catastrophic events (1 – 5). Despite the vulnerability of frail elderly and disabled individuals in emergency situations, nursing homes and other long-term care (LTC) facilities often have been overlooked in emergency preparedness planning and programmatic efforts at all levels (2,4,5). Emergency management entities now are being called upon to improve communication and collaboration with nursing homes and to incorporate nursing homes into disaster response systems at all levels (4,5). As illustrated in this report, State Survey Agencies (SAs) and LTC provider associations can play active roles in promoting collaboration, communication, and coordination between emergency management entities and the LTC community to help meet the common goal of protecting the health and safety of LTC facility residents.

Summary of Examples

This report describes emergency preparedness efforts implemented by the SAs in Florida, Massachusetts, and New Jersey, and by provider association affiliates in Florida and New Jersey. The information presented is based on interviews with SA management staff and emergency preparedness coordinators and association directors or managers at the provider associations, and review of documentation supporting the various programs and efforts.

Although the five examples featured in the report address varying aspects of emergency preparedness, communication, collaboration, and coordination among multiple assisting parties are integral to each effort. The key features of the emergency preparedness practices employed by the SAs and provider associations, the impact of the practices, and lessons learned are briefly summarized below. Detailed information on each practice is presented in individual descriptions that follow this summary.

Key Features

The three SA and two provider association practices bolster emergency preparedness and response in a variety of ways. Key elements of many of the practices are communication, collaboration, and coordination among multiple entities dedicated to ensuring the safety of LTC residents or other individuals who may receive care from some segment of the health care system during an emergency.

The Florida SA facilitates communication and collaboration through the Emergency Status System (ESS), a centralized database accessible via the Internet to individual health care providers, provider associations, and multiple state government entities. The ESS is designed to gather and disseminate information on facility evacuation status, bed availability, event impact, resource needs, and other data to facilitate a coordinated response to health care provider needs.

The Massachusetts SA collaborates with multiple state and local government agencies and acute care hospitals statewide to establish influenza specialty care units (ISCUs) that would help manage hospital overflow if a flu pandemic were to occur. The SA also supports individual LTC provider efforts to develop effective continuity of

operations plans that include plans for a flu pandemic among other potential hazards.

The New Jersey SA promotes local communication and collaboration by enforcing a state regulation that requires individual LTC providers to submit their emergency preparedness plans to local emergency management officials for annual review and to coordinate an annual meeting between the provider's disaster planner and the local emergency management officials.

The Florida Health Care Association (FHCA) and the Florida Association of Homes and Services for the Aging (FAHSA) promote collaboration, communication, and coordinative efforts by participating at the state Emergency Operations Center (EOC) and local EOCs in affected areas during hurricanes and other emergency situations. FHCA also leads a daily conference call throughout emergencies to facilitate communication and coordination among LTC providers, the provider associations, the Florida SA, emergency management entities, local utility companies, and others to identify and meet LTC provider needs. FHCA also spearheaded two Nursing Home Hurricane Summits involving LTC representatives from southeastern coastal states, and national and state leaders in LTC, emergency management, power and transportation companies, state and federal regulatory entities, and other stakeholders to share lessons learned and promising practices and develop key recommendations for strengthening emergency preparedness and response for LTC facilities.

Finally, the Health Care Association of New Jersey (HCANJ) and the New Jersey Association of Homes and Services for the Aging (NJAHSA) actively participate in collaborative efforts as part of the New Jersey Healthcare Associations' Emergency Preparedness Alliance (NJHAEPA), which facilitates ongoing communication and information exchange on emergency preparedness among five provider associations representing the health care continuum. HCANJ and NJAHSA also engage in collaborative meetings and training exercises sponsored by regional Medical Coordination Centers and the Healthcare Associations Coordination Center (both established by the New Jersey Department

of Health and Senior Services). These partnerships, meetings, and trainings promote greater preparedness, enhanced communication, and collaborative relationships among individuals representing emergency management, public health, and health care provider entities throughout the state. HCANJ and NJAHSA also work with state and local Offices of Emergency Management to heighten awareness and a greater sense of responsibility for the LTC community, and designed templates to assist individual LTC providers in developing effective emergency preparedness plans.

Impact

Although the emergency preparedness efforts described in this report vary in their specific intent, design, and scope, the diverse practices are reported to contribute to greater preparedness among LTC and other health care providers. Among other positive practice-specific results, many of the practices are believed to facilitate efficient and effective communication and information dissemination, promote increased collaboration among individual providers and between providers and emergency management entities, and improve coordination of service provision and emergency response.

Lessons Learned

In addition to sharing valuable lessons learned and useful tips regarding specific practices, SA management staff and provider association staff commonly highlighted the importance of establishing relationships, forging partnerships, and increasing communication and collaboration among providers, provider organizations, and emergency management services before disaster occurs. Opportunities that promote communication and collaboration, regardless of the type of activity or even its ultimate goal, contribute to a greater sense of community responsibility for LTC residents, improved preparedness, and more effective response to emergency needs.

Conclusion

The practices featured in this report demonstrate a variety of approaches to advancing emergency preparedness and promoting an integrated response for LTC and other health care providers. The large-scale impact of numerous disaster situations in the recent past underscores the critical need for such efforts. Communication,

collaboration, and coordination among state and local emergency management, public health, and

health care entities are essential to promoting effective emergency preparedness and response.

References

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PROMISING PRACTICES IN STATE SURVEY AGENCIES

Emergency Preparedness Practices

Florida

Summary

The Office of Health Quality Assurance at Florida's Agency for Health Care Administration (AHCA) created the Emergency Status System (ESS) to track the status and needs of health care providers regulated by AHCA, throughout storms and other emergency situations. The ESS, an internally developed software application, promotes communication and collaboration among AHCA staff, multiple partner agencies and organizations, and providers by serving as a central database of information regarding the impact of an emergency event on affected providers, including evacuation efforts and resource needs.

Introduction

This report describes the Emergency Status System created and maintained by the Florida State Survey Agency. The system's design, use, and impact, and lessons learned that might benefit other state survey agencies are discussed. The information presented is based on interviews with AHCA management staff and review of selected materials describing the system.

Background

The ESS was first established in 2004, for internal use by AHCA staff members, in response to the multiple storms that hit Florida that year. AHCA management and IT staff collaborated to develop the ESS to streamline the previously more fragmented approach to recording emergency event information, which relied on reference to staff members' notes, Excel spreadsheets, and e-mail correspondence.

AHCA staff collaborate with the Florida Department of Health, the approximately 20 local Emergency Operations Centers (EOCs) located across the state, other state agencies, provider association affiliates, and providers to assist providers when needed during hurricanes and other emergency situations. To facilitate coordination with these partnering entities, AHCA expanded the ESS to a Web application in 2005, which allows multiple users to enter and

access comprehensive and up-to-date emergency information.

Intervention

The ESS includes data on hospitals, nursing homes, assisted living facilities, in-patient hospice, end stage renal disease centers, intermediate care facilities for developmentally disabled, and other residential or 24-hour care providers regulated by AHCA. Basic information for every licensed facility in the state is contained in the ESS, including name, address, phone number, administrator name, county, number of licensed beds, and other information. To ensure consistency and reduce duplicative data entry, AHCA staff upload facility information nightly from an AHCA licensure database.

Additional information recorded in the ESS is organized around events, most frequently hurricanes or other storms. When an event is open, users can enter information on facility evacuation status and destination; special resident characteristics; facility census; available beds; impact type and severity (e.g., leaks or other structural damage, impassable roads, generator or utilities problems); need for equipment, staff, or supplies; and status of needs requests. Requests for assistance also must be communicated directly to the local EOC. All ESS entries are based on contacts with specific provider facility

staff members, and contact history is recorded in the database. After an event is closed, only selected data are carried forward, with remaining information archived.

The inclusion of special needs information in the ESS facilitates collaboration between AHCA and the Department of Health, the entity responsible for overseeing the special needs shelters located across the state. The ESS indicates the number of residents with each need (e.g., requiring a ventilator, oxygen, or dialysis) at a particular facility, providing vital information to help coordinate evacuation of special needs residents to other provider locations, as necessary. Resident names are not listed to ensure the confidentiality of health information, particularly given the multi-user access to the system.

ESS users can generate reports on facility status related to most of the information stored in the system. Reports thus can be run to provide the most relevant information to particular entities involved in mobilizing resources to address specific provider needs.

State agencies with ESS accounts include the Department of Health, the State Attorney General's Office, and the State Ombudsman, all of which send staff to visit facilities immediately after a storm has hit. State and local EOC staff also have ESS access, to facilitate resource allocation in response to provider needs. Other ESS users include provider associations, providers, and provider affiliates. Provider affiliate accounts were established in anticipation of possible power outages during an emergency. Affiliates are entities typically located in a different region or outside of the state (e.g., a corporate affiliate) that are authorized by providers to enter information about the provider. User types have varying levels of permission and access to the database, in terms of entering, viewing or generating reports on particular information.

Enrollment in the ESS is voluntary, although recent state legislation requires licensed long-term care facilities to report assistance requests to AHCA. Providers are invited to enroll in the ESS at no cost, to facilitate communication

updates, reduce the volume of redundant phone calls, and help coordinate identification of needs and delivery of assistance. Voluntary participation in the ESS has been strong and it is anticipated that ESS enrollment will further increase when storms occur. As of September 2007, approximately 93 percent of the 673 skilled nursing facilities in the state had enrolled in the ESS, 98 percent of hospitals, and about 42 percent of assisted living facilities.

Implementation

AHCA staff developed the original ESS as an Access database in 2004 and soon replaced it with an Oracle database (.NET application) that allowed multiple AHCA field office as well as EOC staff to access information. The ESS was expanded in 2005 to a Web application that allows individuals outside of AHCA's network to enter and retrieve information.

The ESS was developed and modified in six-to-eight month increments, as time permitted between hurricane seasons. The IT team dedicated to ESS development consisted of a developer, a project manager, and four other IT staff. In addition to the IT team, end users such as management staff played a critical role in testing and enhancing the feasibility, ease of access and use, and speed of the system. AHCA regulatory and IT staff are available beyond standard business hours when in the highest level of activation for a storm or other emergency to ensure continued ESS operability.

Impact

AHCA management staff indicate that access to ESS reports has been essential in helping disseminate information to entities that work to meet provider needs. During the severe 2004 hurricane season, for example, data from ESS reports were communicated to the state National Guard and federal Homeland Security offices to help mobilize resources to the areas most in need. The report function also is critical in allowing expeditious and accurate reporting by AHCA to the multiple parties requesting updates during a storm, including Florida's Governor, CMS, and the press.

Although the Web-based, multi-user version of the ESS has yet to be used during a major storm, AHCA management staff report that the system has been extremely useful during the minor storms experienced since its implementation. Many providers used the ESS to report information, which significantly reduced the number of telephone calls for AHCA staff and promoted expeditious information dissemination and coordination among entities. The high level of enrollment in the ESS is expected to substantially reduce the need for AHCA staff to contact providers by phone and should reduce duplicative phone calls to providers from the various state agencies and other entities that are able to access provider status information via the ESS.

Lessons Learned

AHCA management staff emphasize the value of establishing a stable information system that is designed for concurrent use by multiple users. Management staff have found that uploading provider data from their licensure database ensures that information is up-to-date, reduces duplicative effort, and minimizes the opportunity for inconsistencies and errors. Using automated fields with dropdown boxes presenting standard options, rather than blank entry fields, is recommended to promote the use of consistent terminology, streamline data management, and enhance efficient report generation. It is important to consider confidentiality issues, particularly in a database with multiple end users, although it can be tempting to track individual residents by name.

Using internal IT staff to develop and maintain the system allows expeditious implementation of system refinements on an ongoing basis. To save time and resources, it also is useful to allow authorized managers to implement straight-forward modifications to the database structure (e.g., adding a new response option for storm impact), rather than relying on IT staff for all changes. It is critical to have IT support staff available to troubleshoot with the database at all times throughout a crisis.

Each state must consider the type of system and supporting processes and procedures that will fit with their operations and approach. When designing such a system, it is helpful to first identify the type of information to track during emergency situations, both in general and for situations typical to a particular state, and to determine the specific types of reports that will be useful. Management staff attribute much of the system's success to strong partnerships with providers and other agencies in collecting information.

Contact Information and Resources

For more information, please contact Molly McKinstry, Bureau Chief of Long Term Care Services, at mckinstm@ahca.myflorida.com or 850/414-9707. Additional information on the ESS also can be found at http://ahca.myflorida.com/MCHQ/Emergency_Activities/index.shtml.

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Emergency Preparedness Practices

Massachusetts

Summary

The Division of Health Care Quality (DHCQ) of the Massachusetts Department of Public Health is collaborating with multiple agencies and organizations throughout Massachusetts to develop and implement a flu pandemic preparedness plan for health care providers. DHCQ is assisting with the identification and licensing of influenza specialty care units, or ISCUs, which are designed to help acute care hospitals handle overflow patients if a flu pandemic were to strike. DHCQ also is working to ensure that hospitals, LTC providers, and other health care providers have operable Continuity of Operations Plans (COOPs) that include plans on managing a flu pandemic.

Introduction

This report describes the Massachusetts State Survey Agency's role in statewide collaborative efforts to establish ISCUs and otherwise prepare for the possibility of a flu pandemic. DHCQ's efforts, the impact of these efforts, and lessons learned that might benefit others are discussed. The information presented is based on interviews with DHCQ management staff and review of selected materials.

Background

A series of conferences on flu pandemic preparedness held in 2006 by the Massachusetts Governor's Office in conjunction with leadership from Health and Human Services and Public Safety helped launch a statewide effort to establish ISCUs and implement other plans to handle a potential pandemic.

Using software from the Centers for Disease Control (CDC), staff from the Emergency Preparedness Bureau (EPB) at the Massachusetts Department of Public Health projected incident rates, fatality rates, and hospital utilization rates under various flu pandemic scenarios. These data demonstrated the need for additional hospital capacity to help manage pandemic overflow patients, and led to the planned implementation of a regulation to establish alternate care sites, referred to as ISCUs, for all acute care hospitals in the state. Every

community in the state was assigned to a hospital for purposes of ISCU planning and response. A single hospital and its assigned communities form a hospital-based cluster, with each cluster responsible for a single ISCU.

Intervention

DHCQ is collaborating with hospitals and multiple state and local entities, led by the EPB's Hospital Preparedness Coordinator and six regional coordinators, to license an ISCU location for each of the 73 acute care hospitals in the state. The majority of ISCU locations are schools, often based out of the gymnasium, as schools typically meet the necessary criteria (e.g., access to food preparation and dining facilities, availability of rooms with the capacity to hold large numbers of people). It is estimated that ISCUs would be in use for approximately two to four weeks under a flu pandemic situation. The ISCU locations continue their typical operations until they are needed for ISCU purposes. Schools designated as ISCUs are encouraged to collaborate with local schools not serving as ISCUs to plan in advance where students would attend school if the ISCU were activated and the school system was still in operation.

An ISCU is licensed as a satellite facility of the partnering hospital and is intended to supply additional space for outpatient screening and inpatient care to flu patients too sick to be cared

for at home but who do not meet criteria for hospital admission. By establishing the ISCU as a satellite unit of the state licensed and Medicare-certified hospital, hospital reimbursement will not be disrupted. Hospitals assume management responsibility for the ISCU. Flu pandemic preparedness committees are pursuing special legislative appropriation to provide funds for beds and other equipment for the ISCU.

Staffing the ISCU is recognized to be a significant challenge. If a flu pandemic occurs, the health care workforce will be in high demand and at the same time likely will be reduced as workers or their family members may be affected by the flu. Difficulties therefore are anticipated with regard to reaching the ideal number of staff for each ISCU as well securing staff with the preferred level of health care expertise and experience. ISCU likely will require volunteer staffing, including Medical Reserve Corps units, former health care providers, and individuals who do not have health care experience. Local boards of health in each hospital's cluster are anticipated to play a major role in recruiting volunteers to serve as ISCU staff. A statewide health care volunteer registry (Massachusetts System for Advance Registration, or MSAR) being developed by the EPB with funding from the federal Emergency System for Advance Registration of Health Professions Volunteers (ESAR-VHP) program also should serve as a useful resource. DHCQ's own continuity of operations plan states that, in the case of a flu pandemic, surveyors would be transitioned into direct care roles (e.g., at ISCU). The survey agency would substantially curtail team survey activities, although retaining the capacity to investigate complaints, so that clinical staff could be redeployed to assist with such clinical work.

DHCQ is responsible for licensing each hospital's ISCU. DHCQ staff also participate on several subcommittees working to address issues associated with the ISCU. For example, DHCQ is collaborating with the Department of Public Safety to determine whether regulatory changes will be required to allow buildings not certified for health care occupancy (e.g., the majority of schools) to serve as ISCU.

DHCQ also is leading an effort to ensure that long-term care (LTC) facilities have updated and operational COOPs that meet state requirements, including plans for managing a flu pandemic. DHCQ sent a letter informing LTC providers of the obligation to develop a COOP and is supporting providers' efforts to meet this requirement by collaborating with the local nursing home provider associations and participating in a joint public-private committee of stakeholders organized by the provider associations to identify provider needs, communicate regarding emergency preparedness and COOP issues, and supply training to providers.

In 2006, DHCQ designed and implemented a provider review tool to be completed by each LTC provider every two years. The document delineates the elements that must be addressed in each provider's COOP (e.g., COOP activation/deactivation criteria, essential functions, order of succession, communication plans, and pandemic preparation) in accordance with state and federal emergency preparedness requirements, and includes an attestation confirming that the provider has developed a COOP that includes the listed elements. The document is designed as an all-hazard emergency preparedness educational tool and an ongoing regulatory enforcement tool. Surveyors use the provider review tool to assess COOP adequacy at each LTC facility annual recertification survey, with the initial roll-out focused on guidance and education. Ongoing use will be both educational and supportive of regulatory enforcement efforts.

DHCQ also is collaborating with the Mass Extended Care Federation, the MassAging Association, and various providers and state agencies in the process of enhancing LTCF providers' all-hazard preparedness, including development of mutual aid agreements among LTCF providers for pandemic and other hazards. A key objective of the agreements is to ensure adequate staffing during a flu pandemic or other emergency situation for all providers. Based on CDC estimates of a 40 percent reduction in staff associated with flu pandemic (due to staff illness or their need to care for ill family members),

DHCQ is encouraging providers to plan strategies to ensure that basic functions would be covered if staffing resources were limited to such a degree. Providers are encouraged to act now to coordinate arrangements with nearby facilities to share staff, thereby distributing limited staffing resources to ensure at least minimal coverage at each collaborating facility rather than leaving individual facilities to work within the staffing patterns that occur.

Implementation

Implementation of the ISCU model began in early 2006. Initial activities focused on hospitals identifying ISCU locations and establishing agreements with those locations. Hospitals were requested to submit to DHCQ an application for licensure approval of their designated ISCU and a Memorandum of Understanding between the hospital and the entity that owns or controls the space in which the ISCU is to be located (e.g., school system), by the end of 2006. DHCQ and EPB collaborated to develop an *Emergency Influenza Specialty Care Unit (ISCU) Preparation Checklist* to assist hospitals with meeting ISCU requirements.

DHCQ is one of multiple entities across the state collaborating on the effective design and implementation of ISCU. Several flu pandemic preparedness committees continue to work on various aspects of ISCU implementation, particularly the critical challenge of staffing the ISCU.

DHCQ developed the COOP provider review tool to support providers in developing their COOPs to meet state and federal emergency preparedness requirements and standards of practice. Requiring providers to complete the tool every two years will promote efforts to keep COOPs current and operational over time.

Impact

The collaborative efforts of DHCQ and multiple other entities across the state have resulted in substantial headway in preparing health care providers for the possibility of a flu pandemic. Eighty-one percent of hospitals in the state have submitted their application for licensure approval

of the ISCU site (as of September 2007). Although staffing the ISCU remains a concern, ISCU planning activities have raised awareness of this issue and efforts to address the problem continue.

Ninety-five percent of LTC providers have submitted attestations of having a COOP. The process of developing mutual aid agreements has led many LTC providers to establish partnerships and agreed upon plans prior to the occurrence of a flu pandemic or other hazards. LTC providers also continue to work to establish contingency plans within their own facilities to help cover key functions if a drastic reduction in staff were to occur. DHCQ management staff believe that the efforts invested in COOP development activities has promoted the evolution of a positive culture of all-hazard cooperation and support within the LTC industry, across healthcare provider types, among various private stakeholders and with the responsible state agencies.

Lessons Learned

It is critical to anticipate and carefully plan in advance for potential emergency situations. DHCQ management staff advocate for directly involving providers in a collaborative process toward achieving preparedness. In planning for ISCU, it is important to explicitly acknowledge hospitals' potential concerns regarding their capacity to run an effective ISCU and provide high quality of care with only limited, and likely largely volunteer, staffing as well as other constraints. It is valuable to recognize that many issues beyond the control of the hospital are likely to arise. Hospitals, however, should be prepared to open an ISCU even without ideal staffing or other care factors. It is important to work with hospitals to ensure that they understand and accept that, in light of such issues, an altered standard of care is expected, and ideal care is not anticipated.

DHCQ management staff emphasize that productivity can be considerably greater if multiple, interrelated steps are underway concurrently and tasks are completed on the assumption that other associated tasks will be accomplished. For example, hospitals should

move forward with identifying ISCU sites and forging partnerships with those sites simultaneously with the pursuit of legislation by other parties regarding liability issues for volunteer-staffed ISCU. Individuals involved in the planning and implementation process should resist getting overly focused on accomplishing tasks sequentially, and leadership must be prepared to continuously address reluctance to move ahead on interrelated tasks until others have been completed.

Contact Information and Resources

For more information, please contact Paul Dreyer, Director, Division of Health Care Quality, Massachusetts Department of Public Health at Paul.Dreyer@state.ma.us or 617/753-8100. The *Emergency Influenza Specialty Care Unit (ISCU) Preparation Checklist* developed by DHCQ and EPB can be accessed at http://www.mass.gov/Eeohhs2/docs/dph/quality/hcq_circular_letters/hospital_flu_unit_checklist.pdf

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PROMISING PRACTICES IN STATE SURVEY AGENCIES

Emergency Preparedness Practices

New Jersey

Summary

The Standards for Licensure of Long-Term Care Facilities (N.J.A.C. 8:39) enforced by the Division of Health Facilities Evaluation and Licensing (HFEL) at the New Jersey Department of Health and Senior Services require long-term care (LTC) providers to coordinate with local emergency management agencies to develop and maintain effective emergency preparedness plans. These requirements promote communication and coordination between providers and the emergency management agencies in their communities prior to the occurrence of emergency situations.

Background

The licensure standards for emergency preparedness for LTC providers were in effect well before the events of September 11, 2001. The current licensure standards were readopted with amendments in February 2007, with no significant changes to the emergency preparedness requirements. The requirement for providers to partner with local emergency management agencies was designed to ensure that LTC providers possess comprehensive and operable emergency preparedness plans and to promote the establishment of collaborative and coordinative relationships between providers and emergency management agencies before a crisis situation occurs. The requirements also are intended to promote a sense of community responsibility for facility residents.

Intervention

The licensure standards require LTC providers to submit their emergency preparedness plans to municipal or county emergency management officials for review. In addition, the provider's disaster planner must meet with the local emergency management agencies on an annual or more frequent basis to review and update the provider's written evacuation plan. If the county or municipal officials are unavailable to assist with this process, the provider must notify the State Office of Emergency Management. Emergency management coordinators are

designated at local levels across the state, and typically serve as sheriffs, police chiefs, and fire chiefs in their communities. The nature and degree of collaboration between providers and emergency management agencies tends to vary by locale. Emergency management agencies that are heavily involved with their communities may assist providers in the detailed development of plans, while others review the completed plans after the developmental process has been completed by the providers. Activities spearheaded by the recently developed Division of Health Infrastructure Preparedness and Emergency Response at the New Jersey Department of Health and Senior Services have fostered greater collaboration and coordination on several fronts among emergency management agencies and health care providers, particularly through participation in simulated disaster exercises and other training activities that promote interaction and communication. These stronger ties appear to have resulted in a greater degree of collaboration in developing and reviewing providers' emergency preparedness plans.

In New Jersey, the Division of Health Facilities Evaluation and Licensing (HFEL), which is part of the Department of Health and Senior Services, fulfills the responsibilities of the State Survey Agency. Life safety code surveyors from HFEL are responsible for confirming during the annual survey process that each LTC provider has an emergency preparedness plan and that the plan

has been reviewed by a local emergency management agency, as reported by the provider. Surveyors do not typically review the contents of the plans, and providers are not routinely required to submit plans to HFEL. However, HFEL may request the plan if a problem or potential problem is under review (e.g., possible roof collapse or other structural damage, potential labor strike, potential flooding hazards, an issue identified through complaints and surveillance), to ensure that evacuation procedures and other elements are detailed in the plan.

Impact

In December 2005, HFEL conducted an evaluation to examine the extent to which LTC providers were meeting the requirement for collaboration. HFEL selected 11 providers in four counties of particular interest with regard to emergency preparedness, due to their proximity to New York City, a major nuclear power plant, and/or having increased risk for flooding. As part of the evaluation, HFEL staff reviewed the providers' emergency preparedness plans and investigated the level of involvement of emergency management agencies in developing and reviewing the plans. HFEL staff also considered whether the collaborative efforts led to stronger relationships between the providers and emergency management agencies. Ten out of the 11 plans examined during the evaluation were found to be current and eight of those plans had been reviewed or were actively under review by local emergency management officials. Two providers later sent documentation that the plans had been reviewed. One provider received a citation because the plan had not been sent to or reviewed by the local emergency management officials. HFEL staff also concluded that the efforts contributed to stronger links between the entities, by promoting communication between key individuals at both entities.

HFEL management staff believe that several factors have led to heightened awareness and greater effort by providers and emergency management agencies to establish collaborative relationships and ensure the effectiveness of

emergency preparedness plans. These factors include the September 11 attacks, recent experiences with resident evacuation at several LTC facilities in New Jersey due to flooding and fire, and the requirement in the licensure standards. LTC providers seem to have strong interest in ensuring that they are in compliance with the requirement and that they have a connection with local emergency management agencies, as they are the first to assist when transfer of residents is necessary. HFEL management staff note that provider associations and some providers are participating more in training activities in partnership with emergency management organizations.

The requirement appears to have fostered in emergency management agencies a stronger sense of the LTC providers as part of the community and a greater sense of responsibility for the residents. HFEL management staff report that the state-level Office of Emergency Management (an organization staffed predominantly by the State Police) also appears to have greater awareness of LTC providers, as demonstrated by their request for data regarding LTC providers from HFEL. The information has been integrated into their systems, promoting communication and sharing of critical information in order to assure access to emergency management procedures and services in each community.

Lessons Learned

It is essential to monitor ongoing adherence to the regulation as LTC providers' administrators and management staff change over time. Efforts by emergency management agencies also should be monitored, to ensure that plans submitted by providers receive more than minimal and perfunctory review. In the past, it appeared that some reviewers approved plans each year based on the adequacy of the plan when initially submitted, rather than reviewing the plan in its entirety each time. It is important that the emergency management agencies carefully assess the plans each year to ensure that changes have been implemented according to hazard and risk analyses as well as the specific needs of the community.

HFEL management staff comment that emergency preparedness efforts continue to evolve. The more opportunities for communication and interaction between providers, provider organizations, and emergency management agencies, the better, whether through collaboration on providers' emergency preparedness plans, participation in simulated disaster training, or otherwise. It is valuable to forge partnerships and increase the sense of community responsibility before disaster occurs.

Contact Information

For more information, please contact Alison Gibson, Director, Office of Health Facilities Assessment and Survey Division of Health Facilities Evaluation and Licensing at the New Jersey State Department of Health and Senior Services at Alison.Gibson@doh.state.nj.us or 609/292-9900.

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Emergency Preparedness Practices

Provider Association Affiliates - Florida

Summary

Since late 2004, staff from the Florida Association of Homes and Services for the Aging (FAHSA) and the Florida Health Care Association (FHCA) have served at the State and county Emergency Operations Centers (EOCs) in Florida during hurricanes and other emergency situations to improve communication and better coordinate the provision of assistance to long-term care (LTC) facilities. To further promote collaboration and the timely exchange of information on LTC providers' needs and services during emergencies, FHCA established daily statewide conference calls involving providers and multiple assisting parties.

Introduction

This report describes key efforts of two provider association affiliates in Florida to improve communication and better coordinate the provision of assistance to LTC facilities during hurricanes and other emergency situations. The efforts of the provider associations, the impact of these efforts, and lessons learned are discussed. The information presented is based on interviews with provider association directors and management staff (referred to as association "staff" in this report).

Background

After the first two hurricanes of 2004, the two provider associations recognized the need to better coordinate information and services on major issues affecting LTC facilities, including restoration of power, fuel delivery, availability of oxygen, and access to transportation. The associations thus requested representation at the State and local EOCs, as they are at the center of decision-making on needs and distribution of goods and services during emergency situations. The provider associations pursued EOC participation with the goals of having more timely access to important information, improving collaboration with other parties working to assist LTC facilities, and providing dedicated representation of LTC residents' needs.

Major difficulties encountered with restoring power to LTC facilities during the 2004 hurricane season prompted FHCA leadership to establish daily conference calls in 2005 to help identify needs, coordinate services, and quickly disseminate information to a broad audience throughout emergency situations. The daily calls also were designed to streamline communication during emergencies by drawing together all involved parties, thereby reducing confusion and duplicative effort due to provider facilities contacting various entities (e.g., the provider associations, local EOCs, State EOC, or State Survey Agency [SA]) to request services and assistance.

The daily calls evolved from conference calls FHCA initiated on an as-needed basis during the intense 2004 hurricane season. The calls then involved only FHCA provider members and SA representatives, with provider needs later communicated to utility or other vendor companies. Based on the effectiveness of the conference calls to identify needs and coordinate services, FHCA expanded the calls during Hurricane Wilma to include FAHSA, vendor companies, EOC staff, and others, and set the calls to occur at the same time each day.

Intervention

Upon receiving notice from the EOCs of storm warnings, the provider associations send staff to

the State EOC and the county EOCs in the areas expected to be affected by the storm. FHCA also dispatches disaster response volunteers who are members of FHCA's Disaster Preparedness Committee and have received training as part of the EOC-FHCA partnership. The staff and volunteers manage telephone inquiries from LTC facilities and assist with identifying and prioritizing needs, decision-making and problem solving, and arranging for the delivery of services.

To further promote collaboration and communication, FHCA coordinates toll-free conference calls held each day at 11:00 a.m. throughout emergency situations. Based on the efficacy of the daily calls during Hurricane Wilma in 2005 (and with multiple 2004 hurricanes, when the calls were less formally established), the provider associations plan to activate the daily calls during all major events in the future. The conference calls, which originate at FHCA, focus on expediting needs requests that require immediate action and sharing up-to-date information. The calls have involved up to 250 people, and typically include representatives from provider facilities, the SA, utility companies, the state and county EOCs and other Health Department representatives, the press, and other entities. The daily call is scheduled for an hour, although at times a second and even third call are scheduled during a single day to ensure that call participants are apprised of critical updates.

The conference call provides an opportunity to disseminate information relevant to the majority of participants, such as storm status updates, instruction regarding resource availability, or clarification of direction from the SA, Health Department, or others. Conference call discussion has addressed such critical topics as instruction on accessing temporary fuel stops established during Hurricane Wilma for use by health care providers and emergency workers, special access to restricted roads, and utility restoration for facilities. The call also is used to identify provider difficulties and needs (e.g., fuel shortages, transportation needs, access to beds for evacuation) and to coordinate resources to meet

such needs. Utility companies have joined the call to identify facilities that have critical need for immediate power restoration due to high-risk residents. The participation of members of the press is perceived to encourage an open exchange of information.

The provider associations also use the daily calls to actively promote LTC facility enrollment in the Emergency Status System (ESS) coordinated by the Florida SA, as this central database is designed to help expedite and coordinate efforts to meet facility needs related to evacuation or sheltering in place during hurricanes and other emergency situations. Facilities already enrolled in the ESS are encouraged to update their information, particularly with regard to bed availability to assist with placement of evacuating residents.

Impact

Although limited resources can constrain the capacity to fully respond to all needs, provider association staff believe that participation at the EOCs has resulted in improved access to information, enhanced collaboration among helping entities, and better prioritization of needs. In addition, their involvement is believed to have helped heighten awareness of LTC facility needs, and likely influenced the move by several power companies in 2005 to dedicate staff to manage LTC facility requests.

Provider association staff report that the daily conference calls are highly productive and efficient, and provide useful and comprehensive information that helps individuals know what to expect with regard to the storm and efforts to provide services. The call also is noted to increase providers' sense of connectedness, particularly for those with power outages and limited communication capacity, as it provides an opportunity to hear from others who are enduring the same difficulties.

The calls also have promoted greater collaboration and coordination among involved parties and therefore more effective provision of services. For example, the calls have been key in helping coordinate effective restoration and maintenance of utility services, a critical priority

for LTC facilities. The call has been used to organize other services as well, such as the establishment of a shelter in Sarasota by FHCA volunteers and the Florida Department of Health within just eight hours of Hurricane Charley making landfall, using beds and staff from local LTC facilities.

In addition, the provider associations have used the conference calls to promote more expeditious and efficient dissemination of information from such entities as CMS, as relying on written communications during emergency situations can be problematic. For example, staff from the CMS Central Office joined a call during Hurricane Wilma to clarify payment issues related to evacuation, medications, payments for the receiving facility, and other critical and time-sensitive provider concerns.

Additional benefits of the daily conference calls include stronger communication among the two provider associations, the SA, and other state agencies, and the provision of a platform for encouraging providers to supply information in the ESS on bed availability and resource or service needs, reducing the volume of calls to facilities from the provider associations and SA to obtain such information. The provider associations believe that efforts to promote ESS enrollment during the calls have contributed to the high level of facility participation in the ESS, as the system's utility becomes more apparent in the midst of emergency situations.

Lessons Learned

Provider association staff have been impressed with the capacity of individuals and entities to efficiently and effectively accomplish critical tasks when given a means, such as the daily conference calls, to facilitate collaboration and coordinate efforts. They note that it is beneficial to hold the daily conference call on a consistent schedule, as this allows individuals from LTC facilities and others without easy access to

telephones or telephone lines to arrange for satellite phones or another way to join the call to receive updates and connect with others affected by the storm. Although the daily conference calls have promoted effective communication among a large number of providers and other entities, provider association staff comment that it remains a challenge to ensure that all member providers receive important information (e.g., where fuel can be accessed in an affected county) due to power outages often associated with storms and other emergency situations.

Participation at the EOCs is believed to have enhanced the visibility of the provider associations and increased EOC recognition of the associations as reliable sources of assistance and information related to LTC facilities throughout the state. The EOCs refer LTC issues and questions to the provider associations with greater frequency than in the past. Provider association staff highlight the value of developing relationships with local authorities and emergency management organizations prior to the occurrence of emergency situations.

Provider association staff note that the ESS offers great potential in helping coordinate emergency services to meet provider needs. It is important to promote providers' understanding of the value of submitting up-to-date information to the ESS (or similar central databases in other states) to expedite communication and facilitate efficient resource allocation.

Contact Information

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Addendum

The Florida emergency preparedness work with LTC facilities in 2004-05 led the John A. Hartford Foundation to fund FHCA's two Nursing Home Hurricane Summits and the development of a report entitled *Caring for Vulnerable Elders during a Disaster: National Findings of the 2007 Nursing Home Hurricane Summit*, released on August 29, 2007. The report delineates ten recommendations for improving how frail and elderly people are cared for during major disasters, such as hurricanes, to prevent needless deaths. Representatives from seven southeastern coastal states, state agencies, the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services, the Federal Emergency Management Agency (FEMA) of the U.S. Department of Homeland Security, and others attended the May 2007 summit convened by FHCA. The report can be found on the FHCA Web site at <http://www.fhca.org/news/summitfinal.pdf>. The Hartford Foundation grant to FHCA and the University of South Florida also will result in a software template (CD-ROM) for disaster preparedness plans, which will be developed in accordance with the Centers for Disease Control and Prevention all-hazards emergency response approach, in addition to a hard copy disaster management guide and a framework for evacuation decision-making.

This document is part of an issue brief on emergency preparedness practices in State Survey Agencies and long-term care provider associations. The issue brief is one of a series by the Division of Health Care Policy and Research, University of Colorado Health Sciences Center, for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in State Survey Agencies. The entire series is available online at CMS' Web site, <http://www.cms.hhs.gov/SurvCertPromPractProj/>. The issue briefs are intended to share information about practices used in State Survey Agencies and other organizations and are not an endorsement of any practice.

PROMISING PRACTICES IN STATE SURVEY AGENCIES

Emergency Preparedness Practices

Provider Association Affiliates – New Jersey

Summary

To strengthen emergency preparedness and response for the long-term care (LTC) community and across the health care continuum, the New Jersey Association of Homes and Services for the Aging (NJAHSA) and the Health Care Association of New Jersey (HCANJ) are involved in a number of efforts designed to increase collaboration and communication among public health entities, health care providers, and emergency management services throughout New Jersey. The two provider associations participate in the New Jersey Healthcare Associations Emergency Preparedness Alliance (NJHAPEA), a group viewed to be uniquely effective at facilitating discussion among multiple provider associations regarding emergency preparedness programs and methods and promoting communication with the New Jersey Department of Health and Senior Services (DHSS). NJAHSA and HCANJ, along with other health care, public health, and emergency management representatives, also participate in simulated disaster trainings and emergency planning meetings sponsored by regional Medical Coordination Centers (MCCs) and the Healthcare Associations Coordination Center (HACC) established by the DHSS. Additional NJAHSA and HCANJ efforts are aimed at heightening awareness of the LTC community among emergency management services through trainings, meetings, and participation in conferences. NJAHSA and HCANJ also have used DHSS grant funds to develop templates for provider-level emergency preparedness plans to assist providers with updating and refining their plans.

Introduction

This report describes key efforts of two provider association affiliates in New Jersey to strengthen emergency preparedness and response for the LTC community and other health care providers, largely through collaborative efforts involving emergency management services, public health, and health care providers throughout the state. The efforts of the provider associations, the impact of these efforts, and lessons learned are discussed. The information presented is based on interviews with a director and emergency preparedness coordinators from the provider association affiliates (referred to as association “staff” in this report) and review of selected supporting materials.

Background

The September 11 attacks in neighboring New York City in 2001 sparked greater awareness throughout New Jersey of the critical need for effective emergency preparedness and response systems. As part of the New Jersey DHSS’

strengthened efforts in this area, the DHSS established regional MCCs and the HACC to coordinate emergency preparedness and response among public health, health care delivery, and emergency management¹ entities. The DHSS also provided grant funds to HCANJ and NJAHSA and other health care provider associations to improve emergency preparedness and response for vulnerable populations.

With the heightened focus on emergency preparedness following the September 11 attacks, HCANJ and NJAHSA found that emergency management representatives tended to refer to acute care hospitals when discussing emergency preparedness for the health care community, with minimal discussion of the needs of LTC providers and other parts of the health care continuum. Needs assessments conducted in NJAHSA member communities (which include skilled

¹ In this report, emergency management services refer to first responders such as fire, police, and EMS services, as well as governmental entities such as state and county Offices of Emergency Management.

nursing, assisted living, continuing care retirement communities, affordable senior housing, and home and community-based services) and interviews with Office of Emergency Management (OEM) coordinators and first responders supported the conclusion that many in the emergency management community had limited awareness of the diverse LTC population and its needs.

To ensure that LTC community needs are considered under emergency preparedness and response planning, HCANJ and NJAHSa dedicate substantial time to representing LTC in the collaborative efforts coordinated through the NJHAEPa, MCCs, and HACC, and to promoting greater awareness and a stronger sense of responsibility for the LTC community among emergency management services. In addition, to help individual LTC providers strengthen their own preparedness, HCANJ and NJAHSa used DHSS funds to develop templates for provider-level emergency preparedness plans.

Intervention

HCANJ and NJAHSa participate in multiple efforts to facilitate ongoing communication and collaboration among public health entities, health care providers, and emergency management services throughout New Jersey to strengthen emergency preparedness and response.

New Jersey Healthcare Associations Emergency Preparedness Alliance

NJHAEPa, established in 2003, is a volunteer workgroup consisting of the emergency preparedness and response leads from the New Jersey Hospital Association, New Jersey Primary Care Association, NJAHSa, HCANJ, and Home Care Association of New Jersey. Each of the member associations run emergency preparedness initiatives partially supported through DHSS grants. NJHAEPa meets monthly, with DHSS representatives attending quarterly and as needed to facilitate coordination and communication with the associations. NJHAEPa was established to facilitate the exchange of information among the five provider associations regarding their and their members' emergency preparedness programs and methods, and their collaborative efforts with OEMs, health departments, first responders, and volunteer

organizations active in disasters. The associations also share information from state meetings on emergency preparedness and response and from communications with their counterpart associations in other states and nationally. Guests occasionally attend the NJHAEPa meetings to promote understanding of critical functions of emergency preparedness or enhance planning efforts. NJHAEPa monitors the spectrum of preparedness activity, including that of local first responders, county agencies and organizations, and State and Federal agencies to identify and share best practices, determine unnecessary duplication and counterproductive policy and programs, define education and training requirements for the future, and provide recommendations to strengthen preparedness and response efforts.

Medical Coordination Centers and Healthcare Associations Coordination Center

Starting in 2003, the New Jersey DHSS established one or more MCCs in each of the state's five public health regions to lead regional emergency preparedness and response planning for medical facilities, emphasizing an integrated response involving public health, health care delivery, and emergency management sectors. Each MCC is housed in an acute care hospital in a build-out equipped with state-of-the-art communication technology and large-scale conference and training facilities. The MCCs provide hands-on training through disaster simulation and other exercises involving regional representatives from each of the three sectors. The MCC also directs collaborative efforts to update each region's emergency preparedness standard operating procedures (SOPs), ensuring that they meet state requirements and address region-specific needs. MCC activities promote in-person communication and interaction among the key individuals from multiple entities who will lead assistance efforts in emergency situations.

In 2004, DHSS established the HACC, which is housed at the New Jersey Hospital Association in Princeton, to serve as a command center for coordinating communications and activities of the healthcare continuum during a public health emergency or widespread disaster. The HACC would be staffed primarily by NJHAEPa

members and is equipped with interactive audio and video capabilities, power back-up, and other features central to an effective command center.

Promoting Awareness of LTC Community among Emergency Management Services

In addition to representing LTC in the multi-party trainings and meetings coordinated through NJHAEPA, MCCs, and HACC, HCANJ and NJAHSA work independently to promote stronger awareness and encourage a greater sense of responsibility for the LTC community among emergency management services. The associations provide training and informational materials to enhance the emergency management community's understanding of the LTC population and to promote emergency response methods suited to the nature and needs of LTC residents. For example, the associations address concrete, practical aspects such as managing the physical lifting, transfer, and transport of LTC residents and planning evacuation approaches specific to facilities housing LTC residents, rather than relying on methods used with the general population.

Association efforts primarily target the state-level OEM and the 21 county-level OEM coordinators in the state, with the intent that information and a greater sense of awareness will filter out to the approximately 560 local OEM coordinators in New Jersey. HCANJ and NJAHSA representatives participate in the statewide OEM coordinator annual meeting and county-level OEM coordinator meetings across the state, often running exhibit booths and actively networking. To further increase visibility, eliminate barriers, and promote a friendly as well as an official exchange of information, HCANJ and NJAHSA also involve the OEM and DHSS in the annual conferences for their associations, where these governmental entities may run exhibit booths, make presentations, and network. HCANJ and NJAHSA also encourage their provider members to establish and maintain communication with their local OEM coordinators and first responders to discuss plans for managing emergency situations.

NJAHSA and HCANJ, both independently and through participation in NJHAEPA efforts, dedicate substantial time to working with the New

Jersey OEM, which is considered to be the nucleus of emergency preparedness and response efforts in New Jersey, to increase their awareness of LTC provider needs in a catastrophic situation. The associations have worked to heighten awareness of LTC providers as not only takers of services but also as givers of services because of the physical plant, staffing, and other attributes they can provide. For example, skilled nursing facilities can offer a safe location for less acutely ill hospital patients to be transferred on a short-term basis, given the facilities' round-the-clock staffing, mass feeding capability, and trained medical staff, as acute care hospitals in a mass casualty situation would be rapidly overwhelmed.

Templates for Emergency Preparedness Plans

HCANJ and NJAHSA used part of their DHHS emergency preparedness grant funds to develop templates for provider-level emergency preparedness plans, in response to the extensive variation in emergency preparedness plans across providers, the need to expand plans to encompass such potential hazards as terrorist attacks and anthrax, and greater surveyor scrutiny of plans during routine surveys. The associations independently developed standard all-hazard emergency preparedness plan templates suited to the needs of their provider members, while collaborating with one another and NJHAEPA to promote a baseline of consistency within regions and across the state. HCANJ and NJAHSA have shared their templates with association affiliates across the country via presentations and training, as well as posting on the Web.

Impact

HCANJ and NJAHSA staff believe that NJHAEPA is a key component contributing to New Jersey's progress in integrated emergency preparedness and response. In addition to promoting consistent and effective collaboration and coordination among the five provider associations representing the health care continuum, NJHAEPA provides a single platform for efficient, ongoing communication between DHHS and the multiple participating associations.

The association staff believe that the MCC and HACC activities have strengthened preparedness, enhanced visibility of all segments of the health

care continuum, and provided opportunities for health care representatives to develop positive, friendly relationships with first responders, OEM coordinators, and public health representatives. It is noted that these activities have resulted in significantly improved communications among the participating entities. The association staff comment that MCC-coordinated collaborative efforts to update regional emergency preparedness SOPs, in particular to reflect region-specific considerations (e.g., proximity to New York), also have improved preparedness across the entire health care continuum.

Association staff believe that their outside efforts to increase awareness of the LTC community among emergency management services, in combination with heightened visibility resulting from participation in MCC and HACC activities, have resulted in measurable success. They report that discussion at state- and county-level OEM meetings and DHSS meetings now typically references the "health care continuum" and often LTC specifically, rather than the past emphasis on acute care hospitals. The association staff note that many local first responders also demonstrate a greater sense of awareness and responsibility for LTC providers by recognizing local LTC facilities in their community emergency preparedness planning.

Finally, the association staff indicate that many AHCA and AAHSA affiliates across the country utilize their organizations' model templates for provider-level emergency preparedness plans, adopting key elements and format features while tailoring the plans to meet their own state regulatory requirements.

Lessons Learned

HCANJ and NJAHSA staff emphasize the critical lesson of assuming nothing. It is vital to gauge the awareness and knowledge of the emergency management community with regard to their role in assisting LTC providers during emergency situations. Association staff also caution against assuming that individuals are knowledgeable or prepared simply because they have attended a training session; it is important that trainers encourage individuals to devote careful attention to a training exercise, and in some cases, to repeat the exercise until thorough understanding is attained. Training and information dissemination efforts should be designed to equip individuals and organizations to be able to handle 90 percent of an emergency situation out of habit, allowing them to focus energies on addressing the 10 percent unexpected. It is valuable for LTC providers to establish open lines of communication with their local OEM and first responders, while also ensuring that they are as self-sufficient as possible, as it is difficult to predict issues and obstacles that may arise during an emergency situation. HCANJ and NJAHSA staff comment that their organizations' efforts to share expertise and ideas, while still advocating for their own members' interests, is beneficial to both organizations' efforts and their shared goal of helping the LTC population.

Contact Information

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