Virginia Long Term Care Mutual Aid Plan (LTC-MAP)

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Overview

This Long Term Care Mutual Aid Plan (LTC-MAP) provides a method to coordinate and manage requests for assistance when one or more long-term care (LTC) facilities are faced with an incident that exceeds their ability to manage the event independently. The LTC-MAP facilitates the use of resources from member LTC facilities to manage the incident and provides a coordinated approach to support evacuated residents in single or multiple facility evacuations.

The LTC-MAP is designed to enhance regional response capabilities to better manage the impact of all-hazards events on LTC facilities.

A. Plan Objectives

1. Voluntary Agreement

Create a voluntary agreement among individual plan members to assist each other in times of a disaster.

2. Regional Inclusion

Incorporate the LTC-MAP into Regional Healthcare Coalitions (RHC) response capabilities.

3. Scenarios

Ensure a functional methodology to address the following three (3) disaster scenarios:

i. Single Facility / Isolated Incident (e.g., Fire, Loss of Emergency Power);
ii. Single Facility / Local or Area-wide Incident (e.g., Flooding, Ice Storm, Blizzard);
iii. Multiple Facility / Statewide or Regional Incident (e.g., Derecho, Hurricane, Tornado).

B. Plan Scope

1. Title

Virginia Long Term Care Mutual Aid Plan (LTC-MAP) and shall be cited as such, and shall be referred to herein as “LTC-MAP”.

2. Participation

This Plan includes long-term care (LTC) facilities in all six (6) RHCs in the Commonwealth of Virginia.

3. Purpose

The general purpose of this Plan is:

i. To place and support care of residents evacuated from a Disaster Struck Facility (DSF);
ii. To provide supplies, equipment, and pharmaceuticals, as necessary, to a DSF;

iii. To assist with transportation of evacuated residents within the state region, outside of the state region, and outside of Virginia;
iv. To provide staffing support, as necessary, to a DSF or Resident Accepting Facility (RAF), whether evacuating, surging and sheltering residents above licensed bed capacity, or Sheltering-in-Place.

C. Memorandum of Understanding

The LTC-MAP Memorandum of Understanding (MOU) defines the relationship among the LTC facilities that have agreed to voluntarily provide support to accept evacuated residents and/or provide other assistance to LTC- MAP member facilities.

D. Responsibility of Plan Members

Refer to the LTC-MAP MOU for additional details.

1. LTC-MAP members agree to accept additional residents up to 110% of their licensed bed capacity. It is understood that no facility will be asked to accept residents whose required level of care is beyond the normal capability of the RAF and all facilities must assess their own capabilities before accepting residents.
2. LTC-MAP members shall activate their internal disaster plan and shall activate their internal Command Center to request LTC-MAP resources.
3. LTC-MAP members agree to update facility status boards, when requested, to report open bed capacity and operational status on the Virginia Healthcare Alerting and Status System (VHASS).
4. LTC-MAP members agree to participate in regional drills and exercises.
5. LTC-MAP members are encouraged to use the Resident Emergency Evacuation Form and the Resident / Medical Record / Staff / Equipment Tracking Sheet or a facility specific tracking sheet.
6. LTC-MAP members should send the Active Medical Record/Chart (or copy of) with each evacuating resident. In some situations, alternative means of accomplishing this will be acceptable (e.g., Electronic Health Records access from alternate locations). If a fast evacuation prohibits sending the medical chart, then the Resident Emergency Evacuation Form shall serve as the primary tracking document for the resident.
7. LTC-MAP members shall accept responsibility for providing current critical information to the LTC-MAP and shall update that information as needed annually, at minimum on the VHASS. Critical information includes, but is not limited to:
    i. Complete contact information of administrators and other key personnel
    ii. Changes in their facility's bed capacity or service capability
    iii. Changes in available resources and surge information
8. LTC-MAP members acknowledge that the LTC-MAP may include additional requirements as specified by the RHC or the Virginia Department of Health (VDH) at the time of the incident.

E. Regional Healthcare Coordination Centers (RHCC)

This plan includes the RHCC. The responsibilities may include contacting member facilities to secure bed capacity and resource/asset information, providing coordination/prioritization support to the RHCC, support resident placement, and communication with RAFs.

F. General

1. Plan Inclusion

This plan complements the existing regulations and plans in the Commonwealth of Virginia and the specific regions, as applicable.

2. Plan Expansion

It is the intent of this plan to evolve over time and be an inclusive plan. The objective is to ensure that boundaries between RHCs do not obstruct the ability to manage regional evacuations and resources or assets in a disaster.

3. Internal Emergency Operations Plan

In disaster response planning, LTC- MAP members should not rely solely on this plan. After a flood, ice storm, hurricane, or other substantial statewide disaster, facilities may not receive immediate support from vendors, first responder agencies, Health Department District Emergency Coordinator and/or Emergency Management Agencies based on the severity of the disaster and prioritization of resources. Therefore, this plan does not replace the requirement for facilities to have:

i. Internal Incident Command Systems (ICS) that are compliant with the National Incident Management System (NIMS) such as the Nursing Home Incident Command System (NHICS);
ii. Full-building evacuation plans to safely transport the residents to the sidewalk and appropriately match the resident care levels to RAFs;
iii. Internal and external communication plans;
iv. Influx of Residents / Surge Capacity Plans;
v. Isolation / rationing plans when supplies, equipment, staffing, or other resources will not allow a facility to stand alone for a 96-hour period or greater.

4. Payment

For supplies, equipment, staffing, transportation, and resident care payment will be coordinated between the Borrower/DSF and the Lender/RAF. See additional details in the LTC-MAP MOU.

5. Independent City, County and State Responsibility

Since evacuation assets are vulnerable to natural and technological disaster events, they may be overwhelmed in a disaster, requiring the activation of this plan. The Commonwealth of Virginia and local departments, independent cities, counties, and state agencies can only attempt to make every reasonable effort to support this plan based on the situation, information, and resources available at the time of the disaster.

Plan Activation & Communication

A. Activation Algorithm

Use LTC-MAP Activation Algorithm (Appendix A) to activate the LTC-MAP.

B. Disaster Struck Facility in Need of Resources/Evacuation Actions:

1. Develop and communicate an Incident Action Plan:
    i. Establish incident goals and objectives
    ii. Prepare response strategies and tactics
    iii. List positions in the Incident Command System organizational chart
    iv. Document critical situation updates and assessments
    v. Develop communications plan (how functional areas can exchange information)
    vi. Formulate logistics plan (equipment, transportation, etc.)
    vii. Attach incident map (floor plans or site plan)
2. DSF assesses if evacuation is necessary or if they can continue to provide resident care and remain open with additional staff, supplies, and/or equipment**. If evacuation is necessary, resident life safety is priority.**
3. Unified Command with Emergency Management (usually via ESF 8) should be established at the DSF to support key decision-making, resource coordination, and communications.
4. When working with local emergency agencies or the RHCC, ensure you:
    i. Leave a dedicated phone line available for incoming calls.
    ii. Be prepared to communicate the following information:
        - Who: Your contact name and phone number
        - Where: Facility Name, Address, and Town/City
        - What: What is the issue?
        - When: Window of time the resources will be required
        - Why: Reason

C. LTC-MAP Communications

Communication is a key element to any operation. This section of the plan encompasses Communication Systems, 100% Communications Failure, as well as communication with the community referred to herein as Media/Public Communications. Communication systems must provide redundancy to support operations during an event. On a daily basis, the facilities use telecommunications systems, cell phones, pagers, and internet as primary methods of communication. If primary communication systems become inoperable, another should be available as back-up.

1. Virginia Healthcare Alerting & Status System (VHASS)

VHASS is a secure, web-based emergency management system used to coordinate and streamline individual and regional health care response to all hazards. This is a system that will be managed by RHCC for the LTC-MAP member facilities. The RHCC will send

out alerts, notifying individual healthcare facilities, their assigned leadership and critical partners via text messaging and email of situations or response.

2. Region Specific Communication / Redundant Communication

Refer to your RHCC and local emergency management communication plans for region specific modes of communication. It is encouraged that facilities work with local and regional partners when establishing facility specific redundant communication methods to ensure continuity and connectivity during a disaster.

3. 100% Communication Failure

i. If there is an immediate Life Safety or Life threatening issue: Go to your local authority (e.g., Police Station or manned Fire Department) or to your local hospital to request assistance. Provide as much information as possible as to the situation. Communications trailers, via local Emergency Management or the RHCC, could be provided if available to support overall communications.

ii. If there is no Life Safety or Life threatening issue: A facility is best served, if there is NO immediate life safety or life threating issue, by staying in place. Local or regional authorities will come to your facility to check in on you and the RHCC will be identifying all facilities that have not communicated their operational status on VHASS or via phone.

- Important: Each facility should work with their local jurisdiction to determine the appropriate locations where they would like you to report. Additionally, it should be reviewed if there will be any form of distress flags that should be hung outside the facility, in a visible location, to alert emergency responders of your status in a large-scale regional disaster.

4. Media/Public Communications

i. In the event of a public health emergency, healthcare organizations, as well as the RHCC, should anticipate high demand for information requests from the media. RHCC will play a central role in communicating with the media about the impact of the disaster event, either serving as the lead agency or with an active role in the statewide Joint Information Center (JIC), the primary conduit for messages, press releases and press conferences.

ii. While the objective is to have all communications flowing through the JIC, a member facility is still a private entity and shall be able to address necessary communications with residents, families, and other facility- specific information based on the emergency with media outlets. It is strongly recommended that the LTC-MAP member facilities coordinate with their RHCC for press statements.

Facility Evacuation

A. General

1. Slow-out evacuation

This plan supports using close proximity open beds and having the LTC-MAP member facilities surge to 110% of licensed beds only as necessary.

Note: If the evacuation is a "slow-out" situation whereby all parties are aware that the facility will not be re-opening in the near term (flooding, facility damage, etc.), then the RHCC should be supporting the Disaster Struck Facility (DSF) to find open beds within the region and potentially outside the region, or state for long-term resident placement, if required.

2. Fast-out evacuation

Residents will be moved to a Stop Over Point or may bypass the Stop Over Point and move directly to the RAF utilizing their surge capacity plan to exceed licensed bed capacity to "shelter" the residents for a short period of time until they can return to the DSF or be moved into open beds (typically a 72-hour window).

Note: The LTC-MAP member facilities should have a written agreement with Stop Over Points (Senior Centers, Continuing Care Retirement Communities, etc.). Agreements should be updated annually. This is the member facility's responsibility.

B. Actions of a Disaster Struck Facility

1. General

i. Each facility should pre-select evacuation sites within the LTC-MAP and determine the number of facilities necessary to handle their total resident population based on acuity levels. It is recommended that facility representatives visit the pre-selected sites at some point in the selection process.
ii. Make every effort to relocate residents to an accepting facility that offers an equivalent level of clinical care or higher (otherwise, provide staff, equipment, and resources to support that resident).
iii. If a resident has a significant medical emergency, utilize the standard process of transporting via EMS to a hospital. Hospital transport should be considered for residents who present a "Danger to Self or Others" (24-hour observation), residents who are ventilator dependent, and those requiring hemodialysis.
iv. If there is considerable damage to the DSF and it will not be reopening within 72 hours, work with Resident Accepting Facilities (RAFs) and the RHCC to find longer term placement for residents within open beds.
v. Each facility should be familiar with the function and extent of community emergency services such as Police, Fire, EMS, the RHC and RHCC, the Health

Department District Emergency Coordinator, Local Emergency Management, Red Cross, Salvation Army, etc. and advise them of your needs.

- Establish advance communications with the local responders to improve communication for resources and support during a disaster.

2. Census Reduction

Activate census reduction plans as time permits. This includes:

i. Discharge to Home
Identify residents who could be discharged, whereby the residents would either be discharged home, if the family or responsible party is able to pick them up, or moved to an off-site Family Assistance Center (FAC) (as determined in the facility-specific evacuation plan).

ii. Site Selection
The DSF, working in cooperation with the Incident Commander at the scene for Fire / EMS / Police / Emergency Management, should identify a location in close proximity where discharged residents can be relocated prior to being picked up by family members (e.g., outside of the police perimeter).

- Family Assistance Center: If a family assistance center is activated the DSF should have a staff member available to fill out a Resident / Medical Record / Staff / Equipment Tracking sheet, verify with whom the resident is leaving, and accommodate other resident and family interactions.
- *Statewide Family Assistance Center:* In the event of large scale incident in which there needs to be coordination with family members on locating a loved one who may have been evacuated or transported, the Virginia Department of Health and the Virginia Department of Social Services will support plans to establish a statewide Family Assistance Center (FAC) to coordinate these reunification efforts. If activated, the Plan would utilize the 2-1-1 Virginia hotline.

3. Stop Over Point

A Stop Over Point is defined as a facility or facilities that are in a suitable location to be utilized for a slow or fast-out evacuation. The Incident Commander of the DSF will alert the Stop Over Point that a disaster has occurred. This will provide advance warning to the Stop Over Point to begin preparation.

i. The intent is to use this site in the event the residents are:

- Quickly forced to the sidewalk in adverse conditions and sheltering is necessary for the residents prior to relocation to other healthcare facilities or to home. Example: It is 25 degrees outside and snowing – if you are forced to evacuate to the sidewalk, where can you go right away to shelter your residents? These conditions assume that it is unsafe to keep the residents in unprotected space (e.g., parking lot) while full transportation resources are mobilizing, and Resident Accepting Facilities are being informed of the evacuation.

- Evacuated from the facility, yet the facility should be able to reopen in a short period of time (hours instead of days).
- Unable to be transported at greater distances due to regional disaster conditions (transportation infrastructure impacted due to flooding, ice storm, etc.).

ii. The Disaster Struck Facility (DSF) will be responsible for the following at the Stop Over Point:

- Having a staff member present as residents arrive.
- Ensuring the provision of appropriate clinical care.
- Increasing staffing appropriately as more residents arrive.
- Transporting staff, supplies, pharmaceuticals, and equipment in coordination with the appropriate RHCC and Local Emergency Management (usually via ESF 8).
- Managing the set-up, activation, operations, and demobilization. If the staff from the DSF are unable to provide all of the resources necessary to support the Stop Over Point, a request for additional staffing may be submitted to the RHCC to support the DSF in working with other plan members, based on reported staff availability, and local Emergency Management (usually via ESF 8).

4. Notifying the RAF

Prior to actual transfer of residents from the DSF or the Stop Over Point, during a slow evacuation, the person in charge of the DSF should notify the Resident Accepting Facility(ies) of the following information:

- The specific number and type of residents (e.g., wheelchair, stretcher, ambulatory, special needs, acuity level) being transferred to them. Use information from the LTC Resident Care Categories chart (report from VHASS), which describe the type of care each facility is qualified to render.
- The number of supporting personnel they can expect to receive (staff from your facility).
- The approximate time of arrival.

5. Responsibility for Resident Tracking

A Resident Emergency Evacuation Form should be used to record pertinent medical information by each individual resident. Use the plan-specific Resident / Medical Record / Staff / Equipment Tracking Sheets (Appendix B), which follow the residents as they pass through the internal holding area, Stop Over Point, and finally the RAF. Send or make available sufficient resident medical information to ensure proper care.

i. All residents that leave the DSF should have:

- Resident Emergency Evacuation Form (Appendix C), containing pertinent medical information for a quick review of the resident. This should be pinned to the residents' clothing (on their back or other area where this cannot come free).

- Commonwealth of Virginia Triage Tags and (Northern Region) Washington Metropolitan Area Disaster Tag. These tags may be utilized by EMS to provide a unique identifier ("Patient Number") and stickers, that will be used on the Resident Emergency Evacuation Form and any associated paperwork, to ID belongings, etc. Tag can be tied to resident's wrist or ankle.
- If possible, residents should have a facility issued wrist band showing resident name, date of birth, and medical record number. If unable to provide a wrist band, utilize a permanent marker on the forearm or other immediately identifiable location with the resident's last name. Review having a digital photo of each resident to link up to their Resident Emergency Evacuation Form or a photo that can be printed and go with the resident. At times, a digital photo is taken of each resident as they leave the building with a close-up picture of their Resident Emergency Evacuation Form and Triage/Disaster Tag number
- If possible, all residents that leave the DSF shall be sent with:
    a. During a Slow Evacuation (attempt to ensure the following information accompanies the evacuating resident):
        i. Face Sheet
        ii. Physician Orders
        iii. Code Status
        iv. History and Physical
        v. MAR (Medication Administration Record)
        vi. TAR (Treatment Administration Record)
        vii. Care Plan
        viii. Current Nursing Notes (if possible)
        ix. Therapy Notes
        x. Resident Photo (if available)
    b. During a Fast Evacuation: Face Sheets and binder of MARS/TARS at a minimum (see Electronic Health Records section for planning considerations)
    c. Resident / Medical Record / Staff / Equipment Tracking sheet should follow a group of Residents.
- Other Considerations
    a. If possible, send staff with the evacuating residents to make copies of key information in the Medical Record and bring back to the Disaster Struck Facility (DSF).
    b. As nurses and physicians from the DSF go to various RAFs to resume care of their residents, it is recommended they bring the current charts, if not already transported, and controlled substances (if requested by the RAF) needed to care for these residents.

6. Medications

i. If time permits, pre-medicate the resident prior to leaving the facility. Certain disasters will force the residents to travel extended distances or be in traffic for extended periods of time, and thus, movement with their medications may be necessary.
    - It is the discretion of the DSF whether they will send controlled substances. The disaster will dictate this. If a resident is in acute distress requiring administration of a narcotic, the DSF may choose to send him/her directly to a hospital.

ii. If possible, send each resident's prescribed medications and Active Resident Record/ Chart, including insurance information (if discharging), to the RAF with the resident.
    - When sending resident-specific medications, package them in a tamper-evident 1-gallon Ziploc bags along with the resident's other personal effects. Label with their name and Medical Record Number before sending with the residents (as they are transferred).

iii. If either facility is unwilling to send or receive medications, the RAF will obtain and provide essential medications.

iv. Federally controlled substances will either go with the resident or be brought to the RAFs, if necessary, when nurses from the DSF arrive.

v. A licensed healthcare practitioner may bring the medications to the RAF during or immediately post disaster. If large volumes of medications are necessary, the DSF may provide larger quantity shipments to the RAF.
    - If civil unrest is taking place or there is potential, consideration should be given for security or law enforcement personnel presence for transfer of controlled substances.

7. Staff, Equipment, Supplies, & Pharmaceuticals

Send nursing and support services personnel and supplemental staff to the RAF as soon as possible, if necessary. Nurses may take federally controlled substances (if necessary) and Active Resident Record/Charts (actual charts or copies if they did not initially accompany the residents). If required, send any other required equipment or supplies (e.g., useable mattresses/beds, wheelchairs, and other equipment) with residents and laptop computers to access any electronic health records from the RAF.

i. Use your facility vehicles or request additional transport resources from the Local Emergency Management (usually via ESF 8) or the RHCC. Administration must work closely with RAFs throughout the process.

8. Resident Transportation by LTC-MAP Members

RAF may use their own wheelchair accessible vehicles to pick up residents that are being relocated and transport them to the Stop Over Point or their own facility. Transportation and lodging for staff evacuating with residents will also have to be considered, especially if staff members are from out of the area.

9. **Staff Supervision**

   The staff of the DSF will be under the administrative direction of the RAF when working at the RAF (see MOU).

10. **Notification of Family / Primary Care Physician**

    The DSF is responsible for contacting the residents' responsible parties and physicians, as appropriate. Once the RAF has confirmed the receipt of the resident, they will take over communications with the family. This should be agreed upon by both parties.

11. **Contact Information**

    To facilitate communications, each DSF and RAF should have the RHCC, local emergency management, and Health Department District Emergency Coordinator contact information. In cases where the DSF has already evacuated ensure the RAF has the appropriate contact information to "close the loop" and report the receipt of residents.

C. Actions of a Resident Accepting Facility

1. **Long Term Care Status Board**

   Update your facility Status Board at www.vhass.org to identify open bed status and operational issues.

2. **Command Center**

   Establish a Command Center and review key positions necessary to coordinate efforts and facilitate communication (Incident Commander, Liaison Officer, Public Information Officer, Safety/Security, Operations Section Chief, Logistics Section Chief, Planning Section Chief and Finance/Administration Section Chief).

3. **Influx / Surge**

   The RAF must have an internal plan to appropriately receive and care for incoming residents. Customize the Influx of Residents/Surge Capacity Guidelines to support your pre-event planning efforts with the appropriate amounts of supplies, equipment, staffing, and other resources necessary to manage a surge to 110% of licensed bed capacity or greater.

4. **Resident Arrival**

   When evacuated residents arrive at the RAF, the site agrees to temporarily provide supportive coverage until the DSF can provide staff to support their residents (the impact on the DSF may prevent staff from being sent to the RAF in the short term). The Medical Director or designee of the RAF will assume responsibility for care on an interim basis. In many situations, the DSF may be unable to send staff due to the large number of facilities to which they distributed. Therefore, the RAF may be required to provide continued clinical support to these residents with internal staff. A request can be made to the RHCC to support with additional clinical staffing needs if the RAF is unable to expand staffing.

5. Documentation of Medical Information

All residents arrive at the RAF shall be documented:

i. Influx of Residents Log completed for all arriving residents.
ii. Controlled Substances Receiving Log as necessary.
iii. There are two options regarding the documentation of medical information. When the Active Resident Record/Chart arrives with the resident, a review is conducted of the records along with an assessment of the resident, and the facility begins documents in the following manner:
    - Start a new chart for each newly accepted resident, clearly noting the time in the existing chart to delineate where the documentation ended.
    - If using the existing chart, clearly delineate when and where the RAF began documenting in the chart (when/if the determination is made that the resident will not be returning to the DSF, a new chart will be started for the resident).

6. Medications

i. If possible the DSF will send each resident's prescribed medications and Active Resident Record/Chart, including insurance information (if discharging), to the RAF with the resident.
ii. If a resident arrives with medication, it is the discretion of the RAF to continue to use these meds or order their own. It is recommended that medications be placed in water resistant, tamper evident containers/bags (1-gallon tamper evident Ziploc is recommended).
iii. Physician Orders for newly arriving residents (MAR should accompany the resident) are filled by the RAF, if necessary, until a physician with privileges at the RAF is present and can write a new order. In some situations, a licensed Health Care Professional (HCP) may go with the resident and be responsible for the Controlled Substances. If meds are administered during transport, appropriate documentation on name of medication, quantity and dose administered must be documented.
iv. The RAF may also request that the residents' same LTC pharmacy dispense a new supply of medication to the new location. The LTC pharmacy computer system will have the current medications of the resident.
    - The Department of Medical Assistance Services (DMAS) or other payer may comply with request to fill before usual due date.
    - The name of residents' pharmacy will be supplied to new site.
v. If primary LTC pharmacy is not able to dispense medication due to loss of function:
    - The medication request should be sent to another LTC pharmacy from MAR and/or medical record.
    - If it is necessary to move outside of pre-designated pharmacies, a new pharmacy will be allowed to (72 hours up to 10 days) until new signed physician orders can be obtained (requires state waiver to implement).

vi. A licensed healthcare practitioner may bring the medications to the RAF during or immediately post disaster. If large volumes of medications are necessary, the DSF may provide larger quantity shipments to the RAF.
    - If civil unrest is taking place or there is potential, consideration should be given for security or law enforcement personnel presence for transfer of controlled substances.

7. Resident Care Responsibility

Once received for "sheltering" and/or admitted, the resident is under the care of the RAF's admitting physician until discharged, transferred, or sent back to the DSF. The DSF is responsible for transferring extraordinary pharmaceuticals or other special resident needs (e.g. equipment) along with the resident, if requested and if possible. When the situation that led to evacuation has been resolved and it is safe and practical to do so, residents may be returned and must be accepted at the DSF.

8. Resident Placement

Residents will initially be placed in open beds* at the RAF. Surge areas will be used when open beds are unavailable. In the initial phase of the disaster, staff and equipment will be provided by the RAF; if more supplies are needed, contact vendors listed in the plan. As soon as possible, the DSF will send staff, equipment, and supplies as requested by the RAF.

** Beds with a confirmed admission may be held open for an incoming resident.*

9. Staff, Pharmaceuticals, Supplies, Equipment

The RAF should agree to arrange for or provide the necessary resources until the DSF can provide the appropriate resources. Refer to Section 4 for more details.

10. Notifications

i. Resident Arrival
The DSF should be notified right away when their residents arrive. This avoids any delay in their awareness of the status of their residents. At the DSFs request, the RHCC will operate as the central coordinating center for notifications of the arrival of residents. Therefore, all RAF's should notify the RHCC about arriving residents and verify specific names of residents that have been received following communication with the DSF. The RHCC will communicate with the DSF to close the loop and confirm all resident locations are accurate. If the RHCC is not operational and no central body is in place to coordinate the final disposition of the residents, communicate only with the DSF for resident information until an RHCC or other coordinating entity is established. The DSF should be notified of any major changes in resident medical condition if DSF staff has not arrived at the RAF as of that time.
    - The RHCC will be utilized as a central location for information to be gathered and ultimately reported to other state agencies. Unless otherwise determined, all necessary communications with the Center

for Medicaid and Medicare Services (CMS) will take place directly from VDH and other state agencies as necessary (e.g., DMAS).

ii. Resident Family (Responsible Party) and Primary Care Physician
Communicate with the DSF when you are taking over communication with the residents' responsible parties and physicians.

iii. Staff
Notify the DSF of their staff presently at the RAF

11. Sheltering vs. Admission

Sheltering of residents will be the standard process when an LTC-MAP member evacuation occurs. The resident will not be admitted, yet necessary clinical assessments and documentation will be completed. The resident will remain a resident of the DSF. Other options for residents that have been relocated include:

i. Admission to RAF (if deemed they cannot return to the DSF – see Memorandum of Understanding).
ii. Transfer & admission to hospital if required.
iii. Transfer & admission to another nursing home.
iv. Discharge to home.

12. Return Residents to DSF

At the end of the disaster, all residents, along with their medical records and equipment, must be returned to the facility of origin, unless other agreements have been made between sender and receiver or intervention from VDH/DMAS.

i. All supplies and equipment that arrived with the resident should be returned to the DSF, unless a consumable.
ii. Copies of all records completed while at the RAF should be provided to the DSF.

D. Considerations for like-to-like (level of care) transfer of residents

1. Evacuation Strategy

The LTC-MAP evacuation strategy is based on the concept that residents being evacuated from a Disaster Struck Facility (DSF) will be transferred to a Resident Accepting Facility (RAF) that offers a similar level of clinical care or higher. Some examples include

i. Nursing Homes shall evacuate to other Nursing Homes.
ii. Dementia Secured Units shall evacuate to other facilities with Dementia Secured Units
iii. Ventilated Residents shall be evacuated to other facilities capable of managing ventilator residents.
iv. When Levels of Care Do Not Match: If conditions dictate an evacuation to a facility that does not provide an equivalent level of care, staff from the DSF shall relocate to the RAF, or teams from other facilities shall be deployed as necessary with the appropriate equipment and supplies.

E. Transportation of Residents

1. General

Coordination should take place with the Fire Department in the city/municipality of origin and the contracted private transportation company. The ideal plan is to transport higher acuity residents to the nearest long-term care facility available that could handle their acuity based on the LTC Resident Care Categories (report from VHASS), while taking those who could tolerate a longer transport time to more remote healthcare facilities. It is recognized that vehicle availability, specialized resident needs, bed, and staff availability will contribute to final decision-making.

2. Transportation of Residents

The Disaster Struck Facility (DSF) should assign an individual (Transportation Officer) for direct coordination with the EMS Transportation Officer and Loading Officer. The DSF Command Center (or the RHCC) should inform the Resident Accepting Facility (RAF) of the expected resident numbers they will receive. The DSF Transportation Officer, in consultation with the DSF Operations Section Chief and Planning Section Chief, should assemble the following information:

i. Resident Pick-up Point - Resident pick-up points should be part of each facility's internal plan.
ii. Total requiring Critical Care Transport (RN / Advanced Paramedic)
iii. Total requiring Advanced Life Support transport (Paramedic)
iv. Total requiring Basic Life Support transport (EMT)
v. Total requiring Wheelchair Van/Bus for standard ground transport
vi. Additionally, information regarding specific needs should be incorporated:
    - Total requiring Isolation for Infectious Disease
    - Total dementia secured
    - Total requiring bariatric transport (non-ambulatory and >350lbs).

3. Nurse/Physician Decision-Making Guide

Utilize the Nurse/Physician Decision-Making Guide (Appendix D) to assist in assigning patient transportation needs based on clinical criteria.

4. Tracking and Transfer Forms

Refer to G. *LTC-MAP Tracking Sheets/Tools* to support resident movement and tracking. If the facility, due to the emergent nature of the event, has no ability to transport medical records, the standard MCI management system by EMS is currently relied upon (complete a Commonwealth of Virginia Triage Tag or, for the Northern Region, a Washington Metropolitan Area Disaster Tag) and, at minimum, the Resident Emergency Evacuation Form and Resident / Medical Record / Staff / Equipment Tracking sheet should be utilized (whether completed in the parking lot or at a Stop Over Point).

NOTE: The Resident Emergency Evacuation Form and Resident / Medical Record / Staff / Equipment Tracking sheet (Appendix B) will only be excluded from use if

an event with multiple victims and all transports taking place are going to the hospital (substantial fire, building collapse, etc.).

5. Other Modes of Transportation

To supplement and expand upon EMS Capabilities
the Resident Emergency Evacuation Form or a similar document should be utilized for each resident, even if the medical records and other information are accompanying the resident.

i. Long-term Care Facility Vehicles: Many facilities have vehicles that could help transfer residents, supplies, and/or equipment from the Disaster Struck Facility to the RAF or Stop Over Point. The DSF should advise the Scene Incident Commander of any facility-owned vehicles that can be used for moving residents, staff, and equipment. An EMS Officer (from EMS, Fire, or private transportation company) provides support for the staging of these vehicles upon their arrival.
ii. Private/Public Wheelchair Accessible Buses and Wheelchair Cars/Vans: Move moderate- to low-acuity residents to other RAFs or Stop Over Points.
iii. Other Transfers
    - Movement of Family: Local Public Transit, Private Bus Transports, and Personally Owned Vehicles could be utilized. Family members would have to be instructed to go to a Family Reunification area, due to potential high-level security at the RAF and/or Disaster Struck Facility.
    - Movement of Staff: Local Public Transit, Private Bus Transports, Long Term Care Facility Shuttles and Personally Owned Vehicles could be used to move staff.
    - Movement of Equipment/Supplies: Work with the RHCC and the local Emergency Operations Center for transport vehicles, for utilization of facility-owned vehicles, and for supplier trucks.
iv. Grouping for Resident Movement: Resident movement should be established in batches of 5 to 15 residents at a time. This will align with a typical Ambulance Strike Team approach.
v. Traffic Control: The Department of Transportation, State Police, and the local law enforcement for the areas impacted are responsible for traffic control.

6. Facility Overview report & Transportation Evacuation Survey

i. Facility Overview Report - Information included in the VHASS provides emergency responders and planning partners with additional information about each facility. This includes key phone numbers to the facility, pre-designated Stop Over Points and healthcare facility evacuation sites. Additionally, this provides the total number of residents a facility could have at maximum occupancy. This provides emergency response agencies and other LTC-MAP Member facilities with a general impact that each facility has on statewide bed capacity.

ii. Transportation Evacuation Report - Information included in the VHASS provides a transportation evacuation report to inform EMS and other agencies of the total number of residents, their required means of transportation, and any unique information to support the residents during transit.

7. DSF Internal Resident Prioritization

For internal full building evacuation plans, DSF should work with EMS to review how many residents can be moved per hour down the stairs in the event the elevators are non-operational. This assists EMS in knowing the resident volume they need to move over specific periods of time. Estimates should also be taken for standard resident movement using elevators and stairs for evacuation purposes.

NOTE: This is a recommended approach and not required by the LTC-MAP or MOU.

F. Electronic Health Records

All Virginia facilities are moving toward or have fully implemented EHR systems. If EHRs are currently in place, it is still critical that a strong effort be made to provide a clear and concise Resident Emergency Evacuation Form if access to the computers is limited and you are the Disaster Struck Facility (DSF). Facilities will have to determine their most efficient method of transferring EHRs to a RAF, but in all cases the evacuating resident will need to have Facility wristbands and Resident Emergency Evacuation Forms.

1. Considerations for Internal Evacuation Planning & EHRs

i. Can the EHR vendor provide a simple "Disaster Print-out" of information needed to mirror the Resident Emergency Evacuation Form?

ii. When advance notice of a potential disaster is provided, ensure your Emergency Operations Plan includes provisions for what information should be printed in hard copy in advance of the weather event or other potential event (strike event, etc.). At a minimum, this should include the Face Sheet and MAR.

iii. Priority Order for an evacuation to ensure proper Medical Record documentation is sent with the resident:

- Batch print information on the unit or in one select area
- Grant access to other healthcare facilities
- Send staff to remote locations or to Resident Accepting Facilities (RAF) to access (bringing laptops that have been set-up in advance is optimal)
- Send information electronically to a RAF (potential HIPAA issues).

iv. Can the EHR be accessed and printed from an outside location? If yes, the facility's internal full building evacuation plan should address the steps necessary to secure access. Usually, this is accessed via a physician portal or other IT means, with the DSF granting access to the receiving facility.

- It is recommended that the IT teams from each of the receiving facilities be briefed by the DSF on what options there are to access records.

a. Consideration should be given to controlling the firewall at the RAF and IT should be consulted if the firewall becomes an issue in accessing information on the resident.

- A representative from the DSF may be sent to the RAF to assist with accessing information.

v. Is there independent emergency generator back-up to run the server(s), computer(s), and printer(s) that provides the facility the ability to print out the records?

vi. Can batch printing be completed by the facility:

- Either at one central location OR on the evacuating floor?
- In the event the floor does not have printing capability at the time?
- If the floor is overwhelmed with providing resident care and needs an alternate location to print out each record?

2. Consideration for Downtime Procedure Planning & EHRs

If a clinical team from the DSF will be taking over a unit at the RAF, the RAF should review moving to downtime procedures to ensure that resident care is the primary focus, and not the short-term re-education of the clinical team on a computer system.

i. The facility should consider downtime procedures if they are not going to be admitting the resident (if "sheltering" or using the surge capacity plan to exceed licensed beds). This either requires downtime procedures or an override field that will not submit the MDS information to Medicare or information to Medicaid.

G. LTC-MAP Tracking Sheets/Tools

1. Resident Emergency Evacuation Form (Appendix C)

Supplies critical information on the resident to enable care to start for the evacuated resident until the "chart" can be reviewed. It should be pinned to the residents' clothing, on their backs or other locations where it cannot be lost. These forms should also be used on a day-to-day basis for the transfer of residents between facilities. Copies of this form are:

i. One Copy: Retained by the Resident Accepting Facility with a copy made for any local, regional, or state groups involved with tracking support
ii. Second Copy: Retained by EMS
iii. Third Copy: Retained by the Disaster Struck Facility (DSF)

The Resident Accepting Facility (RAF) continues tracking of incoming residents, using the Comment Field on the Face Sheet (inserting the previous MR# and Disaster Tag # into that field). The RAF also should be tracking the location of their original charts. They keep the DSF advised by contacting them to confirm the residents' arrival.

2. Resident / Medical Record / Staff / Equipment Tracking Sheet (Appendix B)

The Resident / Medical Record / Staff / Equipment Tracking Sheet is intended to track residents, their medical records, and their equipment as the residents leave the DSF.

The fields should be used to capture aggregate resident data for anticipated transportation locations and sent to the RAF for verification of receipt of the residents.

i. A sheet should be filled out for each RAF that is receiving one or more of the residents. Additionally, if multiple residents are being discharged to home, several sheets could be used for "discharge to home" and note the vehicle they left in, if possible, to minimize the risk to the DSF. The bottom sheet or a copy of the tracking sheet is kept by the DSF as a record of where the residents have been sent.
ii. It is important that the Resident Accepting Facility (RAF) continue this tracking process when receiving residents. The final column on the form should be used to confirm time of residents' arrival. The RAF should confirm the arrival of the residents with the Disaster Struck Facility (DSF) and the RHCC.

3. Influx of Residents Log (Appendix E)

The Influx of Residents Log should be completed at the intake point for the residents at the RAF. This will mirror the Resident / Medical Record / Staff / Equipment Tracking Sheet. The RAF will then have a clear understanding if they have accountability for all residents they are supposed to have received.

4. Controlled Substance Receiving Log (Appendix F)

The Controlled Substance Receiving Log must be completed for each resident by a licensed health care professional at the RAF and must also be utilized for larger volume movement of pharmaceuticals facility to facility.

5. The LTC Tracking Board (Appendix G)

The LTC Tracking Board (Aggregate) should be completed by the RHCC and/or by the DSF to have complete tracking for all residents and resource/asset needs. Final confirmation of the exact location of the residents is verified between groups via the information on the Influx of Residents Log, which is matched against the Resident / Medical Record / Staff / Equipment Tracking Sheet. This aggregate tool is used to ensure that no resident is misplaced and to support coordination between the DSF, the RAF, and the RHCC.

6. Resource Requests

Resource Requests (Supplies, Equipment & Pharmaceuticals) should be made to the RHCC via VHASS and/or regional protocols. Facilities may also use the Resource Request Form (Appendix H).

H. Other Tracking Tools/Documents

1. Medical Record/Chart

When a new medical record number is assigned to the resident (due to a new resident medical record/chart being started), this should be noted on the Tracking sheet by the RAF.

i. RAF should “flag” these charts either physically or electronically to aid in tracking/documenting residents cared for during an evacuation.
ii. The chart must be safely kept for return to the DSF at the appropriate time.

2. Commonwealth of Virginia Triage Tags and (Northern Region) Washington Metropolitan Area Disaster Tags:

These tags are on Emergency Medical Services vehicles and may be used in the event of an evacuation. They contain basic resident (“patient”) identification information and, most importantly, provide a unique “Patient Number” with corresponding stickers (with numbers and barcode) to be used for resident tracking and as part of the VHASS resident tracking system.

i. The tags should be attached to each evacuating resident. The unique identifying number and barcode stickers shall be affixed to each Resident Emergency Evacuation Form, medical charts, personal belongings, etc.

3. VHASS Resident Tracking System

There is a Resident Tracking System module in the VHASS. The system is intended to be used by facilities in the event of an evacuation. There are two primary purposes of the system: (1) to provide situational awareness of the numbers and types of evacuees and their Resident Accepting Facilities (RAFs) to the RHCC and all LTC-MAP member; and (2) to provide the data needed to support regional efforts to reunify residents and family / loved ones.

When operating under emergency operations, the DSF is encouraged to enter all evacuating residents into the VHASS Resident Tracking System. The RHCC will remind DSFs of this request once activated. DSFs can provide this resident information to the VHASS Resident Tracking System in one of two ways: (1) through an interface between their normal registration systems [this interface must be developed and tested before the emergency]; or (2) directly through the VHASS located at www.vhass.org.

Due to HIPAA regulations there are strict rules in place about which organizations in the VHASS can see what types of resident data. LTC-MAP member users who have been given Resident Tracking System rights can see identifiable resident data on all residents registered in the VHASS Resident Tracking System for their facility. The RHCC can see resident data (that is NOT individually identifiable health information) for the entire region. The Virginia Department of Health, The Virginia Hospital & Healthcare Association 2-1-1 Virginia can see de-identified resident information but only when they are functioning as a Family Assistance Center (FAC) for the purposes of reuniting family members and loved ones with residents.
To facilitate the tracking process LTC-MAP members should make every effort to input the following data elements on residents entered into the VHASS resident tracking system:

i. For residents that can be identified by name:
    - First and Last name + at least one of the following:

a. Age
b. Date of birth
c. Race
d. Height Weight
e. Eye Color
f. Last 4 digits of SSN

ii. For residents that cannot be identified by name:
- The following information at a minimum:
  a. Date of Birth
  b. SSN (last 4)
  c. Race
  d. Height & Weight
  e. Eye Color
  f. Distinguishing marks

iii. Additional information that may be entered but will not be utilized to locate a patient:
- Sex
- Status (ambulatory, wheel chair, etc.)
- Disposition (transferring, admitted)
- Acuity level
- Estimated Stay (in days)

Once it has been concluded that the incident is over and the data in the VHASS Resident Tracking System is no longer needed, the resident data in the system will be deleted as to conform to current HIPPA regulations.

I. Suggested "Go-Kit" for evacuation/Influx or Surge

Note that all of these supplies should be kept in an immediately accessible area and be marked as disaster supplies:

- Trash bags or other waterproof containers that residents' medications, records, and basic personal belongings could be transported in
- gallon bags that seal to be tamper-evident for medication
- Resident Emergency Evacuation Forms – enough for all resident
- Resident / Medical Record / Staff / Equipment Tracking Sheets (have at least 1 sheet for every 3 residents – 33% of your beds)
- Influx of Residents Log (enough for 10% of your licensed beds)
- Controlled Substances Receiving Log (enough for 10% of your licensed beds)
- Blank wrist-bands with "lab" labels (enough for all residents)
- Permanent markers and other writing materials
- Other materials as directed by your Emergency Operations Plan

Staff, Pharmaceuticals, Supplies, and Equipment

A. General

1. This section provides the framework for Borrower and Lending facilities to share resources. A Borrower is the Disaster Struck Facility (DSF) and Lender is the non-affected facility providing resources and assets to other DSF.
2. These resources may be needed by:
    i. A DSF that is not evacuating, but is overtaxed by the disaster and in need of support
    ii. A Resident Accepting Facility (RAF) that requires additional resources to handle the influx of residents (beds, linens, pharmaceuticals, staff, etc.).
    iii. A Stop Over Point to which a DSF has evacuated.
3. It is important for facilities to provide realistic orders to suppliers. In certain disasters, facilities order a complete duplicate of their previous order, thus receiving more supplies and pharmaceuticals than needed. The ripple effect is that a vendor may fill an order for a facility when another member has greater needs at that time. Working together is a key to success, and integration through the LTC-MAP and through the RHCC will assist with the prioritization of resources.
4. VHASS (www.vhass.org): It is the intent for the facilities to utilize the website (under reports) for a general listing / inventory of available supplies and equipment along with vendors to support other LTC-MAP member facilities. It is the responsibility of the facilities to update their surge information based on request or on an as-needed basis and to print a hard copy of information on an annual basis to ensure that the paper copy of information from the website is available in the event of a systems failure during a disaster.
5. Special Transportation and Supply Considerations for Vendors and Governmental Agencies: There are three primary concerns in dealing with disaster transportation of supplies to LTC-MAP member facilities:
    i. Elevated requests that overwhelm the inventory of the suppliers
    ii. Inability to communicate with the member facility.
    iii. Verification of safe and accessible routes to the DSF or RAF.

B. Requesting Resources

1. Follow the LTC-MAP Activation Algorithm (Appendix A) for resource request procedures.
2. Attempts should be made to fill resource request through pre-existing contracts or other facilities and vendors.
3. If a facility is unable to secure resources information regarding immediate needs should be provided to the RHCC who will in turn work with member facilities and Local Emergency Management (usually via ESF 8) to identify/secure resources
4. Resource Requests can be made verbally but should be followed up with written documentation via the Resource Request Form (Appendix H) or similar document.

i. Written documentation may be used at police road blocks as these resources are being sent to your facility. Appropriate communication with the Emergency Operations Center (EOC) should be completed to ensure they can inform the appropriate authorities of the resource/assets that should be allowed to access the facility (*NOTE: Access may still be denied by authorities*).

C. Staff Assistance

1. Communication of Request

Borrowing Facilities should clearly document their resource needs to the RHCC via the resource request procedures in their respective RHCC emergency operations plan. A Borrowing Facility may make a verbal request to the RHCC to borrow staff from another Participating Facility to expedite the process; however, a written request should be submitted as soon as possible and prior to Demobilization.

The Borrowing Facility's request shall include:

- The type and number of staff requested,
- How quickly staff are needed,
- Logistic information (parking, where to report, and who to report to), and
- How long staff will be needed.

The Lending Facility will provide:

- A list of names and credentials of the borrowed staff.

Staff should not be requested from a facility that is involved in an active disaster. If the Lender's staff is at your facility when their facility goes into disaster activation, they must be allowed to return at once, if requested. It is recommended that LTC-MAP facilities prepare to create and deploy integrated clinical and non-clinical teams. These would either be off-duty staff responding to the facility or on-duty teams where staff call-backs are initiated and once the responding staff arrives, the facility is able to deploy the on-duty teams.

2. Documentation

The arriving personnel are required to present two forms of identification including their facility identification badges at the Borrower's facility and should also bring a copy of their background checks and other credentialing / privileging information available from their employer, if available. The Borrower is responsible for the following:

i. Meeting the arriving personnel from a Lender facility and signing them into the facility (sign out will also be required);
ii. Confirming each person's ID badge and Picture ID against the list of personnel provided by the Lender facility;
iii. Providing additional identification, such as "visiting personnel" badge, per facility policy, to the arriving personnel;
iv. If possible, conducting an independent background check.

v. You have the right to reject any and all arriving personnel.

3. Supervision

The Borrower's Administrator or designee identifies where and to whom the personnel are to report, and professional staff who will supervise them.

i. Borrowers shall provide a baseline orientation for the arriving personnel to the facility (similar to how "Traveler" or Temporary Staff is handled).

4. Demobilization Procedures

The Borrower coordinates any necessary demobilization procedures and post-event stress debriefing. The Borrower is responsible for providing the personnel transportation necessary for their return to the Lender facility, all documentation of hours worked while on-site, and copies of the sign-in/sign-out sheets.

5. Disaster Credentialing and Privileging

i. The Borrower accepts the professional credentialing determination of the Lender facility, but only for those services for which the personnel are credentialed for and have privileges to provide at the Lender facility. Additionally, the Borrower accepts the professional credentialing determination of the Lender facility only if those privileges do not conflict with privileges provided for similar positions in the Borrower facility.

ii. Each LTC-MAP member facility should have an internal procedure for credentialing of emergency providers / volunteers and granting of temporary privileges in a disaster. These internal procedures should follow the base requirements from The Joint Commission (best practice) and VDH. In order to activate these internal procedures, the facility's Emergency Operations Plan has to be activated. The facility Administrator or designee must determine that the facility is unable to handle the immediate resident needs with their existing staff.

iii. The lending facility shall ensure that the records of all transferred healthcare workers comply with requirements applicable to the lending facility, including licensure and accreditation requirements for healthcare professionals. To the maximum extent possible, the lending facility shall provide the requesting facility with copies of deployed healthcare professionals' credentialing documents to facilitate the granting of emergency staff privileges.

iv. This overall emergency credentialing and privileging with extend for 72 hours and be reassessed at that time.

v. Considerations:

- Some of the baseline Background Check information the facilities should consider include:
    a. OIG Exclusion List
    b. Virginia Department of Health Professions: http://www.dhp.virginia.gov
    c. DHP License Look-up: https://dhp.virginiainteractive.org/

d. Sex Offender Registry: http://sex-offender.vsp.virginia.gov/sor/
e. State Police Background Check (longer process): http://www.vsp.state.va.us/FormsPublications.shtm

vi. All volunteers should have a facility ID badge affixed to them and be signed in to the facility. All outside volunteers should also wear a facility nametag and have two picture IDs with them at all times.
vii. The LTC-MAP facilities, in collaboration with VDH, may use any standardized systems for verifying the credentials of long-term care providers once the systems are in place.
viii. The Joint Commission Emergency Credentialing Standards, these standards provide a good base for best practices; however, are not required unless enforced by the VDH or your accrediting agency (Appendix I).

D. Supplies and Equipment Requests

1. Communication of Request

When requesting supplies or equipment the Borrower should provide the following:

i. The quantity and exact type of requested items
ii. Time estimate of when supplies/equipment are needed on-site
iii. Time period for when the supplies/equipment are needed
iv. Location where the supplies/equipment should be delivered

The vendor or Lender identifies how long it will take them to fulfill the request. Since response time is a central component during a disaster response, decision and implementation should occur quickly.

2. Documentation

The Borrower should honor the vendor or Lender facility's standard order requisition form as documentation of the request and receipt of the materials. The Borrower's designee confirms the receipt of the material resources. The documentation details the following:

i. The items involved
ii. The condition of the equipment prior to the loan (if applicable)
iii. The responsible parties for the borrowed material.
iv. The Vendor or Lender is responsible for tracking the borrowed inventory through their standard requisition forms. Upon the return of the equipment, the original invoice is co-signed by the senior administrator or designee of the Borrower, recording the condition of the borrowed equipment.

3. Transporting of supplies or equipment

The Borrower is responsible for coordinating the transportation of materials both to and from the vendor or Lender. The appropriate EOC/RHCC will support this coordination process. This coordination may involve government and / or private organizations and the vendor or Lender may also offer transport. The Borrowing Facility is responsible for

all costs associated with transportation including handling and loading of any borrowed equipment.

4. **Safety (equipment)**

   The Lender is responsible to verify the operational status and preventative maintenance for all equipment being transported to the Borrower. All reporting requirements, policies, procedures, and documentation following receipt of the equipment (e.g., Safe Medical Devices Act) are the responsibility of the Borrower.

5. **Supervision**

   The Borrower is responsible to ensure appropriate staff competency for use and maintenance of all borrowed supplies and equipment.

6. **Demobilization procedures**

   The Borrower is responsible for the rehabilitation and prompt return of the borrowed equipment to the vendor or Lender. To facilitate this, all facility equipment should be properly identified.

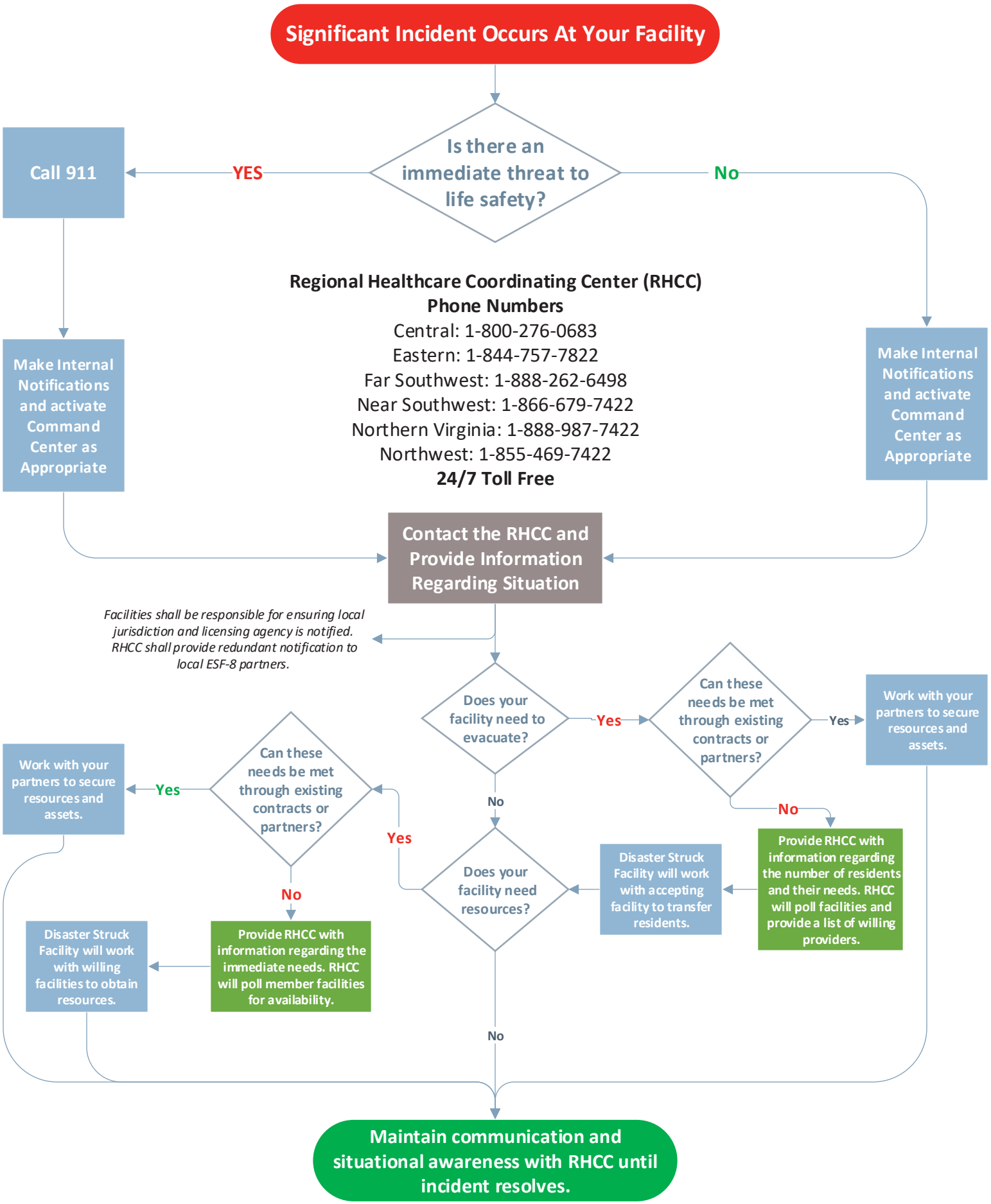
E. Pharmaceutical Requests

Pharmaceuticals follow the same process as supplies and equipment with the exceptions seen in the Section 3 - Evacuation.

1. For a DSF that is not evacuating but is overtaxed by the disaster and in need of emergency support:
   a. The DSF requests emergency support from the residents' primary pharmacy followed by other area pharmacies.
   b. If response is inadequate to meet the facility's needs, the DSF requests emergency support from pharmaceutical suppliers within the region and their regional or national supply chain via the RHCC.
   c. If response is inadequate to meet the facility needs, the DSF requests emergency support from other area facilities. Depending on the severity of the incident, police and security measures should be taken into account to safeguard medications.
2. For a RAF in need of emergency support:
   a. The RAF initially requests emergency support from residents' primary pharmacy followed by other area pharmacies.
   b. If response is inadequate to meet the facility needs, the RAF requests emergency support from:
      i. Pharmaceutical suppliers within the region and their regional or national supply chain via the RHCC
      ii. Other area facilities. Depending on the severity of the incident, security measures should be taken into account to safeguard medications.

      Note: it is expected resident medications will arrive with the evacuated resident and this is primarily referencing controlled substances.

LTC MAP Activation Algorithm



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VIRGINIA RESIDENT/MEDICAL RECORD/STAFF/EQUIPMENT TRACKING SHEET

THIS PORTION TO BE COMPLETED BY EVACUATING/SENDING FACILITY

Sending Facility: ____
Contact Person: ____
Tel (_____) ______________________ Fax (______) _______________________

Receiving Facility: ____
Contact Person: ____
Tel (_____) ____________________ Date/Time Called: ______________

Resident	*Contact Information (Note Date & Time Contacted)*	*Sent with Resident (Check all that apply)*	*EMS or Bus Company Name & Vehicle ID*	*Time Vehicle Departed*	*Time Arrived/Left Stop Over Point*	*Time/Date Arrived* **RECEIVING FACILITY TO COMPLETE**
Name: ______________________ MR or Tracking # __________________ Sex: ☐ M ☐ F DOB: ____/____/_______	*Family Contact*: _________________ Tel (____) _____________________ Date/Time: _____________________ *Physician*: _____________________ Tel (____) _____________________ Date/Time: _____________________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: _________________ ____________________________ ____________________________ ☐ Staff (Name):_______________ ____________________________			A: L:	
Name: ______________________ MR or Tracking # __________________ Sex: ☐ M ☐ F DOB: ____/____/_______	*Family Contact*: _________________ Tel (____) _____________________ Date/Time: _____________________ *Physician*: _____________________ Tel (____) _____________________ Date/Time: _____________________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: _________________ ____________________________ ____________________________ ☐ Staff (Name):_______________ ____________________________			A: L:	
Name: ______________________ MR or Tracking # __________________ Sex: ☐ M ☐ F DOB: ____/____/_______	*Family Contact*: _________________ Tel (____) _____________________ Date/Time: _____________________ *Physician*: _____________________ Tel (____) _____________________ Date/Time: _____________________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: _________________ ____________________________ ____________________________ ☐ Staff (Name):_______________ ____________________________			A: L:	
Name: ______________________ MR or Tracking # __________________ Sex: ☐ M ☐ F DOB: ____/____/_______	*Family Contact*: _________________ Tel (____) _____________________ Date/Time: _____________________ *Physician*: _____________________ Tel (____) _____________________ Date/Time: _____________________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: _________________ ____________________________ ____________________________ ☐ Staff (Name):_______________ ____________________________			A: L:	
Name: ______________________ MR or Tracking # __________________ Sex: ☐ M ☐ F DOB: ____/____/_______	*Family Contact*: _________________ Tel (____) _____________________ Date/Time: _____________________ *Physician*: _____________________ Tel (____) _____________________ Date/Time: _____________________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: _________________ ____________________________ ____________________________ ☐ Staff (Name):_______________ ____________________________			A: L:	

Special Notes: ____
____

THIS PORTION TO BE COMPLETED BY RECEIVING FACILITY

INSTRUCTIONS: COMPLETE THIS BOX, THE FINAL COLUMN ABOVE, AND THE INFLUX OF RESIDENTS LOG.

Receiving Facility Name: ____ City: ______________________ State: ____
Person Completing Form: ____ Time Completed: ______________________
Did you communicate receipt of resident with the RHCC and Disaster Struck (Sending) Facility? □ **Yes** □ **No (if no, please do so now)**
Print Name of Primary Contact: ___________________________ Phone: _________________ Fax: _________________

A copy should be given to the RAF, EMS/Transportation, and the DSF **Send Copy to RHCC**

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VIRGINIA RESIDENT EMERGENCY EVACUATION FORM

(Barcode Label/Triage Tag – All 3 Copies)

_____

Triage Tag Number

Sending Facility: _____
Address: _____
Contact Name: _____ Title: _____
Tel (_____) _____

Receiving Facility: _____
Address: _____
Confirmed Sending with:
Name: _____ Title: _____
Tel (_____) _____ Date/Time Called: _____

Transport Via: ☐ ALS ☐ BLS ☐ Wheelchair Van ☐ Bus/Van

Resident Name *(last, first, middle initial)*:
_____
DOB: ____/____/_____ Sex: ☐ M ☐ F
Language: ☐ English ☐ Other _____
Alternate Communication: _____
Date Admitted (*most recent*): ____/____/_____
Critical Diagnosis: _____
Treatments: _____

Contact Person: _____
Relationship (*check all that apply*)
☐ Relative ☐ Health care proxy ☐ Guardian ☐ Other
Tel (_____) _____
Notified of transfer? ☐ Yes ☐ No
Aware of clinical situation? ☐ Yes ☐ No

Primary Care Clinician in Nursing Home
☐ MD ☐ NP ☐ PA
Name: _____
Tel (_____) _____
Facility Pharmacy: _____
Tel (_____) _____

Code Status: ☐ Full Code ☐ DNR ☐ DNI ☐ DNH ☐ Comfort Care Only ☐ Uncertain ☐ Other (attach advanced directives or DNR)

MEDICATIONS ☐ MAR Attached

DRUG, STRENGTH, MODE	FREQUENCY	LAST GIVEN	DRUG, STRENGTH, MODE	FREQUENCY	LAST GIVEN
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Key Clinical Information:
Relevant diagnoses: ☐ CHF ☐ COPD ☐ CRF ☐ DM ☐ CA: _____ ☐ Other: _____
Vital Signs: BP: _____ HR: _____ RR: _____ Temp: _____ O2 Sat: _____ Time taken (*am/pm*): _____
Most recent pain level: _____ (☐ N/A) Pain location: _____
Most recent pain med: _____ Date given: _____/_____/_____ Time: (*am/pm*): _____

Usual Mental Status: ☐ Dementia
☐ Alert, oriented, follows instructions
☐ Alert, disoriented, but can follow simple instructions
☐ Alert, disoriented, cannot follow simple instructions
☐ Not Alert

Behavior Problems / Safety Risk: ☐ None
☐ Elopement
☐ Verbally Aggressive
☐ Physically Aggressive / Harm to self or others
☐ 1:1 Supervision (Consider evac to Hospital)

Isolation Precautions: ☐ None
☐ MRSA ☐ VRE Site: _____
☐ C.difficile ☐ Norovirus
☐ Respiratory virus or flu
☐ Other: _____

Devices and Treatments:
☐ O2 Rate: _____ L/min ☐ Nasal Cannula ☐ Mask(☐ Chronic ☐ New)
☐ Maintain O2 Sat. above: _____ ☐ Nebulizer therapy (☐ Chronic ☐ New)
☐ CPAP Settings: _____ ☐ BiPAP settings: _____
☐ Pacemaker ☐ IV (Access Type: _____) ☐ PICC line
☐ Bladder (Foley) Catheter (☐ Chronic ☐ New)
☐ Internal Defibrillator ☐ Speaking Valve
☐ Trach size: _____ Sx: _____ Frequency: _____
☐ Vent Settings: _____ ☐ Other: _____

Risk Alerts:
☐ Allergies (*food/meds*): _____
☐ Anticoagulation ☐ Falls ☐ Seizures ☐ Limited/non-weight bearing (☐ L ☐ R)
☐ Swallowing / Aspiration precautions ☐ Needs meds crushed
☐ Skin/wound care: _____ ☐ Needs special mattress
☐ Pressure ulcers (stage, location, appearance, treatment):
_____
☐ Other: _____

DIET: ☐ Regular Diet
☐ Diabetic: Last Insulin _____ Last Meal _____
☐ Religious Restrictions: _____
☐ Thickened Liquids Consistency: _____
☐ NPO ☐ Modified Diet _____ ☐ Meal Assist
☐ Enteral Feeding or TPN Type _____ Rate _____ Daily amount: _____

ADLs (I = Independent D = Dependent A = Needs Assistance)

	I	D	A
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Toileting	☐	☐	☐

Incontinence:
☐ Bladder ☐ Bowel

☐ Can ambulate independently
☐ Assistive device (if applicable):
_____
☐ Needs human assistance to ambulate
Transfers: ☐ Independent ☐ Needs supervision
☐ Partial assist ☐ Total assist

Attachments:
☐ Face Sheet ☐ MAR ☐ TAR (treatments) ☐ POS (doctor's orders) ☐ Pertinent Labs ☐ X-rays, EKGs, scans
☐ Surgical Reports ☐ Copy of Signed DNR Order ☐ Original DDNR ☐ Advance Directives
☐ Skin Guide ☐ Other: _____

Personal Belongings Sent With Resident:
☐ Eyeglasses ☐ Hearing Aid
☐ Dental Appliance ☐ Jewelry
☐ Other: _____

Form Completed By (*name/title*): _____ **Signature:** _____
Report Called in By (*name/title*): _____
Report Called in To (*name/title*): _____ Date: ____/____/_____ Time (*am/pm*): _____

Additional Relevant Information:
_____
_____
_____
_____
_____
_____

A copy should be given to the RAF, EMS/Transportations, and the DSF

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NURSE / PHYSICIAN DECISION-MAKING GUIDANCE:

Assigning Patient Transport Mechanism Based on Clinical Criteria

(Note to clinicians: Use a simple concept – if you were sending the resident out for a test today, what level transport would they need)

a. Patients requiring *Critical Care Transportation* (RN-staffed or Advanced-trained Paramedic)

- IVs with medications running that exceed paramedic capabilities
- IV pump(s) operating (can be provided by the transport crew)
- Need any medications administered via Physician orders by any means in any dosage prescribed
- Cardiac monitoring/pacing (only external pacing can be provided by the transport crew) / intra-aortic counter pulsation device / LVAD
- Neurosurgical ventricular drains
- Invasive hemodynamic monitoring which cannot be temporarily or permanently discontinued (i.e. intra-arterial catheter if noninvasive blood pressure have not been reliable for Patient, they are hemodynamically unstable, and they have a continuing chance of survival.)

b. Patients requiring ALS transport (Paramedic/Intermediate)

- IVs with medication running that are within local/regional protocol
- IV pump(s) operating
- IV with clear fluids (no medications)
- Ventilator dependent (vent can be provided by the transport crew or home vent)
- Need medications administered via Physician orders by limited means in dosage prescribed
- Cardiac monitoring/pacing (only external pacing can be provided by the transport crew)
- BVM only in transport
- Prone or supine on stretcher required.

c. Patients requiring BLS transport (EMT)

- O2 therapy via nasal cannula or mask (can be provided by the transport crew)
- Saline lock and Heparin lock
- Visual monitoring / Vitals (BP/P/Resp)
- Prone or supine on stretcher required or unable to sustain
- If Behavioral Health, provide information regarding danger to self or others.

d. Patients requiring Wheelchair Van/Bus (Medically knowledgeable person to ride on the transport)

- No medical care or monitoring needed, unless they have their own trained caregiver rendering the care.
- Not prone or supine, no stretcher needed.
- No O2 needed, unless resident has own prescribed portable O2 unit safely secured en route.
- If Behavioral Health, provide information regarding danger to self or others.

NOTE: Some wheelchair van companies provide a standard wheelchair, if needed, for the duration of the trip. Buses do not provide wheelchairs. Some electric wheelchairs cannot be secured in wheelchair vans due to size or design. These are NOT to be transported with the resident.

e. Patients requiring Normal Means of Transport (typically a bus – resident must be limited assist transfer or no assist required – Medically knowledgeable person to ride on the transport)

- No medical care or monitoring needed, unless they have their own trained caregiver rendering the care.
- No O2 needed, unless resident has own prescribed portable O2 unit that can be safely secured en route.
- Not prone, supine, or in need of a wheelchair (can ambulate well enough to climb bus steps)
- If Behavioral Health, provide information regarding danger to self or others.
- Limited assist transfers or no assist required.

NOTE: A person with a folding wheelchair, who can ambulate enough to get in and out of a car, could go by car if there was room to bring/pack the wheelchair.

f. Patients requiring bariatric ambulance or transport (A good base is to start at >350lbs.)

- Ensure communication of specifics with your transportation provider. Height, weight, BMI, etc.

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VIRGINIA INFLUX OF RESIDENTS LOG

RECEIVING FACILITY INSTRUCTIONS: COMPLETE AND MATCH AGAINST RESIDENT/MEDICAL RECORD/STAFF/EQUIPMENT TRACKING SHEET

Resident	*Sending Facility (Facility Received From)*	*Contact Information (Note Date & Time Contacted)*	*Received with Resident (Check all that apply)*	*Time/Date Arrived*	*Time Left Triage (T) / Destination (D)*
Name: ________ MR or Tracking # ________ Sex: ☐ M ☐ F DOB: ____/____/_______		*Family Contact*: ________ Tel (____) ________ Date/Time: ________ *Physician*: ________ Tel (____) ________ Date/Time: ________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ________ ________ ________ ☐ Staff (Name):________ ________		T: D:
Name: ________ MR or Tracking # ________ Sex: ☐ M ☐ F DOB: ____/____/_______		*Family Contact*: ________ Tel (____) ________ Date/Time: ________ *Physician*: ________ Tel (____) ________ Date/Time: ________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ________ ________ ________ ☐ Staff (Name):________ ________		T: D:
Name: ________ MR or Tracking # ________ Sex: ☐ M ☐ F DOB: ____/____/_______		*Family Contact*: ________ Tel (____) ________ Date/Time: ________ *Physician*: ________ Tel (____) ________ Date/Time: ________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ________ ________ ________ ☐ Staff (Name):________ ________		T: D:
Name: ________ MR or Tracking # ________ Sex: ☐ M ☐ F DOB: ____/____/_______		*Family Contact*: ________ Tel (____) ________ Date/Time: ________ *Physician*: ________ Tel (____) ________ Date/Time: ________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ________ ________ ________ ☐ Staff (Name):________ ________		T: D:
Name: ________ MR or Tracking # ________ Sex: ☐ M ☐ F DOB: ____/____/_______		*Family Contact*: ________ Tel (____) ________ Date/Time: ________ *Physician*: ________ Tel (____) ________ Date/Time: ________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ________ ________ ________ ☐ Staff (Name):________ ________		T: D:

Special Notes: ____
____

Receiving Facility Name: ________________________ City: ________________ State: ____

Person Completing Form: ________________________ Time Completed: ________________

Did you communicate receipt of resident with the RHCC and Disaster Struck (Sending) Facility? ☐ **Yes** ☐ **No (if No, please do so now)**

Print Name of Primary Contact: ________________________ Phone: ____________ Fax: ____________

A copy should be given to the DSF/Sending Facility and EMS / Transportation **Retain a copy for your records** **Send Copy to RHCC**

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CONTROLLED SUBSTANCE RECEIVING LOG – FACILITY TO FACILITY TRANSFER

DATE: _____ **FACILITY SENDING MEDICATION:** **FACILITY RECEIVING MEDICATION:**

_____ _____

PATIENT'S NAME (if applicable): _____ **DOB: _____**

NAME OF MEDICATION		AMOUNT RECEIVED	VERIFICATION (PRINT)	VERIFICATION (SIGNATURE)

Prescriber's Name: _____ *Signature of Licensed HCP Receiving: _____

*Printed Name: _____

When receiving: Record the date, facility received from, the amount of medication received and then sign off for each. A copy of the **Narcotics Log / Proof of Use** sheets from the Disaster Struck Facility will be cross-referenced after being received from the Disaster Struck Facility.

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Who is Responsible for Communication (note Name of Individual)	Last Updated (Note via Phone or VHASS Status Reporting)	Reg	Operational Issues Y / N (if Yes - Type of Issue)	Facility Name	Facility City	Contact Phone #	Bed Type	# Licensed Beds	# Open Beds	Male	Female	Either	Vent	Dementia Secured	RAF Notified Residents Coming Y / N (Verify if DSF Sent Resident / MR / Equip Tracking Sheets to RAF)	Number of Residents Sent to RAF / Time	Number of Residents Arrived at RAF / Time (Residents Names Verified Y / N)	Resources You Can Provide to Others (e.g. Transportation, Supplies, Equipment, Staff)	Resources Your Facility Needs	Status of Resource Request (Completed, Open, Etc.)

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RESOURCE REQUEST FORM

1. Incident Name:	2. Date/Time:	3. Resource Request Number:

REQUESTOR

4. Order (Use additional forms when requresting different resource sources of supply):

QTY	KIND	TYPE	Detailed Item Description (special info, brand, specs, size, etc.):	Arrival Date & Time:		COST
				REQUESTED	ESTIMATED	

5. Requested Delivery / Reporting Location:		
6. Suitable Substitutes and/or Suggested Sources:		
7. Requested by Name/Position:	8. Priority:	9. Section Chief Approval:

LOGISTICS

10. Logistics Order Number:	11. Supplier Phone/Fax/Email:
12. Name of Supplier/POC:	
13. Notes:	
14. Approval Signature of Authorized Logistics Rep:	15. Date/Time:
☐ 16. Order Placed by (check box):	

FINANCE

17. Reply/Comments from Finance:	
18. Finance Section Signature:	19. Date/Time:

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The Joint Commission Emergency Credentialing Standards

Granting disaster privileges to volunteer licensed independent practitioners (LIPs).
The facility grants disaster privileges to volunteer LIPs only when the Emergency Operations Plan has been activated and additional staff is needed – General.
The medical staff identifies, in its bylaws, those individuals responsible for granting disaster privileges to volunteer LIPs.
The facility determines how it will distinguish volunteer LIPs from other licensed independent practitioners.
The medical staff describes, in writing, how it will oversee the performance of volunteer LIPs
Facility obtains his or her valid government-issued photo identification and at least one of the following: - A current picture identification card from a health care organization that clearly identifies professional designation. - A current license to practice. - Primary source verification of licensure. - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response facility or group. - Identification indicating that the individual has been granted authority by a government entity to provide resident care, treatment, or services in disaster circumstances. - Confirmation by a LIP currently privileged by the facility or a staff member with personal knowledge of the volunteer practitioner's ability to act as a LIP during a disaster.
The medical staff oversees the performance of each volunteer LIP.
The facility determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue.
Primary source verification of licensure occurs as soon as the immediate emergency situation is under control or within 72 hours.
If verification cannot be completed in 72 hours, document (all): - Reason(s) why it could not be performed within 72 hours of the practitioner's arrival. - Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services. - Evidence of the facility's attempt to perform primary source verification as soon as possible.
If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible - General.

During disasters, the facility may assign disaster responsibilities to volunteer practitioners who are NOT LIPs.
The facility assigns disaster responsibilities to volunteer practitioners who are not LIPs.
The facility identifies, in writing, those individuals responsible for assigning disaster responsibilities to volunteer practitioners.
The facility identifies how it will distinguish volunteer practitioners who are not licensed independent practitioners from its staff.
The facility describes, in writing, how it will oversee the performance of volunteer practitioners.
Prior to fulfilling their role, the facility obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and one of the following: - A current picture identification card from a facility that clearly identifies professional designation. - A current license, certification, or registration. - Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice). - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response facility or group. - Identification indicating that the individual has been granted authority by a government entity to provide resident care, treatment, or services in disaster circumstances. - Confirmation by facility staff with personal knowledge of the volunteer practitioner's ability to act as a qualified practitioner during a disaster.
The facility oversees the performance of each volunteer practitioner.
The facility determines within 72 hours after the practitioner's arrival whether assigned disaster responsibilities should continue.
Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice) of volunteer practitioners who are not licensed independent practitioners occurs as soon as the immediate emergency situation is under control or within 72 hours If primary source verification of licensure, certification, or registration for a volunteer practitioner cannot be completed within 72 hours due to extraordinary circumstances, the facility documents all of the following: - Reason(s) why it could not be performed within 72 hours of the practitioner's arrival. - Evidence of the volunteer practitioner's demonstrated ability to continue to provide adequate care, treatment, or services. - Evidence of the facility's attempt to perform primary source verification as soon as possible.
If, due to extraordinary circumstances, primary source verification of licensure of the volunteer practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible.