DISASTER READY

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Skilled Nursing Facility

BEHAVIORAL PILOT STUDY

COMMUNITY PARTNERS

ARIZONA DEPARTMENT OF HEALTH SERVICES
PREPAREDNESS

AHCA
ARIZONA HEALTH CARE ASSOCIATION
SINCE 1959

APRIL 2019

Table of Contents

Disaster Ready Skilled Nursing Facility Behavioral Pilot Study

Executive Summary & Recommendations

Pilot Impetus and Objective

The *Disaster Ready* (*DR*) program has been funded since 2011 by the Hospital Preparedness Program (HPP) Grant administered by the Arizona Department of Health Services (ADHS). The funding has been received and administered by the Arizona Health Care Association which has led the charge in development of the *Disaster Ready* model.

The seed for the *Disaster Ready* program was planted as a growing state and national concern emerged in the last decade regarding the degree of emergency preparedness of long term care facilities. There was a dawning recognition that some of our most vulnerable citizens reside in skilled nursing facilities (SNFs), where emergency preparedness was a priority.

The *Disaster Ready* program has evolved over the past eight years on all fronts, including the delivery of education, advocacy and technical assistance. Through the delivery of *Disaster Ready* technical assistance provided, we recognized the growing trend of behavioral care in long term care in Arizona. More individuals with chronic and serious mental illness and behaviors associated with advanced dementia were being served in SNFs. With this awareness, *unique concerns about evacuation and sheltering in place with a behavioral population* emerged. It became clear that the care of individuals with advanced dementia behaviors and mental health issues in a long term care setting **adds an extra layer of complexity to preparedness.** The time seemed right in 2018/19 to study this issue more intensively and create a roadmap for the future. In a national scan of resources, there was clearly a scarcity of behavioral long term care emergency preparedness resources. This white paper attempts to draw out the road map.

This pilot study concentrates on three skilled nursing facilities based in central Phoenix serving a high proportion of behavioral and gero-psych residents. Our essential goal was to **understand, evaluate and assess the unique emergency preparedness needs of skilled nursing facilities serving the gero-psych and behavioral resident population.** *Our assumption was that there may be a very specific need for disaster readiness for residents with long and short term mental health disorders and chronic behavioral issues*, and this pilot project was designed to consider if that was, indeed, the case. If it was determined to be so, our plan was to answer these questions:

- What gaps currently exist in their readiness?
- What additional resources, if any, are necessary?

This behavioral pilot study was conducted over a course of eight months in the 2018/2019 HPP grant year. The study design and final report includes an introduction and overview of behavioral care in long term care, and a detailed description of the study action steps. The implementation plan for the study was comprised of the following key components:

- Behavioral facility and resident profiles
- Behavioral facility emergency operations plan assessment and gap analysis
- Completion of a behavioral facility specific table top exercise, and
- Community outreach and stakeholder dialogue.

All of these components and their results are outlined in depth in the full behavioral pilot study final report attached.

Recommendations

1. **Recommendation:** ***The findings of this study indicate a need for further technical assistance for SNFs serving the behavioral population.*** The HPP grant should continue to address this need. Ideally, a "Behavioral Best Practice Tool Kit" should be developed addressing the components identified in these subsequent recommendations.

2. **Recommendation:** ***Ensure all behavioral SNFs have participated in Nursing Home Incident Command System (NHICS) training.*** The vast majority of all Arizona SNFs have participated at least once in NHICS training. However, it must be acknowledged that there is substantial turnover in long term care and new leadership and staff must all be trained in each facility. To address this turnover concern, developing a "Train the Trainer" model of NHICS would be valuable.

3. **Recommendation:** ***Behavioral facilities should evaluate their unique composition and location and create and implement additional Hazard Vulnerability Assessment (HVA) scenarios that are specific to their exposure.*** Implementing HVA scenarios that are finely tuned to their unique facility needs will increase their capacity to protect vulnerable behavioral residents in an emergency.

4. **Recommendation***: Create a version of the current NHICS 260 form that allows for specific information about behavioral residents to be noted on the tracking document.* This would include such information such as their elopement risk, propensity for violence toward others or self-harm and special environmental considerations to be addressed. This new tracking resource would also ensure a smoother transition of a behavioral resident to a new site following evacuation.

5. **Recommendation:** ***Ensure that all behavioral facilities have transfer agreements that may be executed locally. These agreements should ensure that there is similar behavioral care provided at the receiving facility.*** Meeting the basic regulatory compliance requirement to have *any type of transfer agreement* is insufficient for true preparedness for behavioral facilities. They must transfer to "like" behavioral facilities if at all possible. All behavioral facilities should have transfer agreements with each other, within reasonable geographic boundaries. It would also be helpful to have all transfer agreements identify payer sources and contracted health plans to assure synchronicity in payment.

6. **Recommendation:** ***All pilot and other behavioral facilities should be educated about the bed poll.*** The *Disaster Ready* program should monitor the degree of their participation in the statewide bed poll system to ensure acute and post-acute occupancy information is available to SNFs in a disaster scenario.

7. **Recommendation:** ***Behavioral facilities should register with their utility providers to receive advance warnings of outages in a given area.*** Most have a "Medical Care Preparedness Program" and provide this information to registered health care providers. (A sample link can be found at: https://www.aps.com/en/Pages/MedicalContactForm.aspx). Given the extreme heat, power outages rank high among the major disaster concerns of all Arizonans.

8. **Recommendation:** ***Clarify and educate SNFs on the need for a formal Memorandum of Understanding (MOU) with their regional coalition***. Some of the coalitions have both a "participation agreement" and a separate MOU. It seems that the participation agreements satisfy the compliance with state survey, but the MOU itself is critical in specifically identifying strategies for sharing resources between acute and post-acute partners in an emergency.

9. **Recommendation:** ***Review state or federal financial resources to assist qualifying facilities in securing generator upgrades.*** It is essential to go "beyond compliance" in protecting the health and welfare of the vulnerable behavioral population in a shelter in place scenario.

10. **Recommendation:** ***Provide additional training for first responders on SNF behavioral care. Connect behavioral care facilities to their local fire and police departments***. Most behavioral facilities are routinely in contact with first responders and tend to be considered "high utilizers" of these services. That said, resources may be necessary to further develop these strategic partnerships. First responders also acknowledge the need for education in managing the behavioral care population, and the lack of available resources to address this need.

11. **Recommendation:** ***The Disaster Ready program should work with clinical and regulatory experts to create a best practice protocol to reduce elopement risk during a disaster.*** Elopement is by far the greatest concern of all of the participating facilities. Behavioral residents generally are younger and more ambulatory, and the risk of elopement in a disaster scenario exponentially grows. This protocol could be a series of exercise scenarios, tips and tools for monitoring and staff training strategies specific to behavioral care facilities.

12. **Recommendation:** ***Create a forum for facility managers of behavioral facilities to connect and communicate*****, either through an on-line discussion group or regular in person meetings.** This will allow for sharing of resources and best practices among essential key leaders who are often overlooked.

13. **Recommendation*****: Identify mental health associations that have volunteer programs in place.*** Partnership with such an organization may be of benefit to behavioral care facilities. It may also be valuable to create a template of volunteer behavioral care training that facilities could employ.

14. **Recommendation:** ***Expand and evaluate emergency transportation agreements for behavioral SNFs.*** Transportation is a significant concern if evacuation is necessary. Some residents cannot sit next to each other or behaviors will erupt. Some residents are not mobile enough to board a bus and others would need a whole row of seats to ensure their compliance. Behavioral residents may also present significant medical complexity and be in need of durable medical equipment such as wheelchairs, walkers and oxygen. Transportation agreements with bus companies and partner organizations must be evaluated and expanded as necessary to address these additional concerns.

15. **Recommendation:** ***Behavioral SNFs should work with their electronic health record (EHR) vendor to ensure the ability to access the EHR in an emergency, within HIPAA guidelines.*** Not all SNFs utilize the same EHR program and access to medical records should be addressed in all transfer agreements. This is especially important due to the high rate of administration of psychotropic medications in this population. Participation in the regional Health Information Exchange (HIE) through Health Current is optimal, though few SNFs currently participate. Arizona is, however, moving steadily in this direction.

16. **Recommendation:** ***Acknowledge what is truly needed in emergency kits for behavioral care facilities.*** Every administrator reported that snacks and cigarettes were uniquely important in incentivizing and modifying behaviors for this specific population in a crisis. Most behavioral facilities currently allow for limited and supervised smoking, within regulations. Even with the incidence of special diets, snacks can also serve as an inducement. It is important to be realistic and ensure these are recommended items in all behavioral facility emergency kits.

17. **Recommendation:** ***Include necessary components of disaster readiness in existing behavioral care plans.*** Behavioral care plans for each individual resident are required by state and federal regulations and payer sources, but they do not always address specific strategies for managing these individual residents in an emergency situation. *Are there concerns about non-compliance for a specific resident in an emergency? Are there unique personal or medical items that should accompany the resident in an emergency transfer?* These types of issues could be further addressed in behavioral care plans and help assure and expedite care in a crisis.

18. **Recommendation:** ***Conduct an annual behavioral long term care facility table top exercise annually.*** The pilot study demonstrated value in bringing together like facilities in a table top exercise. Simulated practice in managing this population in an emergency is important. This will enhance coordination and crisis management when transfer to another behavioral facility is necessary.

19. **Recommendation:** ***Ensure frontline participation in all disaster readiness efforts in behavioral care facilities.*** Certified Nursing Assistants (CNAs) are the frontline, direct care staff in skilled nursing and they are universally acknowledged by administrators as the key to managing the behaviors of the residents they serve. Those frontline staff relationships are essential in ensuring compliance and personal safety for behavioral residents in an emergency. Yet, they are not always included in disaster readiness training, and/or advised of emergency preparation strategies. There should be ample orientation and training of all CNAs on disaster readiness. They are a crucial and irreplaceable component of successful management of behaviors in any catastrophic situation.

20. **Recommendation:** ***Initiate high level dialogue with Managed Care Organizations (MCO) leadership about emergency preparedness partnership with behavioral SNFs.*** MCOs pay for the vast majority of care in behavioral SNFs through Arizona's Medicaid program known as the Arizona Health Care Cost Containment (AHCCCS) program. Yet, the pilot study found a demonstrable lack of communication between facility and plan partners. There must be a directive from AHCCCS MCO leadership to drive change from the top down and ensure case managers are active participants in the emergency preparedness process. This is especially important in behavioral SNFs, given the distinctive vulnerability of the residents and the challenges of evacuation.

Conclusion

The pilot study of behavioral SNFs was a successful endeavor. It allowed us to closely examine the existing gaps in resources and potential for improvement in readiness. The cooperation of the three participating facilities is to be acknowledged and commended. They are true behavioral care pioneers and their investment of time and effort was the key ingredient in this success!

Moreover, we learned that the behavioral facilities are more alike than different from traditional skilled nursing facilities. They face the same concerns about preparedness and accompanying evacuation and shelter in place scenarios. They operate largely under the same regulatory model. *But what is strikingly different about these behavioral care SNFs is the vulnerability of the population they serve*. Resident profiles bear this out. These residents have all of the assumed medical complexity of skilled nursing residents, but the overlay of gero-psych conditions, mental illness and dementia behaviors make them extraordinarily different. More challenging to be sure. Given that, **this study speaks to a compelling need for further close examination of emergency preparedness strategies for behavioral facilities and the development of additional resources to assist these facilities in disaster readiness.**

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Skilled Nursing Facility

BEHAVIORAL PILOT STUDY

THE REPORT | APRIL 2019

Part I: Introduction, Background and Definitions

Historical Perspective on the Disaster Ready Program

The *Disaster Ready* (*DR*) program is funded by the Hospital Preparedness Grant administered by the Arizona Department of Health Services (ADHS). The seed for this program was planted as a growing national and state concern emerged regarding the degree of emergency preparedness of long term care facilities. There was a recognition that some of our most vulnerable citizens reside in skilled nursing facilities (SNFs). The exposure of this population was dramatically portrayed in 2005 with Hurricane Katrina and the devastation and death faced by nursing home residents in her path. This scenario was sadly repeated in the Joplin, Missouri Tornado that followed a few short years later. Arizona took note and began to consider the opportunity for inclusion of the post-acute sector in the HPP grant. In 2011, the first ADHS HPP funds targeted to long term care were granted to the Arizona Health Care Association, and the *Disaster Ready* program was born.

The Arizona Health Care Association (AHCA) is private nonprofit entity (501(c)(6) and is the state's largest association of long term care facilities. AHCA has been in existence since 1953, providing skilled nursing facilities and assisted living centers with regulatory guidance, clinical best practices, technical assistance in operations and legislative advocacy. The *Disaster Ready* service delivery target encompasses all licensed skilled nursing centers statewide, a scope including both AHCA member facilities and non-member facilities. There are currently 149 licensed SNFs in Arizona.

The initial effort of the *Disaster Ready* program in the first three years of the grant was an emphasis on "gap analysis" and understanding the current state of preparedness and identifying necessary resources to fill in the pinpointed gaps. The gap analysis results confirmed *what we already knew… that there was much work to be done to bring the skilled nursing facilities up to speed in readiness.* The grant efforts that followed focused on the delivery of technical assistance to address these identified needs.

As the program evolved over the years, the emphasis grew to address broader community involvement through the growing presence of health care partner coalitions serving geographic regions of the state. *Disaster Ready* began to actively engage SNFs in coalition participation and the potential for collaboration through development of Memorandums of Agreements, in case of emergencies. *Disaster Ready* "champions" were identified and recognized. Slowly but surely, long term care was invited to the table in all high-level health care preparedness dialogue, both at the state and local level. In the last decade, we have seen true leadership emerge in emergency preparedness within the long term care sector. These long term care individuals and companies view themselves, not just as part of the problem, but rather *as part of the solution* in disaster readiness. They also recognize collaboration across the health care continuum as an essential component to their success.

The last two years of the grant have continued to focus on:

- SNF Preparedness
- SNF coalition participation
- SNF compliance with the Centers for Medicare and Medicaid Services (CMS) Requirements of Participation
- Understanding and implementing new requirements for the development and implementation of emergency preparedness plans fits perfectly in the*Disaster Ready* program wheelhouse

One of the noteworthy trends in Arizona has been the development of behavioral care in long term care. In the *Disaster Ready* technical assistance provided, we have identified unique concerns about evacuation and sheltering in place with a gero-psych population. The care of individuals with advanced dementia and mental health issues in a long term care setting adds an extra layer of complexity to preparedness. The time seemed right in 2018/19 to study this issue more intensively in our grant deliverables and create a roadmap for the future. In a scan of resources nationally, there was clearly a scarcity of resources to add to the *Disaster Ready* portfolio of technical assistance.

***Thus, the impetus for our pilot study*: to understand and assess the emergency preparedness needs of long term care facilities serving the behavioral population and develop recommendations for necessary resources to ensure best practices are in place.**

Introduction of the Disaster Ready Behavioral Pilot Project Manager

Kathleen Collins Pagels is the Disaster Ready Behavioral Pilot Project Manager. Her duties in this role have encompassed the development and implementation of the project plan. As part of that effort, she met with individual participating facilities, researched their profiles, and met with their staff and residents. Kathleen is also responsible for the preparation of this final report describing the study components, results and recommendations.

Kathleen was the Executive Director of the Arizona Health Care Association from 2002 through 2018. In that capacity, she led the state of Arizona's largest long term care association, comprised of more than 200 skilled nursing facilities and assisted living centers. She acted as the association's chief lobbyist and was instrumental in advocating for AHCA's role in the receipt of HPP funds and the resulting development of the Disaster Ready program. She retired in April 2018 and now serves as a consultant to long term care companies on a state and national level through her firm, KC Pagels & Associates.

Kathleen has a Master of Social Work degree and Specialist in Aging certification from the University of Michigan. She has worked in the field of aging services for more than 40 years. Prior to her role with AHCA, Kathleen was the Director of Public Policy for the Alzheimer's Association- Desert Southwest Chapter. She has also worked for the Area Agency on Aging Region One, the Foundation for Senior Living and has been a college instructor in gerontology. Kathleen has also served on numerous legislative study committees, boards and commissions including Health Current, the State Medicaid Advisory Council, the Arizona Health Care Cost Containment System Skilled Nursing Facility Assisted Living Workgroup, the Governor's Roadmap to E Health Technology Taskforce,

the National Association of Health Care Assistants (NAHCA) Board of Advisors, the Coyote Crisis Coalition Board of Directors, the National Center for Assisted Living (NCAL) Board of Directors, the Governor's Advisory Council Legislative Coordinating Committee , the Maricopa Elder Abuse Alliance and the Behavioral Health and Aging Coalition.

Definitions

Skilled Nursing Facility (SNF):

A nursing facility in Arizona is licensed by the state through the Bureau of Long Term Care Licensing in the Division of Public Health Services, under the Arizona Department of Health Services. Skilled nursing facilities provide services to residents who require continuous medical care and nursing care and supervision due to physical and/or mental disability. In addition to state licensing, nursing facilities may be certified to provide services to eligible Medicare and Medicaid beneficiaries, and in order to do so nursing homes must meet federal regulations. The Bureau of Long Term Care licensing ensures compliance for state and federal regulations of nursing facilities by conducting regular surveys and complaint investigations. *(Bureau of Long Term Care Licensing "A Consumer's Guide to Nursing Homes" 2018, www.azdhs.gov.)* The *Disaster Ready* program currently focuses only on skilled nursing facilities.

Behavioral Care:

Behavioral care is a descriptive term, not a licensed level of care. It is a description employed by the Medicaid Managed Care Organizations (MCOs) to describe a scope of service designed specifically to care for individuals in licensed skilled nursing and residential settings who exhibit behaviors. These behaviors may be a result of chronic mental illness, advanced dementia or any other illness that results in aberration of behaviors. Behavioral care is different from behavioral health, which is a licensed level of care. Behavioral care is defined distinctively by each MCO and they establish the parameters and levels of that care, and the resulting payment level. Behavioral Medicaid rates are paid for behavioral care. The vast majority of payment for caring for individuals exhibiting behaviors in skilled nursing is paid through behavioral care.

Behavioral care will be the focus of the pilot, as it is the mainstay of SNFs.

Behavioral Health:

Behavioral health is a separate level of licensed care. There are specific requirements for licensed behavioral health professionals and distinct licensure for the buildings themselves. All SNFs providing behavioral care check off the category of behavioral health on their SNF license, but the care itself meets the behavioral care standards of the MCOs and is currently not held to the DHS behavioral health licensed standard.

The Arizona Department of Health Services Division of Licensing Services licenses and surveys all behavioral health facilities, however Arizona's Medicaid program, AHCCCS, oversees the delivery of behavioral *health services* in a newly integrated program (10/1/18) in delivery of services on the acute side. On the long term care side, behavioral care and, to some extent, behavioral health has long been integrated in the ALTCS program.

For purposes of this pilot, we will address only behavioral care in SNFs, the broad descriptive realm of services defined by the MCOs, not licensed behavioral health residential settings.

AHCCCS:
The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid agency that offers health care programs to serve Arizona residents. Individuals must meet certain income and other requirements to obtain services. AHCCCS operates as a Medicaid managed care model, subcontracting with approved health plans for the delivery of covered services authorized.

ALTCS:
The Arizona Long Term Care System (ALTCS) is the long term care division of AHCCCS. This program is intended for those individuals who are age 65 or older, blind, or have a disability (at any age) and need ongoing services at a nursing facility level of care. Those who qualify do not have to reside in a nursing home. Many ALTCS members live in their own home or at an assisted living facility and receive needed in-home services. ALTCS also covers assisted living services.

Gero-Psych Behavioral Care:
Gero-psychology is a branch of psychology that seeks to address the concerns of older adults. Gero-psych is a descriptive term that generally refers to the older adult resident with mental health disorders, anxiety and depression along with other age-related illnesses. Gero-psych care in a SNF is a distinct type of long term care skilled nursing that specifically helps geriatric patients or residents with mental and behavioral health needs.

Advanced Dementia Behavioral Care:
Advanced dementia behavioral care refers to services provided to individuals diagnosed with dementia who experience agitation. This agitation can be demonstrated in such behaviors as verbal and physical aggression, compulsions, anxiety and wandering. These individuals differ from residents receiving Gero-psych care in that they may not have had an underlying mental health disorder prior to the dementia diagnosis.

MCO:
Managed Care Organizations (MCOs) are health plans that subcontract with Arizona's AHCCCS program to deliver covered services to eligible members. They act like a Health Maintenance Organization (HMO) in authorizing and managing these health-related services. The three MCOs that are the program contractor plans for Arizona's ALTCS program are Mercy Care, UnitedHealthcare Community Plan and Banner University Family Care.

Overview of Skilled Nursing, Medicaid, and the Role of Behavioral Care

There are currently 149 licensed SNFs and over 2500 assisted living entities, both residential homes and centers. It is important to note that Arizona is unique in the dramatically high acuity care provided in our state. We serve a very medically complex resident and patient population. Why? Essentially, the long term care delivery system model has been shaped by the major payer of services in the skilled nursing setting, Arizona's state Medicaid program, AHCCCS. Over the course of the 30 plus years of the implementation of its managed care model, AHCCCS has successfully moved individuals into the least restrictive setting possible. This means that individuals who were eligible for nursing home care but could be successfully managed at home or a lower level setting, were moved out of SNFs. Arizona actually has fewer SNFs today than it did 25 years ago, despite the compelling

demographic growth of the aging population in our state. The SNFs that remained viable had to shift their care to synchronize with the needs of the AHCCCS/ALTCS managed care organizations, which was a growing high acuity service demand.

Medicaid is the largest payer source in skilled nursing. It is estimated that 65% of all nursing facility payments are Medicaid. The rest of the payment is comprised of Medicare (approximately 20-30%), private insurance and private pay (approximately 5%). There are some SNFs that depend upon nearly 100% Medicaid payment.

It is significant that in Arizona's AHCCCS/Medicaid program, only 12% of members served reside in skilled nursing or institutional settings. Those that are placed in a nursing facility are generally in great need of high acuity services and the resident population is medically complex. Over the past three decades, service specialty care in skilled nursing has evolved.

Service specialty care in Arizona is defined by each managed care organization. They create service specifications and guidelines for programs in SNFs to operate by. Examples of service specialty programs include behavioral care, ventilator care, bariatric care, advanced dementia care, just to name a few.

Behavioral care in SNFs has been a growing segment for the past decade. Many licensed SNFs check off "behavioral health" on their license through ADHS. This means these SNFs have some sort of unit or specialty program in house to care for those with Gero-psych or advanced dementia behavioral needs.

The unique needs of behavioral care SNFs has been surfacing over the last eight years of our *Disaster Ready* grant implementation. The traditional solutions to evacuation and sheltering in place in a disaster scenario take on new dimensions when considering a volatile population with mental health disorders and age-related illnesses characterized by agitation. These individuals are prone to verbal and physical outbursts, resident-to-resident altercations, and perhaps most significantly, wandering. Add to the picture that these same residents may have a multi-faceted medically complex range of health conditions. Suddenly emergency preparedness takes on a new meaning, and non-traditional strategies must be considered and employed.

This is the impetus for the pilot study. By closely examining these settings, understanding their current level of preparedness, and documenting their best practices, we hope to provide a new depth of understanding of disaster readiness in behavioral long term care service delivery. Identifying policies, procedures and practices that uniquely address this population may help save lives and protect our most vulnerable citizens.

Part II: The Study Design and Plan

Objective

To understand, evaluate and assess the unique emergency preparedness needs of skilled nursing facilities serving the gero-psych and behavioral resident population. (*The emphasis is on gero-psych behavioral residents rather than those solely exhibiting advanced dementia behaviors, though both may be a consideration with this population.)* Three pilot facilities have been selected based on their high concentration of care for these very residents. *It is believed that there may be very specific needs for disaster readiness for residents with long and short term mental health disorders and chronic behavioral issues*, and this pilot project will consider if that is the case. If it is indeed the case, we hope to answer these questions…*what gaps currently exist in their readiness? What additional resources, if any, are necessary?*

Action Steps

Though we hope to assist these three facilities in their immediate readiness, it is not our primary goal. Our primary goal is to understand, assess and evaluate their need and then create a technical assistance model to assist them (*and other such facilities)* to become better prepared for disasters and other emergencies in the future. We recognize that full implementation of the technical assistance necessary to achieve the unique level of preparedness required may be "phase two" of the pilot.

We will intensively engage with the three pilot facilities during the course of this study. We will document table-top exercises developed for the facilities and other strategies employed during the pilot to engage the pilot facilities in identifying issues and concerns about serving this vulnerable behavioral population in an emergency.

The pilot study will extend over a period of approximately nine months and conclude with the development of this "white paper" final report which describes the population and the facilities, analyzes the current state of readiness given the special population served and given this gap analysis, and offers practical recommendations for enhanced readiness.

Pilot Design and Timeline

- Receive DHS approval for pilot study inclusion as an HPP grant deliverable – **July 2018**
- Select pilot study participating facilities - **August 2018**
- Meet with pilot facilities to introduce concept and secure commitment - **August 2018**
- Create facility assessment tool - **September 2018**
- Visit participating facilities to implement assessment **- October 2018**

- Meet with facility staff operating in pilot facilities to assess role in emergency preparedness – interview clinical, administrative and frontline team - **October 2018**
- Deploy *Disaster Ready* consultants currently working with the Arizona Health Care Association *Disaster Ready* program to evaluate participating pilot facilities and the status of their Emergency Preparedness (EP) Plans, Memorandums of Understanding (MOU's), Coalition participation, Hazard Vulnerability Assessments (HVA) and Continuity of Operation Plans (COOP) - **December 2018**
- Conduct behavioral specific table top exercise, inviting all three participating pilot facilities - **January 2019**
- Interview behavioral health leaders in the broader community, managed care plans and first responders for input on recommendations for preparedness – **February and March 2019**
- Compile recommendations and best practice guidelines – **March and April 2019**
- Summarize pilot study and present to the Arizona Department of Health Services

Facility Assessment Tool

The following items will be researched, reviewed and inventoried:

- Size (census, licensed beds) and scope of facility services
- Current CMS data on facility - quality measures from Nursing Home Compare/Medicare.gov
- Resident population analysis - type of mental health and behavioral disorders
- Types of medication and dosage frequency - use of antipsychotics
- Review of sample resident files
- Types of behaviors exhibited, incidents and resident to resident and staff altercations
- Review of current behavior management programs in place
- Staffing model
- Managed care plan relationships
- Incidence of behavioral rates paid by Medicaid/managed care plans
- Family involvement, member councils
- Unique life safety or building considerations
- Past history of disaster scenarios and emergency preparedness concerns

Disaster Ready Assessment Process

There will be the standard *Disaster Ready* readiness evaluation of existing emergency preparedness plans, MOUs, current compliance with CMS Requirements of Participation, and COOP through the intensive lens of the *Disaster Ready* consultants. Where standard gaps are identified, these can be immediately addressed through technical assistance within the scope of the pilot. If major changes are necessary, or unmet needs of a larger scope are identified, these should be documented for future support efforts and included in the study recommendations.

Behavioral Table Top Exercise

Each of the three participating facilities will engage in a full scale tabletop exercise with the same scenario depicted below:

"During a recent storm the city experienced a significant breakdown of electrical, sewer, gas and water services. Sewer lines are in need of replacement. Sewer lines are below the water lines requiring the water lines be cut to obtain access to the sewer lines. Gas lines are also damaged. Utility poles were also blown down during the storm and are in need of repair or replacement.

To minimize future utility disruption, power lines will be installed below ground. ***To qualify for the municipal multimillion dollar emergency grant, all lines/pipes must be replaced and not repaired.*** *All four utilities (electrical, sewer, gas and water) within the one square mile surrounding your facility will be replaced simultaneously. Total facility evacuation will be required, with a potential 7 day stay for residents at a receiving facility.* ***Work is scheduled to begin Wednesday, December 19, 2018 at 8:00 AM."***

Evacuating facilities: Windsor Maryland Gardens Care Center, Desert Haven Care Center, Maravilla Care Center

For the purpose of the tabletop exercise:

- Each facility has 100 beds; 95% capacity; 100% behavioral; "Resident" will describe the people in your care
- Your generator services 15 electrical outlets throughout the building, you have fuel for 24 hours.
- Your company has provided direction to evacuate the facility and to plan on 7 days without utilities. Two neighboring skilled nursing facilities have been identified as reception sites for evacuation and have adequate space to accept residents.

Part III: Assessment of the Participating Facilities

Maravilla Care Center Facility Assessment

Facility Profile

Maravilla Care Center (MCC) is located at 8825 South 7th Street, Phoenix, AZ 85042. As of 10/16/18, it has 194 CMS certified beds, with an actual operating capacity of 156 beds. It has approximately 55,000 square feet of space and the layout of the building centers around four distinct units, each with specific behavioral acuity. The facility is operated by a national skilled nursing for-profit corporation and MCC is one of two facilities in their portfolio in the state of Arizona. The payment model is 90% Medicaid and 10% Veterans Administration (VA) reimbursement. At the time of this profile, the facility is currently rated overall as a 2-star facility (*out of a possible total of 5 stars)* by CMS. To further break down the components of this overall star rating, the facility has a one-star health inspection rating, a 4-star staffing rating and a 5-star quality measure rating. The CMS quality measure rating includes such items as falls, pain management, rehospitalizations, antipsychotic usage, to name just a few of the components.

Resident Profile

MCC accepts residents with all levels of behavioral needs and accompanying medical acuity. It is estimated that the average age of residents is approximately 50 years old. MCC has historically accepted residents as young as 27 years old. The resident population is both ethnically and racially diverse, including Caucasians, Hispanics, African Americans and Native Americans from various tribal communities' statewide.

The types of behavioral disorders diagnosed in the resident population include both serious and chronic mental illness, post traumatic brain injury and substance abuse related health issues. There are also residents with schizophrenia, bi-polar disease, obsessive compulsive disorder, anxiety, depression, and various personality and mood disorders. Behaviors exhibited by residents include physical and verbal aggression, self-harm, flat affect, communication difficulties, confusion, and cognitive impairment. Many of the residents placed in MCC have failed in other residential settings and require an intensive behavior management program. The vast majority of the resident population has a conservator or guardian.

Resident File Review

Two random files were selected and reviewed, and the summaries are as follows:

- ***MCC Resident One*** is a 45-year-old male with a long history of self-harm. He is alert, oriented and in a wheelchair, due to a self-inflicted gunshot wound. He has a diagnosis of schizophrenia and a long history of substance abuse. He takes 17 medications daily including antipsychotics. His behaviors include throwing himself out of his bed, choking himself and threating to bite off his tongue. He has also burned himself prior to MCC placement.
- ***MCC Resident Two*** is a 65-year-old female with a complex medical history that includes a diagnosis of schizophrenia and bi-polar disease. She also has cerebrovascular disease and has suffered a stroke. She is prone to wounds and has had foot ulcers and other sores requiring constant care. *MCC Resident Two* is unable to effectively communicate due to aphasia, an accompanying movement disorder, and COPD (Chronic Obstructive Pulmonary Disorder). She is constantly frustrated and angry, has fallen and tries to throw herself out of her wheelchair. She often refuses to eat and is prone to suicidal ideation, and hypomania.

MCC Current Behavioral Management Model and Staffing

Maravilla Care Center utilizes Bayless Integrated Healthcare for gero-pysch consulting. A psychologist visits one day a week and makes rounds on the units. Consulting Nurse Practitioners are also in the facility an average of three times weekly. Bayless conducts staff training as requested. Staff ratios are generally one Certified Nursing Assistant (CNA) per 7 residents, and one nurse per 17 residents. Contracted pharmacies and lab partners are on site daily.

MCC Managed Care Plan Relationships

Maravilla Care Center works with all three Medicaid/ Arizona Long term Care System (ALTCS) program contractors including Mercy Care Plan, UnitedHealthcare Community Plan and Banner University Family Care. At least 90% of all reimbursement comes from these managed care organizations and the vast majority of their rates are specialty behavioral rates.

Family Involvement, Resident Council, Life Safety Considerations

There is no Resident Council at this time. Family members are generally uninvolved, as many residents are in care of a legal guardian. At any given time, MCC staff estimates that there are 5-10 family members actively involved in resident care and advocacy at MCC.

The physical plant of MCC is at least 65 years old, and the property requires constant maintenance. MCC is currently in compliance with all CMS life safety mandates. One unique feature of MCC that has clear implications for emergency preparedness is that it operates a licensed day care center for its employees on site. There are up to 20 children in day care at Maravilla from 5:00 am to 10:00 pm daily.

Past Disaster Scenarios Experienced at MCC

MCC has not had to deploy emergency plans in recent memory of current leadership. There have been neighborhood lock downs for criminal activity, as the facility resides in a high crime location of south Phoenix. There have also been short term power outages that were handled successfully without need for evacuation.

MCC contacts the Phoenix police and Arizona Department of Health Services (ADHS) with self-reports of abuse or neglect according to CMS requirements and the local police department investigates` such reports an average of 3 times per week.

Maravilla Staff Interview

The *Disaster Ready* Project Manager met with the leadership team of Maravilla Care Center for a three-hour session. Attendees included the MCC Administrator, Director of Nursing (DON), Assistant DONs, social services director, environmental services director, and several CNAs. It was a robust discussion about the resident population, the role of staff and their thoughts, ideas, concerns, and suggestions for improving disaster readiness for a behavioral skilled nursing facility.

The following are some of their key points:

- Behavior triggers are often related to noise, food problems, sharing space, privacy, protecting personal belongings, boredom and past history with other residents.
- The most successful behavioral interventions in crisis all involve staff support. Many staff have special relationships with residents and know how to calm behaviors. Staff support is considered the key component of their behavior management program. There is great longevity in both the staff and resident population at Maravilla and that pays dividends. A staffing shortage in an emergency would be a great hardship and would exacerbate any disaster scenario, because staffing is key to their success.
- Most hospitalizations are related to a fall. Falls sometimes happen when there is a resident to resident altercation, which can occur for no apparent reason. Falls are common in an emergency and would be a significant concern in evacuation.
- Transportation is a worry if evacuation is necessary. Some residents will refuse to leave, which is a very common behavior exhibited. Some residents cannot sit next to each other or behaviors will erupt. Some residents are not mobile enough to board a bus and others would need a whole row of seats.
- What would happen with MCC Day Care Center in an emergency? Would staff rush to take care of their children before addressing residents in need? How could the children be successfully evacuated with behavioral residents?
- As far as types of emergencies, MCC staff and residents seem most calm about an active shooter scenario. Is this because many residents are from the street and have been homeless? Is it because the facility is located in a high crime area and both staff and residents are accustomed to sirens and criminal activity? This was openly wondered about.
- There has been little or no discussion with MCO case managers about the deployment of an emergency plan. The MCC staff was surprised that they would play a role in the placement of residents and think it is now something they should discuss.

- What about necessary equipment in an emergency? Durable Medical Equipment (DME) such as oxygen, walkers, wheelchairs, lifts and bariatric equipment.
- Behavioral residents may not be willing to leave without personal items, such as blankets and photos.
- There is a huge elopement risk. Many residents will wander or even run at the first opportunity.
- How do legal guardians and conservators get notified in an emergency?
- Residents may refuse to return to their primary facility if moved to a shelter in place setting.
- A supply of cigarettes and snacks should be part of an emergency kit.
- Behavioral care plans would be necessary to bring if the residents were to shelter in place. Likes and dislikes are critical in keeping residents calm.
- What about a 7-day supply of medications, especially the antipsychotics?
- How would the resident identification be managed in an emergency? Wrist bands are one idea, how to note potential behaviors on ID is also a consideration.
- How do we address special diets in an emergency? Food and eating plays a key role in managing behaviors. It is estimated that over 80% of MCC residents are on a “mechanical” or soft diet, and a percentage of those need 100% pureed diet.

Desert Haven Care Center Facility Assessment

Facility Profile

Desert Haven Care Center (DHCC) is located at 2645 East Thomas Road, Phoenix, AZ 85016. As of 10/18/18 it has 115 licensed beds certified by CMS, with an actual operating capacity of 88 beds. The average daily census is 80 residents. It is a privately-owned for-profit facility owned by an Arizona independent owner and is one of two facilities owned in the state by this company. The payment model is 100% Medicaid and that Medicaid model includes approximately 10% of Arizona Tribal ALTCS. There is currently no contract with the VA system. At the time of this profile, the facility is rated overall as a 1-star facility (*out of a possible total of 5 stars)* by CMS. To further break down the components of this overall star rating, the facility has a one-star health inspection rating, a 1-star staffing rating and a 2-star quality measure rating. The staffing rating will soon change as there was an error in timeliness of reporting staffing data which has since been corrected and should soon be revised in their CMS star rating.

Resident Profile

The facility accepts some long term care custodial residents, but the vast majority of residents are designated by the MCOs as behavioral specialty care. The length of stay in DHCC is typically a long one, estimated at a minimum of 200-300 days and some residents have been there for several years. Many residents are admitted to DHCC for behavioral management because they have failed to thrive in other skilled nursing residential settings. The average age of DHCC residents is estimated to be 70 years old.

The types of diagnoses include advanced dementia, with behaviors and other chronic and serious mental illness disorders. These include schizophrenia, personality and mood disorders and bi-polar disease. Behaviors exhibited include hitting, pushing, fighting and other acts of physical violence. Verbal aggression is common and Obsessive-Compulsive Disorder (OCD) symptoms frequent.

Resident File Review

Two resident files were randomly selected for review.

- ***DHCC Resident One*** is a male in his 60s who is diagnosed with bi-polar disease and has had a stroke. He also has a leg amputation, is incontinent, and exhibits symptoms of dementia. He has aphasia and often refuses care. His behaviors include random screaming and agitation. He is wheelchair bound.

- ***DHCC Resident Two*** is a female age 70 with severe arthritis and advanced kidney disease. She has also had a stroke and an opioid dependency. She is constantly agitated and exhibits paranoid behaviors and frequently yells. She is very vocal and communicative, but non-compliant in meeting care needs.

DHCC Current Behavioral Management Model and Staffing

Desert Haven also utilizes Bayless Integrated Healthcare for gero-pysch consulting. A psychologist visits the resident an average of three days a week and makes rounds on the units. Consulting Nurse Practitioners are also in the facility one day a week. Bayless conducts staff training as requested. Staff ratios at DHCC are generally one Certified Nursing Assistant (CNA) per 7 residents, and one nurse per 16 residents.

DHCC Managed Care Plan Relationships

Desert Haven also works with all three Medicaid/Arizona Long Term Care System (ALTCS) program contractors including Mercy Care Plan, UnitedHealthcare Community Plan and Banner University Family Care. At least 90% of all reimbursement comes from these managed care organizations and the vast majority of their rates are specialty behavioral rates. Tribal ALTCS covers the remaining 10% and is paid on a fee for service basis.

Family Involvement, Resident Council, Life Safety Considerations

Desert Haven experiences limited family involvement but has a very active Resident Council. Each of the units has their own Resident Council and the administrator attends these meetings quarterly or as requested.

Desert Haven has a unique configuration with their long term care unit divided into segregated male and female units. These residents mix during activities but are otherwise cared for separately.

The location of Desert Haven is a significant consideration, given its immediate proximity to Thomas Road, which is a four-lane busy roadway, with rushing traffic just feet from the entrance of the facility. A vehicle accident on Thomas Road could affect the facility and they are fortunate there has not been an accident on the facility property.

DHCC is an older property, estimated to be over 65 years. Maintenance is a constant challenge, though there has been considerable internal an external renovation over the past three years.

One resource is that the building next door to DHCC is also owned by the owner of DHCC. It operates as a small school for troubled youth during the school year. In the summer the building is empty and could be a shelter in place setting for DH as needed.

DHCC Past Disaster Scenarios Experienced

There has not been a need to deploy emergency plans at Desert Haven in the recollection of current leadership and staff.

Staff work closely with the Phoenix Police Department and are visited for investigations at least once a week. In fact, the police were present on site for such an investigation during this assessment. They are called when ADHS self-reports are made, in order to ensure compliance with CMS abuse and neglect reporting requirements.

DHCC Staff Interview

The DRCC Project Manager met individually with the DHCC Administrator and Director of Nursing. During the course of these productive discussions, the following thoughts, concerns and questions were identified.

- Refusal to leave in an emergency evacuation is a real issue. This is a common behavioral trait and there should be a plan to address it.
- With the segregated male and female units at DHCC, there may be a problem when they are all forced to be together in an evacuation or shelter in place scenario. Behavioral problems could erupt.
- The age of the DHCC behavioral population is older than some other facilities. This creates an even larger concern about mobility. What about those residents that may be bed bound or need electric wheelchairs. How will they be effectively transported?
- There is a high incidence of dementia and associated behaviors. Wandering is a real concern and traffic on Thomas Road is particularly concerning in any elopement.
- The altering of routine and lack of consistent schedule in a shelter in place scenario could create behavior episodes. DHCC has a very liberal and frequent schedule for supervised smoking and snacks and this could present a challenge in another location.
- The school next door is a resource in the summer, but if a localized emergency occurred in the academic year there could be even more problems since troubled adolescents are served there.
- There are a number of DH residents who need dining or feeding assistance. Staffing to ensure this in an emergency is essential. Modified diets are also common.
- Because of the age of the residents there would need to be a close look at DME and needed equipment in any memorandum of agreement for shelter in place. The frailty of this behavioral population is a big factor.

Maryland Gardens Care Center Facility Assessment

Facility Profile

Maryland Gardens Care Center (MGCC) is located at 31 West Maryland Avenue, Phoenix, AZ, 85013. It is a campus of both skilled nursing and assisted living. For the purposes of this pilot study, only the 60 licensed SNF beds are considered. The operational capacity is 55 beds and the average census ranges between 48-52 residents. It is a for-profit corporation owned by a national company headquartered in California, it is one of 5 properties owned in Arizona. The facility currently operates with 100% Medicaid payment, but will occasionally accept a Medicare patient, as it is certified for both Medicaid and Medicare. At the time of this profile, it currently has a 5-star overall rating by CMS. The components of that overall rating include a 2-star health inspection rating, a 4-star staffing rating and a 5-star quality measures score. The facility itself was built in 1949 and used to be a motel. The rectangle configuration of resident rooms leading to an outdoor courtyard make this property unique.

Resident Profile

The facility has 100% behavioral residents, mostly long stay. They are all paid by the MCOs as behavioral specialty care. Like the others in this pilot, the length of stay in is typically a long one, estimated at a minimum of 200-300 days and some residents have been there for many years. The average age of MGCC residents is estimated to be between 60-70 years old. They do accept younger patients and currently have one resident who is 31 years old.

The types of diagnoses in residents tends to focus around chronic mental illness with additional medical complexity. These include schizophrenia, personality and mood disorders and bi-polar disease. There are also residents with Traumatic Brain Injury (TBI) and General Anxiety Disorders (GAD) are also common. OCD symptoms are frequent. Other behaviors exhibited generally do not involve physical aggression, but verbal aggression does occur. Most of the behavior concerns described involved non-compliance, manipulation of staff and anti-social conduct.

Resident File Review

Two resident files were selected for review and were reviewed electronically through the PointClickCare medical records system.

- ***MCGG Resident One*** is a 68-year-old Caucasian female who has been at MGCC for six years. She is a quadriplegic and has chronic kidney disease, bipolar disease, and severe anxiety.

She is also diabetic and prone to pressure ulcers. She takes 10 medications daily including antipsychotics. *Resident One* ambulates in a motorized wheelchair, needs full assistance with lower Activities of Daily Living (ADLs), and requires maximum staff assistance and a lift for transfer. She requires two CNAs to assist because she is manipulative in one on one situations. She is also verbally aggressive.

- ***MGCC Resident Two*** is a 63-year-old African American male who has lived at MGCC for 9 years and had a stroke leaving him with significant right-side deficits. He has a prosthetic eye and limited vision. He also has chronic kidney disease and diabetes. He has mild to moderate cognitive impairment. Resident Two does benefit from strong family involvement. His behavioral issues center around self-isolation, anti-social behavior and resistance to care.

MGCC Current Behavioral Management Model and Staffing

Maryland Gardens utilizes both a psychiatrist and a psychologist, Dr. Gregory Carr and Dr. Steven Domann. Both make weekly rounds and have a weekly behavioral meeting with staff to address behaviors and appropriate interventions. The psychiatrist evaluates residents as needed and directs medication reviews and additionally consults with staff. Monthly staff training is also provided. Additionally, they have supportive counseling provided by the MCOs. MGCC has a certified therapeutic recreation specialist on staff to direct activities. Staff ratios at MGCC are generally one Certified Nursing Assistant (CNA) per 7 residents, and one nurse per 10 residents. Of the total resident population, it is estimated that 39 currently receive some form of antipsychotic medication.

MGCC Managed Care Plan Relationships

Maryland Gardens also works with all three Medicaid/Arizona Long Term Care System (ALTCS) program contractors including Mercy Care Plan, UnitedHealthcare Community Plan and Banner University Family Care. At least 90% of all reimbursement comes from these managed care organizations and all of their rates are specialty behavioral rates. The largest proportion of Medicaid residents come from Mercy Care Plan and United. They also have a contract with the VA and this constitutes 5-7% of their resident population. MCO case managers have not been involved with emergency preparedness to date.

Family Involvement, Resident Council, Life Safety Considerations

Maryland Gardens reports some strong family involvement, but only for a minority of the SNF population. Family involvement is more common on the assisted living side of MGCC. There is a very active and vocal Resident Council on the SNF side that meets monthly.

Maryland Gardens has a distinct layout that is consistent with its former use as a motel. This creates unique concerns because the campus has an open appearance and feel. This is a positive factor with the residents but does require strong security. It is also very close to Central Avenue in Phoenix (one block away) which enhances concerns about elopement, with a relatively busy street so close. The age of MGCC is a factor in the constant need for internal and external maintenance. Maryland Gardens is also located across the street from a church, which is a potential resource for both shelter and evacuation.

MGCC Past Disaster Scenarios Experienced

There have been only minor emergencies in the memory of current leadership. MCGG has experienced some sewer blockage and plumbing issues that required temporary internal relocation of residents, and water damage from storms requiring sandbags and other landscape solutions.

MCGG self-reports incidences of abuse and neglect to ADHS as required by CMS. In accordance, they work closely with the Phoenix Police Department and are visited for investigations approximately 3-5 times per month.

MGCC Staff Interview

The DRCC Project Manager met with the MGCC Administrator and Director of Nursing, the Director of Maintenance, the Assisted Living Manager, and the Regional Clinical Quality Director. It was an engaging discussion and the following thoughts, concerns and questions were identified.

- The biggest concern for emergency preparedness is an incident involving the physical plant, which would require a short or long term shelter in place.
- The potential for fire and power outages are most feared, and constantly monitored by maintenance.
- Behavioral patients' refusal to leave in an emergency is a significant factor in developing and implementing a successful plan.
- Transportation is an issue but ensuring adequate staff in implementing any transporting is the key to success. Staff are especially needed to calm residents and ensure a safe transport.
- MGCC is currently in dialogue with an ambulance company to further discuss new and innovative transportation options in a crisis. MGCC owns a van and could borrow vans from sister facilities.
- At least two other facilities owned by their parent company have behavioral programs and MGCC is fortunate to be able to work with them in an emergency. These facilities also have the capability to manage this population.
- Staff feel confident that the number of drills they are currently conducting are helping them to prepare for any disaster.
- Will rapid triage be needed for behavioral patients in an emergency? Who needs the most care and attention? How do we deploy staff to the residents in most need?
- Staffing is the answer to working with behavioral residents. If staff are not available there would be a huge impact to this population.
- Snacks, water stations, and supervised smoking are especially important for behavioral residents to consider in an emergency. How can they be incorporated?
- The MGCC physical plant is very open and more vulnerable than most in an active shooter "in the area" scenario.
- MCGG works with several volunteer programs, but additional behavioral training would be needed if individual were to be called in to work with residents on a one to one basis in a disaster.

Part IV: Review of Pilot Facilities Emergency Operations Plans; Gap Analysis of Preparedness Process

Pilot Project Manager, Kathleen Collins Pagels, and *Disaster Ready* Consultant, Gil Damiani, met in November 2018 with each of the three behavioral pilot facilities on site for a 2-3 hour meeting to review their existing Emergency Operations Plans (EOPs). The new survey and inspection requirements of the revised CMS Requirements of Participation (ROP) were used as a guide for review of each facility. Additional questions regarding behavioral specific plans were added to the review process. The goal of these meetings was essentially to implement a "gap analysis" designed to ascertain the current level of readiness and identify gaps and best practices in place, in order to assist in creating needed behavioral specific resources and tools for the future.

The meetings were conducted like a "mock survey" reviewing in-depth each CMS survey tag addressing emergency preparedness (EP). Two of the pilot facilities were recently surveyed using the new ROPs. One facility was found to be deficiency free and the other had six violations of EP tags, mostly addressing lack of appropriate documentation. The third pilot facility had not yet been surveyed by the state on the new ROPs and was focusing on readiness for a survey that would likely occur in the next two months. Facility leadership was present in each site visit and in all cases the facility manager acted as the lead.

Rather than review each pilot facility's readiness specifically, though copious documentation of each facility's compliance is available, it seems most useful to identify common ground, best practices, follow up and gaps identified in the review process. Recommendations follow.

EOP Common Ground

- ***All three facilities organized their documentation for compliance with ROP/EP survey tags in a binder format.*** Some were easier to access than others and a clear best practice was identified in keeping the EOP binders organized by survey tag with accompanying documentation in each section. Several tags require the same documentation.
- ***All facilities identified similar potential hazards and perils in their individual Hazzard Vulnerability Assessment (HVA) scenarios.*** These tended to be general power outages, flooding and active shooter situations. ***They met the compliance standard but were not highly individualized.***

- ***Generator capability differed dramatically.*** All met the minimum compliance standard, but one facility could not shelter in place for any extended period due to the fact that their generator only serviced basic power needs and could not support any air conditioning. Another pilot facility has a new generator unit and is well prepared. The third facility has invested recently in a generator upgrade and can provide air conditioning in a central location for a short period.
- ***Resident tracking is the main concern of all facilities in the case of evacuation***. All pilot facilities had a policy that met compliance. Their plan is to utilize the NHICS 255 & Resident Evacuation Tracking form. This form addresses 16 components of the resident's identification and medical history along with specification of the transfer site. There is no room on the form for behavioral characteristics of residents.
- ***There was considerable confusion about the MOUs for the statewide coalitions.*** Some of the coalitions have both a "participation agreement" and a separate MOU. It seems that the participation agreements satisfy the compliance with state survey, but the MOU is critical in specifically identifying strategies for sharing resources between acute and post-acute partners in an emergency. None of the pilot facilities had active MOUs with the coalitions that were available to review.
- ***All pilot facilities had transfer agreements with other facilities in place.*** It is a common procedure to establish transfer agreements with "sister" facilities within one's own company. This may work for a facility providing traditional long term care but is not always advisable for a facility providing gero-psych or advanced dementia behavioral care. A transfer to a traditional facility would be challenging with the lack of locked units, and especially the lack of trained behavioral staff. One of the pilot facilities, MGCC, is fortunate to have at least three sister facilities locally providing some form or degree of behavioral services. Two of the pilot facilities had transfer agreements with each other.
- ***Documentation of occupancy tends to be individualized by facility***. This was true of pilot facilities, as they generally use daily census reports. The opportunity to participate in the DHS statewide bed poll was generally acknowledged but ***none were currently officially submitting census data in the bed poll.***
- ***Throughout the review of the EOPs, it was acknowledged by all pilot facilities that the behavioral population is younger and more ambulatory than the traditional SNF resident.*** This makes it both easier and more difficult to evacuate. Easier in that many residents can walk on their own power, and more difficult because some residents are a significant flight risk. A resident elopement during an evacuation is one of the common areas of concern among the pilot facilities. Behavioral care facilities are clearly at a much higher risk of such an occurrence.
- ***One common theme identified in the review of EOPs was a concern that the behavioral population may exhibit non-compliance in an evacuation***. Essentially, they may refuse to leave their familiar surroundings, even when danger presents itself. This is a common trait of those who may have experienced homelessness, have post traumatic history or PTSD, paranoia or panic disorder. It could take additional staff resources to coax a behavioral resident to evacuate in a real emergency. It may also require additional resources to assist this type of resident to shelter in place, if that is even an option.
- ***The ROPs require a policy for working with volunteers in an emergency. All pilot facilities complied with this at a very basic level. There are many concerns about working with volunteers in a behavioral facility that are different from a traditional SNF***. If they are not trained in behavior management, how can they help? Will they exacerbate the situation? Many family members are known to do that when there is a long history of mental health issues and they may also not be ideal to assist. All of the pilot facilities

have volunteer groups that come to entertain the residents and, though they would have some degree of familiarity, they are not trained in one-to-one interaction. During an emergency evacuation local first responders for the same reasons listed above may not be an option either.

EOP Best Practices and Ideas

- ***Organize resources by ROP tags*** in a binder that provides documentation by tag, including duplicative resources required by each survey tag.
- Make certain that every facility has completed not just the Participation Agreement for one of the four regional AzCHER emergency preparedness coalitions, but also ***has a signed regional AzCHER statewide Memorandum of Agreement in place and available for use.***
- The EOP compliance binders are generally massive and nearly impossible to make available at several locations in each facility. To address this problem, ***one facility purchased a small flip chart EP tool, easy to use and individualize with all emergency contact numbers and initial action steps and*** has this available at every nursing station and every department head location.
- ***Be aware of terminology considerations in working with first responders.*** One pilot facility identifies residents as "neighbors". This can be confusing to external incident command and may add to the chaos in an actual emergency situation. The term *resident* is most commonly used in describing the care recipient population.
- ***Transportation agreements are critical in an emergency. A best practice is to assure that they are highly individualized for behavioral facilities.*** It is notable that some behavioral residents cannot use public transportation easily. A behavioral resident may not be able to sit on a bus in a row of seats with others, due to their tendency to initiate resident to resident altercations. Consider that this might mean doubling the size of the transportation needed in a crisis, a challenge to be sure. Also, many behavioral residents require one-on-one staff escorts to ensure they feel safe, or to ensure they do not elope.
- ***The electronic health record (EHR) is a valuable tool in an evacuation or resident transfer scenario. It is important to understand that not all facilities or long term care companies use the same vendor for EHR and facilities may not be able to communicate critical medical data and medication records easily.*** The ability to access the EHR is especially important for facilities providing behavioral care, given the higher rate of administration of psychotropic medications. The ideal best practice is to ensure your transfer agreements allow for access to the resident electronic health record, within HIPAA guidelines.
- ***When asked if there were specific items important to managing behavior in a crisis, across the board administrators acknowledged that snacks and cigarettes were two important items. These two items are especially important to the behavioral population, many of whom still smoke under supervision in the SNF setting. These two items can help in modifying and incentivizing behavior.*** *Behavioral facilities should have an emergency store of snacks and cigarettes, easy for leaders to access and use as appropriate in an emergency.*
- **Register with the utility (APS) providers to receive advance warnings of outages in a given area at** https://www.aps.com/en/Pages/MedicalContactForm.aspx

Gaps and Considerations

The following are gaps identified, suggestions and considerations for inclusion in final report recommendations.

- There is a concern that, though the HVA scenarios meet compliance requirements, they do not necessary address facility specific behavioral concerns. For example, DHCC is very vulnerable to a traffic accident, this was not specified or addressed in their HVAs. MGCC and MCC are both vulnerable to intruder and active shooter situations due to their geographic location and/or their open campus architecture.

  Consideration: Behavioral facilities should evaluate their unique composition and location and create and implement additional HVA scenarios that are specific to their exposure. Implementing HVA scenarios that are finely tuned to their unique facility needs will increase their capacity to protect vulnerable behavioral residents in an emergency.

- The compliance standard for generator capability may be insufficient for behavioral facilities that would most certainly employ the option to shelter in place if at all possible, given the challenges of evacuating behavioral residents.

  Consideration: Review state or federal financial resources to assist qualifying facilities in securing generator upgrades. It is essential to go "beyond compliance" in protecting the health and welfare of the vulnerable behavioral population in a shelter in place scenario.

- Resident tracking following evacuation is a major issue. It is especially critical with behavioral residents who may exhibit behaviors in any crisis situation due to their mental health conditions and a move to an unfamiliar environment.

  Consideration: Create a version of the current NHICS 260 form that allows for specific information about behavioral residents to be noted on the tracking document. This would include information such as their elopement risk, propensity for violence toward others or self-harm and special environmental considerations needed. This would ensure a smoother transition of a behavioral resident to a new site following evacuation.

- Behavioral facility transfer agreements are not equal in value for purposes of evacuation if there is not a baseline of behavioral care provided in the receiving facility. The pilot facilities did not all individually meet this standard.

  Consideration: Ensure that all behavioral facilities have transfer agreements locally that ensure that there is similar behavioral care provided at the receiving facility. Meeting the compliance requirement to have any type of transfer agreement is insufficient for true preparedness for behavioral facilities, they must transfer to like behavioral facilities if at all possible. All behavioral facilities should have transfer agreements with each other, within reasonable geographic boundaries.

- Actual participation in the DHS state bed poll is slow to arrive with long term care/SNFs. This was evident in the EOP review of the behavioral pilot facilities, as none were submitting occupancy data. This is a missed opportunity. It should be acknowledged that there have been some challenges in the administration of

the bed poll, as several facilities thought they had signed up and were not on the list. Other facilities signed up, but never submitted data.

Consideration: All pilot and other behavioral facilities should be educated about the bed poll and the *Disaster Ready* program should monitor the degree of their participation in the statewide bed poll system to ensure acute and post-acute occupancy information is available to SNFs in a disaster scenario.

- The pilot facilities spoke loud and clear in the EOP review about their greatest fear, which is resident elopement. This may pose one of the greatest challenges to the health and safety of behavioral residents in an emergency. Their mental health issues combined with complex medical conditions could make an elopement a life or death situation.

  Consideration: The *Disaster Ready* program should work with clinical and regulatory experts to create a best practice protocol, or tool kit, to reduce elopement risk. This could be a series of exercise scenarios, tips and tools for monitoring and staff training strategies specific to behavioral care facilities.

- In discussion with the pilot facilities, it was clear that the administrators and nurse leaders often have a chance to connect, whether through education sessions, or other networking opportunities. This is not the case with the facility managers of behavioral facilities. It was mentioned that it would be valuable for leaders in facility management positions to come together to also have an opportunity to share insights and problem solve.

  Consideration: Create a forum for facility managers of behavioral facilities to connect and communicate, either through a discussion group or regular in person meetings. This will allow for sharing of resources and best practices.

- The pilot facilities acknowledged the challenge in working with volunteers in a crisis. This is a very valid concern, yet no facility wants to turn away much needed assistance and support in an emergency.

  Consideration: It would be helpful to identify if there are mental health associations that have volunteer programs in place. Partnership with such an organization may be of benefit to behavioral care facilities. It may also be valuable to create a template of volunteer behavioral care training that facilities could employ.

Part V: Outreach and Stakeholder Dialogue

Facility Managers Networking Meeting

The pilot experience has taught us that facility managers play a pivotal role in the success of emergency preparedness. One of the suggestions that arose from the table top exercise was the recommendation that facility managers be given an opportunity to meet and discuss their own challenges and best practices. **On January 23, 2019, the three facility managers from the pilot facilities were invited for a networking meeting hosted by the *Disaster Ready* program.** Two of the facility managers attending informally discussed a wide range of issues including generator issues, Legionella testing, Memorandums of Understanding, video surveillance, experiences with fire drills and evacuation, to name just a few of the topics. There was also a great deal of discussion about the distinct role facility managers play in working with behavioral residents. They know each of the residents personally and have a sense of how to best engage them to cooperate in a disaster situation. The meeting culminated in sharing contact information to set up visits and tours of each of their facilities. It proved to be a valuable networking opportunity for all involved. This type of informal dialogue should be considered a best practice and cultivated with similar facilities with a shared mission.

First Responders Collaboration Meeting

The Arizona Health Care Association meets regularly with a coalition of first responders including fire and police. The focus of this coalition for the past year has been addressing improvements in managing advanced directives and "Do Not Resuscitate" (DNR) issues, along with reducing the number of non-emergent 911 calls associated with falls. We utilized this group as a vehicle to report on the *Disaster Ready* behavioral pilot and gain feedback at the January 31, 2019 meeting. Over 30 attendees participated, representing both the first responder and long term care provider communities. There was a great deal of general interest and support expressed for the behavioral pilot. First responders noted that this population is one of the most challenging to serve and stated that even though additional behavioral training is needed to better serve this vulnerable population, there are currently no resources available to address this need. Other feedback included the need to do more community outreach to educate behavioral facilities about working with their local first responders. There was also a concern expressed that there are frequent incidences of behavioral residents calling 911 on their own, perhaps inappropriately. This coalition will continue to serve as an excellent resource for information and feedback on issues related to emergency preparedness and behavioral care.

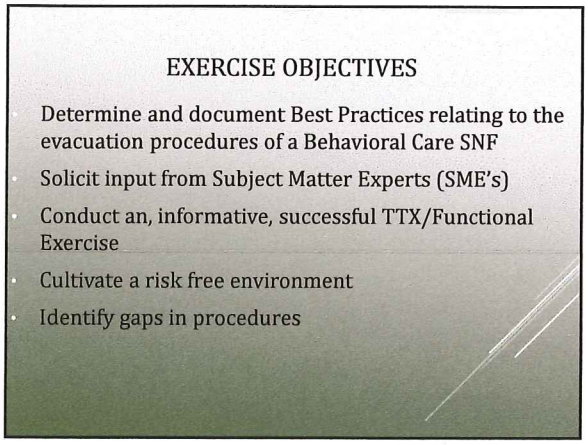
Managed Care Organization Case Managers' Meeting

One of the gaps identified in the course of the pilot was the lack of communication with managed care organization (MCO) case managers about emergency preparedness. This communication is essential because the MCOs are the payers for the Medicaid/Arizona Health Care Cost Containment System (AHCCCS) residents. The vast majority of behavioral care residents are covered by Medicaid MCOs contracted by AHCCCS. In order to further consider opportunities for collaboration in preparedness, a meeting with case managers serving one of the pilot facilities, Maryland Gardens Care Center, was initiated. All of the AHCCCS/Arizona Long Term Care System (ALTCS) case managers assigned to Maryland Gardens Care Center were invited. This meeting was held on site at the facility on February 20, 2019. Those in attendance included the MGCC administrator, the UnitedHealthcare Community Plan case manager, the University Health Plan case manager and *Disaster Ready* Consultant. The Mercy Care case manager was unable to attend. The behavioral pilot was introduced and reviewed, and discussion ensued regarding the case management perspective on disaster readiness. The case managers noted that they had no real awareness of the facility's disaster plan, and it is not currently a requirement on their side to engage with their assigned facilities in preparedness efforts. The case managers both agreed that it would be a good idea to learn more, and further education on facility emergency plans would be beneficial. There was discussion on the vulnerable nature of the behavioral population and the case managers expressed concern that change is a challenge for these residents, and familiarity with staff is essential in protecting them in a crisis. The administrator present noted that it would be helpful to have a list of facilities contracted with each plan so that they could synchronize MOUs with plan contracted entities to ensure continuity in care planning and payment. A high level list of MCO contacts would also be useful in the event the case manager cannot be reached. A "takeaway" from this meeting was the recommendation that there needs to be a higher level discussion with MCO CEOs and supervisors about behavioral care and emergency preparedness. The case managers themselves feel they would need approval from their supervisors to actively engage in this issue. It seems that emergency preparedness has not yet been identified as a plan priority for case management. There is great opportunity to enhance communication to ensure the safety of behavioral residents in an emergency situation through both advocacy and education. Case management participation in fire drills and table top exercises would be a strong starting point.

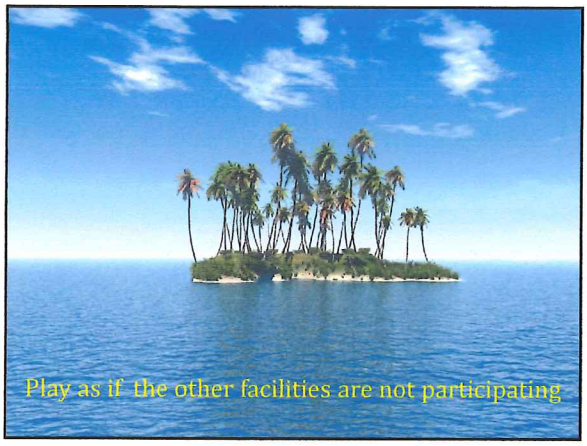
Addendum


PUBLIC WORKS?
The Cost of
Our Aging
Infrastructure
Behavioral Long Term Care Table Top Exercise
December 18, 2018

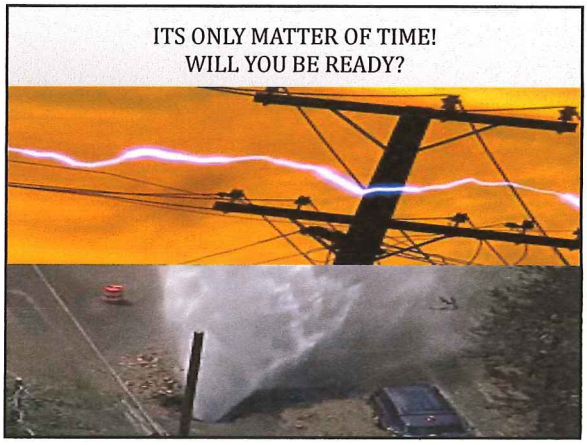
1


EXERCISE OBJECTIVES
Determine and document Best Practices relating to the evacuation procedures of a Behavioral Care SNF
Solicit input from Subject Matter Experts (SME's)
Conduct an, informative, successful TTX/Functional Exercise
Cultivate a risk free environment
Identify gaps in procedures

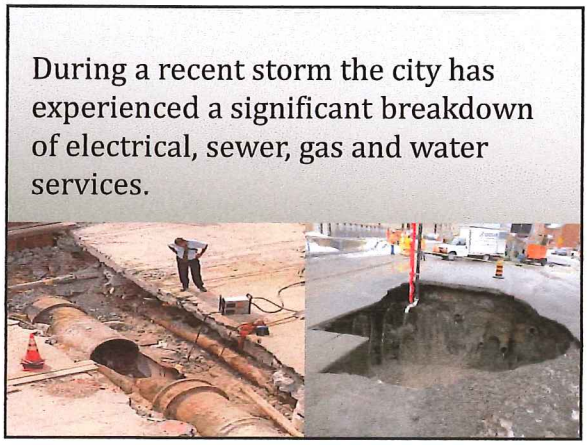
2


Play as if the other facilities are not participating

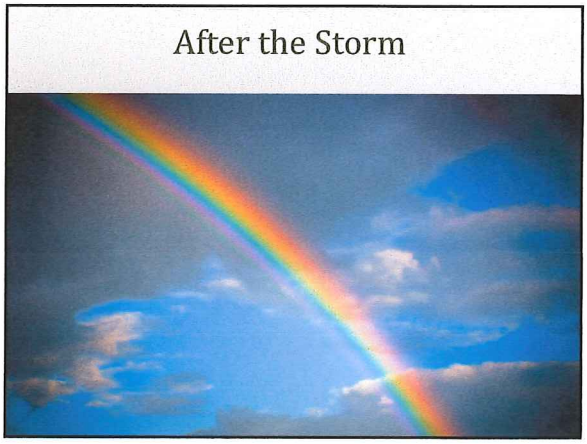
3


ITS ONLY MATTER OF TIME!
WILL YOU BE READY?

4


During a recent storm the city has experienced a significant breakdown of electrical, sewer, gas and water services.

5


After the Storm

6

The city is eligible for a Federal Grant;
Aging Infrastructure Mitigation Funding (AIMF).

Sewer lines are in need of replacement.

Sewer lines are below the water lines requiring the water lines be cut to obtain access to the sewer lines.

Gas lines are also damaged

Utility poles were also blown down during the storm and are in need of repair or replacement

To minimize future utility disruption, power lines will be installed below ground. **To qualify for the multimillion dollar grant, all lines/pipes must be replaced and not repaired.** All 4 utilities within the 1 square mile surrounding "Your Facility" will be done simultaneously.

Work is scheduled to begin Wednesday,

December 19, 2018 at 8:00 am

CITY OFFICIALS ARE ADVISING THAT YOUR FACILITY MAY BE WITHOUT ALL UTILITIES FOR UP TO 7 DAYS.
***** IF EVERYTHING GOES ACCORDING TO PLAN***

7

Tuesday, 7:00AM December18, 2018

Evacuating facilities

Windsor Maryland Gardens Care Center

Desert Haven Care Center

Maravilla Care Center

For the purpose of the exercise

- Each facility has 100 beds
- 95% capacity
- 100% behavioral
- Your generator services 15 electrical outlets throughout the building, you have fuel for 24 hours.
- "Resident" will describe the people in your care

8

Your company has provided direction to evacuate the facility and to plan on 7 days without utilities

9

Red Mountain Nursing and Rehab Center

Receiving Facility #1 (Simulated Site)

- 130 bed facility
- Focus on Behavioral care 100%
- 60% capacity
- Recently conducted NHICS Training
- Survey history (no tags) last year

Not affiliated with your facility

10 miles away not affected by utility outage

10

Cactus Rose Nursing and Rehab Center

Receiving Facility #2 (Simulated Site)

- Focus is on behavioral care
  - 75% of residents are behavioral care
  - 150 bed capacity
  - 75% capacity
  - Participates in the AZ Bed Poll
  - Recent NHICS training
  - Survey 2018 history tagged for E0018 inadequate procedures
  - Is a sister facility 25 miles away

11

ASSUMPTIONS

Receiving facilities should have adequate beds space to accept residents from evacuating site (verify)

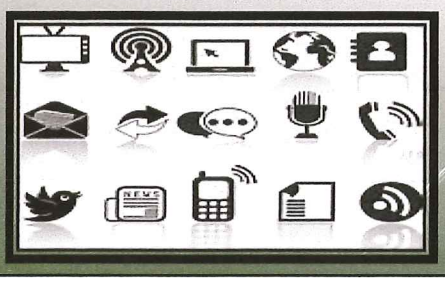
Assume no sites are experiencing any unusual staff shortages

Medical Directors are approving evacuation/reception

12

Communication Requirements

The evacuating facility must effectively communicate with the receiving facilities



13

COMPANY LEADERSHIP GUIDELINES

- You have **some** latitude ($$) to acquire the resources you need to accomplish the complete evacuation.
- Complete Evacuation in <24 hours
- Identify what resources are necessary to complete the task.
  - Human
  - Equipment and supplies
  - Medical
  - Transportation

14

SCENARIO OBJECTIVES

- Safety of residents and staff
- Tracking of all stakeholders
- Establish communications with
  - Families
  - Plans (Case Managers/payers)
  - Vendors
  - Licensing Agency
  - Media

15

Transportation Resources

VA Hospital has provided 2 Ambuses for your use (at cost)

Reliable Medical Transport (on your vendor list)

Red Mountain Medical Transport (on your vendor list)

ValTrans has offered one of their wheelchair accessible vans

16

QUESTIONS TO PONDER....

Immediate Actions

Management

- Who's in charge?
- What are the priorities?

Planning

- Next Steps
  - Potential long term impact
  - Staffing
  - Residents (order of evacuation, who goes first)
  - Transportation Plan

17

TIME TO MANAGE WITH NHICS

Activate your NHICS Team

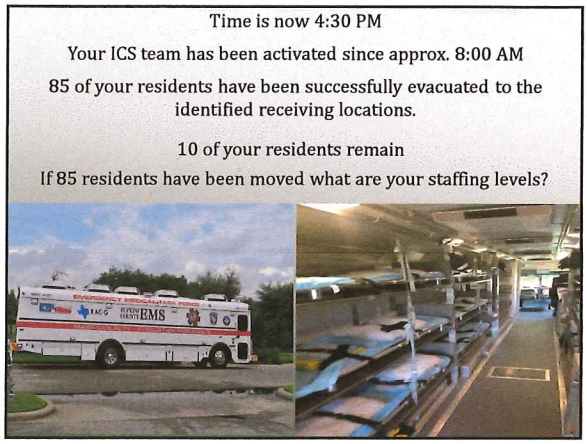
Objectives have been established

NHICS 200 Form

- Conduct an Incident Action Planning (IAP) meeting with the team
- Establish an Operational Period
- Identify at least one (1) priority objective for each position on the IMT
- Discuss tasks and strategies needed to support all objectives

18

19



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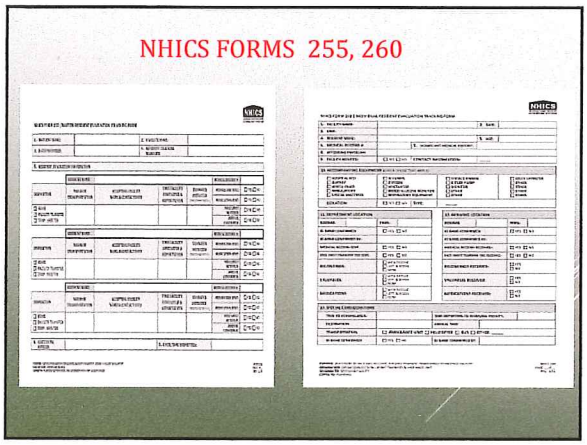

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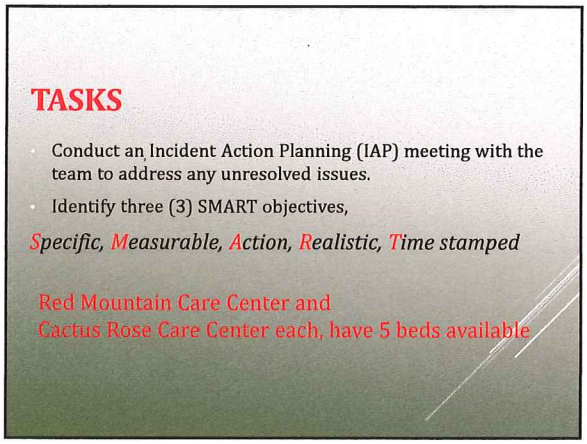

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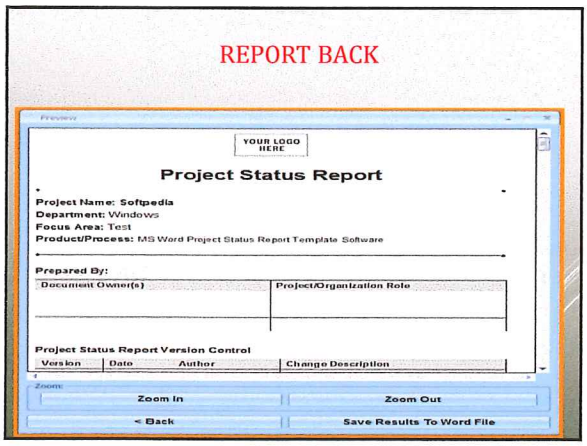
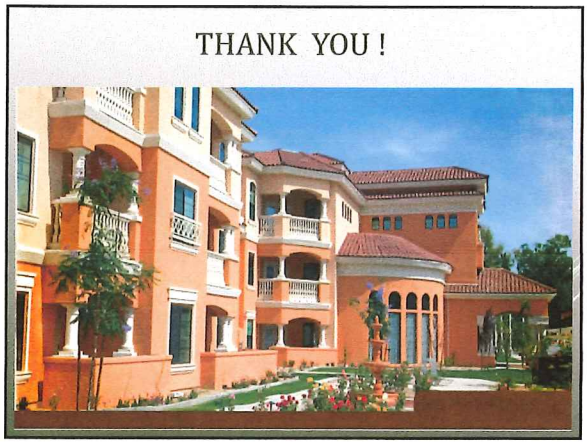


23

24


WHO IS AFFECTED, WHO CAN HELP?
Whole Community
Emergency Management
Resource Typing
Fire Service
EMS/Rescue
Search and Rescue
MOUs
MOAs
Businesses
Expertise/Advisors
Warehousing
Refrigerated Container Service
Distribution Centers
Food/Water
Public Transportation
Bus
Rail
Taxi
Schools/Colleges
Shelters
Evacuation Centers
Academia (SMEs)
Religious Organizations
Churches
Counseling Services
Non-Profits
Red Cross
Salvation Army
Counseling Services
Social Networking
Facebook Groups
Google + Groups
Cultural Organizations
Public/Private Partnerships
MOUs
MOAs
Medical Facilities
Hospitals
Nursing Homes
Clinics
Private Ambulance

25


THANK YOU !

26

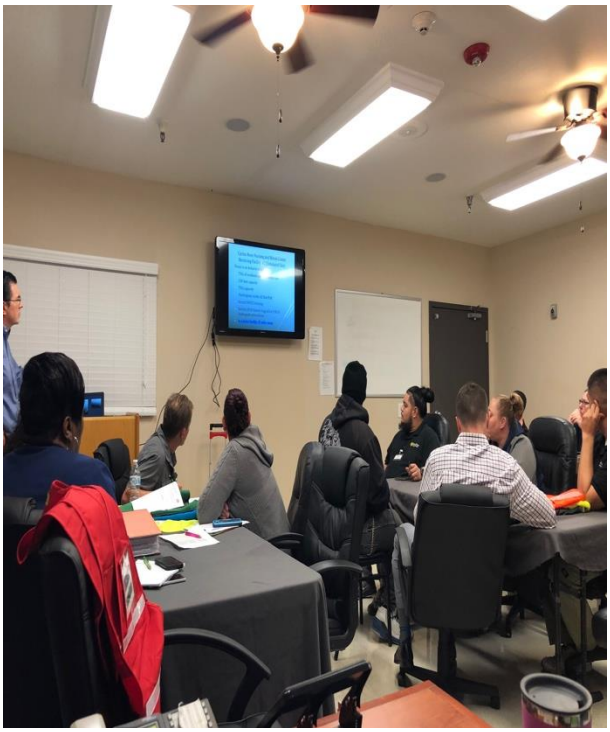
Table Top Exercise / Behavioral Care Pilot After Action Report

December 1

Kathleen Collins Pagels, Consultant,
Disaster Ready Program

Disaster Ready Behavioral Care Pilot

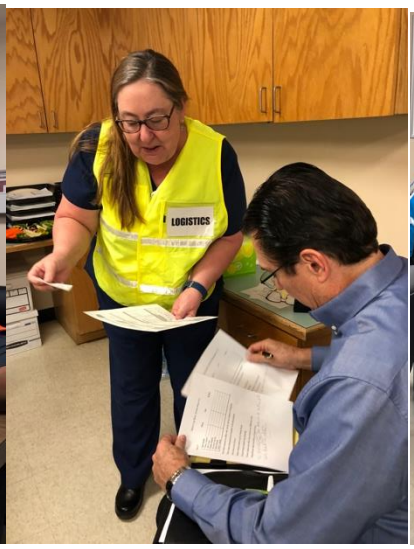
CONTENTS



EXPLANATION OF TERMS

Examples:

AAR	After Action Report
Administrator	Licensed professional with oversight of SNF
ADHS	Arizona Department of Health Service
CMS	Centers for Medicaid/Medicare
CAN	Certified Nursing Assistant
DON	Director of Nursing
EOP	Emergency Operations Plan
EP	Emergency Preparedness
FM	Facility Manager- maintenance, life safety and operations
HVA	Hazard Vulnerability Assessment
Injects	Randomly distributed situational descriptions of complications in crisis
LTC	Long Term Care
MOU	Memorandum of Understanding
NHICS	Nursing Home Incident Command System
ROP	Requirements of Participation/CMS
SNF	Skilled Nursing Facility
Survey	Annual State Health Department Inspection
TTX	Table Top Exercise



INTRODUCTION

The following is a brief synopsis of the TTX scenario:

During a recent storm the city experienced a significant breakdown of electrical, sewer, gas and water services. Sewer lines are in need of replacement. Sewer lines are below the water lines requiring the water lines be cut to obtain access to the sewer lines. Gas lines are also damaged. Utility poles were also blown down during the storm and are in need of repair or replacement.

To minimize future utility disruption, power lines will be installed below ground. ***To qualify for the municipal multimillion dollar emergency grant, all lines/pipes must be replaced and not repaired.*** *All four utilities (electrical, sewer, gas and water) within the 1 square mile surrounding your facility will be replaced simultaneously. Total facility evacuation will be required, with a potential 7 day stay for residents at a receiving facility.*

Sequence of events:

Work is scheduled to begin Wednesday, December 19, 2018 at 8:00 AM

- *Evacuating facilities: Windsor Maryland Gardens Care Center, Desert Haven Care Center, Maravilla Care Center*

For the purpose of the TTX:

- *Each facility has 100 beds*
- *95% capacity; 100% behavioral*
- *Your generator services 15 electrical outlets throughout the building, you have fuel for 24 hours.*
- *"Resident" will describe the people in your care*
- *Your company has provided direction to evacuate the facility and to plan on 7 days without utilities*
- *Two neighboring skilled nursing facilities have been identified as reception sites for evacuation and have adequate space to accept residents.*

TTX Participating Facilities:

Windsor Maryland Gardens Care Center, Desert Haven Care Center, Maravilla Care Center

Each facility brought a team of five leaders to participate in the TTX including the administrator, a nurse leader, the facilities manager and a Certified Nursing Assistant. Other department representatives present included social services, human resources and dietary leadership.

AFTER ACTION REPORT OVERVIEW

This report is a compilation of information and insight gathered from the three facilities participating in the TTX. It is important to note that all three facilities provide behavioral care in a licensed skilled nursing setting and have been participating in the Disaster Ready behavioral pilot. This is the first time a TTX has been designed and implemented specifically for behavioral care providers in long term care in the state of Arizona. All of the participating facilities had been trained in NHICS prior.

The goal of the exercise was to employ NHICS training to address the evacuation scenario presented. The premise of this TTX was that behavioral care SNFs serve a unique population with special needs, and a specialized TTX would help the Disaster Ready program further identify needed resources for emergency preparedness specific to the behavioral population. Bringing all three behavioral pilot facilities together in one room, we believed that there would be an opportunity for shared wisdom, resource suggestions, and best practices would also be illuminated.

Some of the questions discussed included:

- Management - Who's in charge? What are the priorities?
- Planning - What are next steps? What is potential long term impact
- Staffing - How do we maintain staff in crisis?
- Residents - What is the order of evacuation, who goes first?
- Receiving Facilities - Do facilities have the capacity to serve
- Transportation - What is the availability and who are the vendors?

Injects were included in the TTX and they were accompanied by dissemination of symptomology cards that described the complex medical and behavioral conditions of residents being evacuated. A typical symptomology card for a behavioral facility is as follows…

Alice is 60 years old with a diagnosis of schizophrenia and personality disorder. She has severe anxiety and is non-compliant. Additionally, Alice has kidney disease, diabetes and oral health problems requiring a soft diet. She has some cognitive impairment and is prone to wandering.

STRENGTHS

- Each of the three facilities have familiarity with NHICS and this is clearly a strength. They easily identified the incident commander and the appropriate individuals for the other roles in the NHICS model.
- Each of the three facilities is currently in compliance with the emergency preparedness CMS Requirements of Participation (ROP)and have completed HVAs and participated in other table top exercises. They demonstrated a comfort level with the exercise process and were able to build upon past experiences with disaster scenarios.
- The facility leaders are clearly behavioral experts. They know their resident population. They have a clear vision of how to successfully implement emergency procedures and they are very tuned in to the unique psychological and medical considerations of the behavioral population served.

AREAS OF CONCERN

- During the "hot wash" discussion of the exercise experience, each incident commander stated their worst fear in evacuating a SNF behavioral resident population. These fears are: elopement, lack of behavioral competency in first responders and "receiving" facility, facility geographic traffic hazards (busy roads, proximity to highway), staffing problems that could further impact successful evacuation.

RECOMMENDATIONS

- There was a clear consensus that it was helpful to exercise with "like" providers, all focusing on behavioral population. RECOMMENDATION: *Continue to offer this table top exercise option for behavioral SNF providers and include additional behavioral facilities outside of the pilot group.*

- The capacity of a behavioral facility to successfully manage an emergency is rooted in the availability of key staff, especially those at the front line. These nursing assistants are the ones that truly know the residents and their unique needs and are able to manage their behaviors in a crisis. RECOMMENDATION: *Consider implementing a table top exercise for front line staff only, focusing on nursing assistants to enhance their awareness and capability in disaster readiness.*

- In a traditional SNF, medical equipment and medications are the first items considered to take in an evacuation. In a behavioral SNF, other tools to incentivize and modify behavioral are also important. Like it or not, availability of cigarettes is key. Many of the behavioral population are smokers and the availability of cigarettes is one way to influence behavior, especially for those individuals who exhibit non-compliance. This is also true of snacks, or sweets. Sugary snacks can

provide stimulus in a crisis to move individuals out of a non-compliant behavioral pattern. *(Let's call it the "Smokes and Skittles" principal.)* That is not to underestimate the value of more traditional emergency kit components that include medication and first aid tools, which are undeniably important. But participants in this exercise all agreed about the importance of an additional emergency cache of cigarettes and snacks. RECOMMENDATION: *Encourage behavioral SNF providers to have an emergency kit of cigarettes and snacks at the ready in case of evacuation.*

- Each of the participating facilities were familiar with each other, but all were part of different companies. There was a genuine consensus that it would be helpful to have Memorandums of Understanding (MOUs) with each other. The common ground they all share, the similar depth of knowledge about behavioral care, and the collective level of staff training would make them all strong partners in a crisis. RECOMMENDATION: *Recommend and facilitate the development of MOUs between behavioral SNFs in a shared geographical area.*

- Participants in the exercise reported trepidation about the ability of 911/first responders in handling the complexities of skilled nursing residents with complex psycho-social behavior. This lack of familiarity could add an additional layer of problems in the leadership managing an evacuation or disaster. RECOMMENDATION: *Work with the first responder community to hear their concerns about serving this population and identify opportunities for cross training.*

CONCLUSION AND NEXT STEPS

This was the first behavioral SNF specific table top exercise. What we learned is that there are more similarities than differences in comparison to a TTX composed of SNFs serving a more traditional, general population. Both clearly benefit from NHICS training. Both are successfully focusing on compliance with the new CMS Requirements of Participation. Both are actively engaged in identifying successful solutions to emergency preparedness.

What felt very different was the degree of vulnerability of these facilities. Examples of this:

- Most of the behavioral facilities are older (60-80 years) and prone to physical plant problems making a disaster scenario feel very, very possible. All three locations are in high traffic and/or high crime areas.

- Elopement is a greater risk in behavioral facilities than in traditional SNFs. Why? Because there are more ambulatory residents, and generally a younger population. Many also exhibit exit seeking behavioral patterns. Should elopement occur, it is even more frightening for a behavioral resident who may be mentally ill, and a greater challenge for the leadership to locate. The potential for catastrophe, and even potential loss of life, feels very significant.

- The dependence upon front line staff and their ability to manage behaviors in a crisis is more intense. There are generally longer lengths of stay in a behavioral SNF. Nursing assistants come to intricately know and understand how to work with a particular resident. Oftentimes the facility is dependent upon this relationship to successfully care for a resident with complex behaviors. Should such key staff be unavailable in an evacuation or emergency, the challenges mount.

Next steps will be focused on implementation of the After Action Report recommendations and the recommendations of the overall SNF behavioral pilot.