

2011

Long Term Care Mutual Aid Plan

Storm Alfred - After Action Report

A review of actions and responses for Long Term Care Facilities to Storm Alfred



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Preface

The State of Connecticut is divided into five (5) emergency preparedness and planning regions designated as Division of Emergency Management and Homeland Security (DEMHS) Regions. Each of these regions has a DEMHS Regional Coordinator who acts as the State's liaison to local municipalities within the respective DEMHS Regions. The CT Department of Emergency Services and Public Protection (DESPP), through its Division of Emergency Management and Homeland Security (DEMHS), maintains and operates the State's Emergency Operations Center in the State's Capitol City, Hartford, CT.

The Regions maintain Regional Emergency Planning Teams (REPTs) which are responsible for the regions Regional Emergency Support Plan (RESP) as well as local administration and management of US Department of Homeland Security Grant Program (HSGP) funds.

In DEMHS Region 3, also known as the Capitol Region, the Capitol Region Emergency Planning Committee (CREPC) acts as the Region 3 REPT. CREPC is a sub-committee of the Capitol Region Council of Governments (CRCOG). There are 41 municipalities in the Region representing approximately 1,082,000 individuals (US Census 2010). The region is a 1,074 square mile mix of Urban centers and Rural farm areas.

In addition to REPT and HSGP responsibilities CREPC has built out an "operational" functionality to coordinate resources for large incidents impacting the region. To achieve this CREPC adheres to the National Incident Management System (NIMS) and models its operations after the National Response Framework (NRF) through the use of Regional Emergency Support Functions (RESF). These efforts are the most fruitful when done in collaboration and coordination with the DEMHS Region 3 Coordinator and the State which represent significant challenges at times due to legal authorities and disparity in resource management infrastructure.

In 2009, using Homeland Security Grant Program funds, the Capitol Region Council of Governments (CRCOG) contracted with Russell Phillips and Associates, LLC (RPA) to develop a mutual aid plan for the Long Term Care (LTC) facilities in Region 3. The region's LTCs offer the full range of services associated with independent living adults/retirement communities, assisted living elder care, and skilled nursing and rehabilitation.

The intent of the Long Term Care Mutual Aid Plan (LTC-MAP) is to build resiliency among LTCs enhancing the capability to maintain operations and/or surge as dictated by a singular incident or events such as the storm reviewed in this document. The enhanced capability for the facilities to support themselves alleviates added burdens to the municipalities where the 78 LTCs reside in the region and adds to the region's ability to absorb medical surge across the healthcare system.

The resident population represented by the LTCs in the region is approximately 7,500 to 8,000 with operational strategies to manage a 10% surge given the appropriate resources and assets. Among the resources cataloged within the LTC-MAP are transportation assets to move approximately 2,000 residents without taxing municipal resources, or accessing the Emergency Medical Services system.

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An integral part of the LTC-MAP is the web based reporting tool developed and maintained by RPA; this website is critical to gaining situational awareness and allows each of the facilities to log into the “Mutual Aid Plan” website and report on current status, bed availability, available resource and any anticipated needs.

Executive Summary

Emergency preparedness and response for any organization, jurisdiction, or agency involves assessing pertinent vulnerabilities and capabilities; a cycle of outreach for planning and capability development, plan and scenario based training, exercising and actual incident response itself.

Achieving progress is based upon openness to honest evaluation and then a commitment to that on-going program and process of improving. This report is intended to assist the member facilities of the Region 3 Long Term Care Mutual Aid Plan and those associated regulatory and support services. The LTC-MAP relies upon member participation and each of the 78 facilities in the Region have signed the LTC Mutual Aid Agreement which provides the covenant for the LTC-MAP itself. Part of the Plan is an annual MAP education and workshop session as well as a Functional Exercise to test the Plan. This After Action Report (AAR) should be viewed as part of that continuous process of planning, training, exercise and improving which is critical as LTC facilities strive for emergency preparedness excellence by analyzing preparedness and response efforts to a specific event or series of events. This analysis is intended to:

- Identify strengths upon which to maintain and build
- Identify challenges and potential areas for improvement
- Aid in the development of a plan for corrective actions as indicated

Key strengths identified during the After Action Review conducted on November 3, 2011 included:

- LTC Coordinating Center staff and support from RPA
- LTC-MAP web portal – data collection tools and Situation Report output for Region 3 and the Department of Public Health
- Collaboration and Coordination with CT-DPH – Facility License and Investigation Section
- Communication and facility follow up

Areas for Improvement included:

- Requesting and implementing certain payer source waivers such as an “1135 waiver” under the Social Security Act, and Public Health Emergency declaration or flexibility in identified requirements for LTC admissions
- Coordination with Acute Care Hospitals for medical surge
- Unfamiliarity with LTC-MAP or certain Mutual Aid Plan web portal processes.
- Lack of Public Health Emergency declaration

The events in this immediate instance were indeed unprecedented. The long-term care industry has survived blizzards, labor strikes, and the events and aftermath of 9-11. Yet the Region 3 LTC facilities

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were unprepared for the magnitude of damage on the morning of October 30th, and the unforeseen consequences of LTC life-on-generator-power for one week to ten days, when the final facility was back on commercial power.

Introduction

“The Halloween storm, the October storm, the storm that left as many as 884,000 properties without power.

Millions of people shivering in the dark. Hundreds of thousands of damaged trees.

Tens of thousands of downed power lines. Thousands trolling for open gas stations.

Hundreds flocking to shelters and hotels in dozens of towns.

Dozens of carbon monoxide poisonings.

Travelers stranded on planes. Schools shuttered. Halloween canceled. Phone service erratic.

Eight storm related deaths.

The only time we’ve had an October storm this bad was – NEVER.”

- Storm Alfred Special Section-the Hartford Courant November 13, 2011

These words give some insight into the events and experience of Storm Alfred which hit the state of Connecticut on October 29, 2011, and had some residents without power until 11 days after the storm. The storm brought over 12 inches of heavy wet snow clinging to autumn leaves on tree limbs and branches, a “perfect storm” which would damage hundreds of thousands of trees and down tens of thousands of power lines. The storm was unprecedented in the damage to utility infrastructure and properties affected, virtually leaving the entire Region without commercial power for days. Add to the damage cold, and some nights frigid, temperatures and an already overburdened healthcare system faced a system wide surge. At the peak of the outage 55 of the 78 member Long Term Care facilities reported being on generated power. Most of those were located in the central part of the Region which sustained the greatest amount of damage to the power distribution system. The Long Term Care facilities in the Region, although not immune to the pressures caused by these stressors, are uniquely positioned due to the LTC Mutual Aid Plan.

The LTC Mutual Aid Plan (LTC MAP) was activated on 29 October to support the potential demands of its member facilities. The LTC Coordination Center was activated and staffed with volunteers from the LTC MAP and staff from RPA beginning on 30 October and issued its first member alert for all LTC facilities to log into the mutual aid plan web site and report on operational status and bed availability. The LTC Coordination Center is a designated location within the Duncaster Retirement Community in Bloomfield, CT (conference room in the Aquatic Center) with additional phone lines, computer/printer-fax access, charts and screens.

It should be noted and appreciated that during the week the volunteer LTC members at the LTC Coordination Center were administrators and facilities maintenance directors from LTC facilities in the region that were facing problems of their own as a result of the storm. The final stand down notice to the LTC-MAP member facilities was issued six days later on Friday November 4th with a Duty Officer for the LTC-MAP assigned over the weekend and through Tuesday to support the Department of Public Health Facility License and Investigation Section that took the lead over that window of time.

Incident Timeline

Summary overview of major actions

Saturday, October 29, 2011

Emergency reporting system activated

Sunday, October 30, 2011

First LTC-MAP Alert – LTC Coordinating Center opened at Duncaster

Fifty-five facilities determined to be at-risk locations due to operational issues (i.e. loss of commercial power)

Monday through Friday October 31, 2011 – November 4, 2011

Daily LTC-MAP Alerts for facilities to report by 10:00 AM

Follow up directly to contacts from non-reporting facilities

Assigned staff between DPH FLIS and the LTC Coordinating Center to monitor the 55 at-risk facilities

Monday through Friday – cont'd

LTC-MAP conference calls – LTC Coordinating Center, LTC facilities, CT-DPH-FLIS, CREPC RCC – 11:00AM-12:00PM

Information / report push to CT-DPH no later than 1:00PM

Follow up status and resource availability – Coordinate with LTC, acute care hospitals and DPH

Section 1

Information Sharing and Communications

Discussion:

Starting with the Sunday request for facilities to report to the Mutual Aid Plan web portal the focus for the LTC Coordinating Center was to gain situational awareness of what was happening in the LTC community. This awareness was framed around the following:

1. What were the baseline resources at each facility?
2. What was happening internally at each facility / facility status, e.g. on generator power, on site staffing, etc.?
3. What was the available bed count at each facility broken down by male, female, either?

Although not complicated in nature the responses to these questions set the tone of work at the LTC Coordinating Center for the ensuing week and created the basis for discussions with all collaborators and resource request processing. Once a baseline was established it was easier to discuss and coordinate surge measures among the LTCs and CT-DPH. The maximum exposure occurred on Sunday, October 30 and Monday, October 31 with 55 of 78 facilities on emergency power or experiencing other operational issues (staff shortages, temperature issues in building, short term generator failures).

Operational issues were reported with the obvious damage to communication infrastructure such as the internet, some phone systems, and in certain areas decreased cellular phone capability. Not all facilities could log into the LTC-MAP web portal and in those instances reports were phoned in. If facilities did

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not report by the requested time of 10:00AM each morning, LTC Coordinating Center staff would reach out and contact those not reporting directly. It is estimated that 40-60% of the LTCs were able to, and did, use the LTC-MAP web portal or other means to report to the LTC Coordinating Center. LTC representatives at the After Action Review meeting reported that once they were able to gain access to the internet the process within the MAP portal was pretty straight forward and easy to use. This reporting did not have to take place at the “disaster struck”, or affected facility, it was reported that LTC representatives reported from:

- Home
- Another LTC property site in a less affected area
- Smartphone applications directly via phone web browser

Once information was received Russell Phillips and Associates (RPA) would build aggregate reports to share among collaborators. This was time consuming (approximately 1.5 hours to aggregate all data to format for DPH and other regional partners) and represented somewhat of a static snapshot in time. During the week of operations, RPA staff was able to build a web based interface which would automatically aggregate inputted data and develop reports. This information would be updated with each piece of data that was entered at any given time offering a somewhat more dynamic look at LTC facility status. This information still needed to be “pushed” regardless of form or format to non-MAP stakeholders. This would include local Emergency Management Directors/Local Emergency Operations Centers, CT-DPH, DEMHS, etc. Discussion was held concerning the availability to post this data as either a static situational report, or through an integrated “board” on the State’s information and crisis management software platform WebEOC. Even though the LTC-MAP and its Coordination Center was intended to help the LTC community manage a disaster with their own resources it is critical that the State, and Local municipalities, have visibility as to what is happening within the Region or their respective cities or towns.

During the aftermath of the storm (throughout the week) it was noted that CT-DPH, especially the Facility License and Investigations Section, was heavily engaged in coordination with the LTC facilities and the LTC Coordinating Center. Early on there was some confusion or redundancy in communication, but by mid-week it was decided that the LTC Coordinating Center would be the primary contact point for gathering data and CT-DPH/FLIS would handle all matters requiring State intervention or outstanding LTC issues. It was also reported that during off hours when the LTC Coordinating Center was not staffed, or after the LTC Coordinating Center stood down on Friday the 4th, that CT-DPH was asking for information the LTC facilities were not familiar with. It was suggested that there be a better understanding among all collaborators of what would constitute those essential elements of information that the LTC community and stakeholders could be more “conversant” with and be included in annual LTC-MAP training sessions.

LTC representatives report that off shift emergency reporting (nights and weekends) is problematic at some facilities due to the fact that internet access may be restricted or nursing staff may not be familiar with the Mutual Aid Plan web portal / reporting mechanisms. One of the issues associated with restricting internet access in facilities is older IT systems or software which limits the ability to make certain web sites such as the LTC-MAP web portal available during the off hours and weekends.

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Observed Strengths

- Willingness of the LTC community to engage in process
- LTC-MAP Steering Committee
- Russell Phillips & Associates (RPA) staff
- Communication, Collaboration, and Coordination with CT-DPH/FLIS
- LTC-MAP web portal and reporting tools
- RPA Information Technologies service building dynamic data interface

Areas for Improvement

- LTC-MAP training and familiarization
- Essential elements of Information to be shared
- Coordination of information with Acute Care Hospitals
- Outdated IT systems and software packages
- Communications redundancy
- Web EOC accessibility and usage protocols

Analysis:

As a whole the LTC-MAP operated as intended, serving as the gathering hub and clearing house for information, and coordinating the actions of all LTC stakeholders and collaborating agencies. Some methods of communication were damaged or compromised, but the LTC community showed exceptional resiliency and creativity in meeting its mission to support not only their individual facilities but the LTC-MAP, as well as assisting the Acute Care Hospitals in managing the evolving hospital surge issues as the week progressed.

A singular Incident Action Plan involving the LTC Coordination Center, as well as the Region 3 Regional Coordination Center (RCC) and the State EOC and DPH ECC, is the ultimate goal of inter-agency coordination and collaboration. It can be achieved only by the entry of timely and accurate data into a web-based system that results in a common operating picture. That is the exceptional strength of the LTC-MAP web-based system of resource management.

The LTC Coordination Center relies on those LTC-MAP Steering Committee members who volunteer to staff the LTC Coordinating Center even while their respective facilities may be facing the same level of problems as those they are working to alleviate. Additionally, The RPA personnel that managed the work and flow of the LTC Coordinating Center proved critical to the successful operation of the LTC-MAP. These two elements are the linchpin of LTC-MAP success, and if either is unavailable could lead to failure of the LTC-MAP.

Accurate and timely information is also critical to the CREPC Regional Coordination Center as it coordinates the efforts of the Region 3 member municipalities in trying to preserve and maintain access to the regional healthcare system. Unfortunately during the response to Storm Alfred, the LTC Coordinating Center was sharing information with the 11 acute care hospitals in the Region but there is no clear understanding of what the hospitals were doing with the data supplied by the LTC Coordinating Center.

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Recommendations:

- 1.1 Better socialization of the Long Term Care Mutual Aid Plan and the Mutual Aid Plan web portal with all member LTC facilities.
- 1.2 Train all administrators, key managerial staff and nursing supervisors to the LTC-MAP and emergency reporting process.
- 1.3 Collaborate and coordinate with LTC stakeholders in the development of what essential elements of information are needed in order for the LTC-MAP and CT-DPH/FLIS to function more efficiently.
- 1.4 Integrate information sharing across IT /software platforms such as WebEOC.
- 1.5 Develop the appropriate protocols on Web EOC usage.
- 1.6 Upgrade older software packages to allow access to certain internet sites.
- 1.7 Explore feasibility and cost of redundant communication systems, especially PBX based systems (Private Branch Exchange) which allows for offsite transfer of phone system to any other telephonic device.
- 1.8 Develop information sharing and emergency reporting checklist for LTC facilities.

Section 2

Resources and Supplies

Discussion:

There were no reported significant shortages of supplies during the aftermath of the storm. Each LTC facility in the Region has a generator, or has power generation capability. However supplies associated with “surge-beds” created some areas of concern.

LTC facilities did report that power generation becomes problematic as the duration of operation increases. Generators need to be serviced during periods of extensive use and to do so will require shutting down the generators for maintenance and service. The fear is that the generators will not re-start once the service is complete. Some facilities bring in generator service professionals and electricians during these periods to assist with re-start operations and to trouble shoot problems.

RPA staff at the after action meeting reviewed the vendor list developed through the LTC-MAP which is posted on the LTC-MAP web portal. The LTC-MAP maintains the vendor list by service category and includes Points of Contacts and emergency reporting/request numbers. They reminded LTC member facilities of its value to the LTC community and to the Region. LTC representatives state it is a good practice to develop “backups to your backups”, e.g. multiple generator fuel sources, on-call generator service or access to mobile generators, etc., for these periods where extended use can lead to system failures.

Immediately following the storm, LTC facilities reported that initially there were concerns regarding staffing due to road closures by storm debris. Closed roads created temporary staff shortages, and/or extended hours for those already on duty. However, the larger impact on employees being able to report to work was the lack of available functioning gas stations, or gasoline supplies to stations able to operate pumps. Despite the fact that the Region 3 RCC published a list of open gas stations on the third day, the entire Region experienced very long lines at operating stations for days, with individuals “trolling” for gas over great distances outside of the Region. Some LTC facilities also become a second

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home to staff and their families who were without power or access to school or daycare for extended periods of time.

Observed Strengths

- Fully developed and vetted LTC community vendor list
- Economy of Scale when collaborating with vendors
- Willingness to share resources among facilities

Areas for Improvement

- Vendor list training and familiarization with LTC community
- Vendor list awareness with CREPC-RCC

Analysis:

As facilities prepare for emergencies they do so with an eye towards the “bottom line” in determining what is that level of prudent investment that meets the emergency preparedness needs of the facility and stays within any prescribed budget. Having said that, studies indicate that for every dollar spent on preparedness and mitigation efforts there is a cost benefit of savings from four to eleven dollars in response and recovery¹. Clearly preparedness dollars spent pre-event can result in major savings to the LTC facilities when disaster strikes.

When a disaster occurs, there is real concern that all affected institutions including hospitals and LTC facilities will turn to the same vendors for assistance in meeting their equipment and supply needs. During the development of the LTC-MAP, it was determined that lists of vendors identified by need (e.g., generators, linens) would become a valuable resource to the LTC facilities when they needed to reach beyond their normal vendor list, and allowed the facilities to identify backup sources even before an incident occurred. Furthermore, vendors have exhibited a willingness to be part of the planning process and should be included as such. These preparedness efforts should include determining an estimate of facility supply usage rate (i.e., how quickly do “we” consume supplies) during normal operations, as well as during emergency operations, when operations and access to the supply chain may become more austere.

Recommendations:

- 2.1 Ensure vendor list and all pertinent components of the LTC-MAP web portal are part of annual LTC-MAP training
- 2.2 Socialize vendor list with CREPC-RCC resource data bases
- 2.3 Engage vendors and other private sector stakeholders in pre-event planning and preparedness
- 2.4 Determine what resources can be cached vs. those that are just in time (perishables) and supply chain processes under austere conditions
- 2.5 Determine if LTC facilities are suitable for the emergency sheltering of staff and family
 - This would include availability of space and traditional shelter supplies

¹ Multi-hazard Mitigation Council – Natural Hazard Mitigation Saves Lives Vol. 2 Study Document, 2005 - <http://www.nibs.org/client/assets/files/mmc/01-Chapters1-7.pdf>
Harvard School of Public Health – Humanitarian Initiative, 2006 – <http://www.hsph.harvard.edu/news/hphr/files/HSPHPrioritiesHHLJan08.pdf>

Section 3

Facility and Medical Surge

Discussion:

LTC facilities reported that their ability to meet expanded healthcare demands and to implement surge procedures proved to be daunting. Most of the challenges centered on payer source issues. There are defined state processes and federal regulations that dictate what a facility must do to be eligible to receive reimbursement for expenses incurred during a disaster response. Deviations from normal procedures require state declarations and federal waivers.

Efforts by Region 3 LTC facilities to respond to “disaster” circumstances without certain declarations affected their ability to efficiently coordinate healthcare resources, both regionally and statewide. Despite conversations between the CT Department of Public Health and both the Region 3 RCC and the LTC Coordination Center, there remained considerable confusion regarding the implementation of protocols required to obtain waivers from standard procedures, especially regarding the elusive 1135 waiver process (Sec. 1135. [42 U.S.C. 1320b–5]² of the Social Security Act). Questions of whether federal reimbursement to healthcare facilities and agencies would be possible without a declared state public health emergency, as defined in C.G.S 19a-131a, were never clearly answered.

Following Storm Alfred, and despite requests from a variety of healthcare entities, the CT Commissioner of Health chose not to declare a Public Health Emergency, even though CT Governor Malloy issued a statewide declaration of emergency the day the storm hit³. The reasoning behind the Health Commissioner’s decision not to declare may be related to the fact that the “entire” state was not impacted to the point that there were no more resources available but it was felt that this should not have impacted waiver requests for certain LTC facility admission processes.

Private conversations with several DPH personnel suggested that the circumstances surrounding Storm Alfred did not meet the criteria for a declaration of a Public Health Emergency in accordance with C.G.S. 19a-131a. As reported by Region 3 hospitals and community shelter operators, there was a sense that a declaration of a public health emergency was clearly warranted, if only by the sheer numbers of medically affected citizens impacted by the storm in Region 3. Acute Care Hospital emergency departments, and soon thereafter the community shelters, were burdened with hundreds of “boarders”, mostly medical device or medication-dependent victims who under normal conditions were able to live at home in a self-sufficient manner. These unfortunate individuals needed help in the form of a place to plug in their equipment or to receive medications, and they did the logical thing: they managed to get themselves to a hospital or to a community shelter. Yet hospitals, already operating at or above capacity, found themselves with a group of individuals who, though clearly in need of assistance, did not require hospital admission. Region 3 hospitals absorbed many of these “boarders” (a term newly coined by the hospitals early on in the event) throughout the course of the storm, most at hospital expense

² See Attachment 3

³ Pursuant to C.G.S. 28-9: Civil Preparedness Emergency proclaimed by CT Governor filed with the CT Secretary of State at 5:30PM, October 29, 2011.

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Similarly, many communities provide shelter to victims of disruption routinely. After Storm Alfred however, many of these shelters received medically dependent individuals in large numbers who required varied levels of assistance from trained healthcare personnel, some of them arriving with caregivers who also had to be accommodated in the austere environments in which shelters normally are located. Shelter personnel in many communities were immediately overwhelmed by this development, and lacked the trained staff and the administrative experience to manage the growing demand.

Both the hospitals and the communities thus turned to the Region 3 RCC for assistance in locating equipment and personnel to meet their needs. Late on 30 October, CT DPH advised Region 3 RESF 8 (Public Health and Medical Services) to consider establishing a “regional medical shelter”, a location where equipment and healthcare personnel could be concentrated for maximum effectiveness, and to where both the hospitals and the community shelters could relocate their boarder populations to relieve the pressure on those facilities. CT DPH recommended that a hospital Alternate Care Facility (ACF), as defined in hospital emergency operations plans, might be activated by a regional hospital and supported administratively by community and regional personnel. CT DPH indicated also that CT-1 DMAT would be available to assist at the ACF if needed to manage the medical issues there.

It should be noted that the concept of a regional medical shelter had been discussed on many occasions, but no policies or protocols had ever been written at the state level in support of the idea, so this was new territory for the region and the state agencies. Over the next 24 hours, Region 3 RESF 8 personnel who were located at the Region 3 RCC conducted conversations with local and state agencies to determine how a community-based, regionally administered medical shelter could be implemented in Region 3. Questions of altered standards of care and waivers to normal policy (i.e., use of certified EMS for transport to an ACF, modifications to admission procedures, etc.) were discussed at length.

Finally, the RCC RESF 8 staff spoke with administrators at several of the region’s larger hospitals to determine if any of them were in a position to open an alternate care site that would serve as a regional medical shelter and could be staffed by regional and state resources. Though the hospitals recognized that doing so would help them directly by decompressing their rapidly surging patient load, none was in a position to activate an ACF, as each was overwhelmed by their increased internal operational demands, as well as by a shortage of staff who could not report for work at the hospitals. Clearly RESF 8 needed to develop a Plan B.

The RESF 8 turned then to the CT Region 3 LTC-MAP for assistance in managing the regional influx of medically ambulatory but electronically dependent storm victims. The LTC-MAP had been activated and the LTC Coordinating Center had been staffed on 30 October. On the morning of 1 November, RESF 8 presented a proposal to the participating members of the LTC-MAP, asking them to accept as many boarders as they could from the hospitals and the LTC facilities readily agreed to help. RESF 8 then held a series of teleconferences with the hospitals, with DPH and with several EMS agencies to present the hospital decompression plan, with a target activation time of noon that day. It should be noted that DPH personnel were extremely helpful in facilitating the procedures required to make this heretofore untried process work. Many of the region’s LTC facilities, despite operating with reduced staff and on generator power, prepared for the influx of patients from the hospitals.

At noon, the transfers began as planned, but very soon a number of major obstacles appeared that threatened to cause the process to fail. In a hastily arranged teleconference at 1:00 pm between Region 3 RESF 8, DPH and the CT Department of Social Services (DSS), the identified obstacles were presented

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one-by-one and discussed in detail to find ways to work around the issues. While some problems were amenable to solution, others could not be altered or suspended, and these remained as obstacles for the remainder of the event.

DPH issued a directive to communities advising them of their requirement to accept all comers into their shelters regardless of their medical status, and only those acutely ill were to be transferred to the hospitals. In addition, DPH/FLIS was able to offer a waiver to the LTC facilities that allowed an accepting facility to increase its capacity to 110% of its licensed bed capacity⁴, and 15 Region 3 LTC facilities applied for that waiver. DPH also released a guidance document, effective upon release and valid until 5 November, that detailed the process and standards for accepting boarders at the LTC facilities, and described pre-admission screening and admission resident review (PASRR) procedures, regulatory exemptions, and admission requirements, including the CT W10 form requirement⁵. In the LTC-MAP after action review held on 10 November, the participating LTC facilities stated that the DPH guidance document was helpful and appreciated, but did not solve the need for waivers relating to the payment process, and payer uncertainty remained the primary source of confusion. Additionally, LTC-MAP members stated that further discussion with DPH is necessary to clarify procedures for accepting patients into a sheltering environment vs. having to admit them.

RPA staff representing LTC CC operations spoke to doing a better job of assuring all LTC facilities know and understand LTC MAP bed availability information and process. It was noted that facilities may not have had to surge if they had all the information regarding bed availability within the LTC Mutual Aid Plan.

Also in the after action review, LTC representatives reported a willingness to take boarders to assist in the hospital decompression process, but felt they were inhibited not only by payer uncertainty but by potential liabilities associated with “just taking folks in” that needed some sort of assistance but did not meet admission criteria. Examples cited included:

- When does a facility assume responsibility for providing services that an individual usually receives at home through the local Visiting Nurse Association, or by a Certified Nursing Assistant or personal care giver
- How would LTC facilities provide access/transportation to outpatient dialysis services or peritoneal lavage, etc., and when the facility provides access to that service does that constitute an admission?

LTC facilities reported they noticed a significant increase in visitors from families and other individuals from private residences still without power seeking warmth and comfort. No report was made that this created any significant problems within the LTC facilities.

The process for the LTC-MAP members receiving patients followed the following protocols:

1. Standard Discharges from hospitals
2. Medicare eligible patients – 3 day length of stay needed in the hospital and only an Public Health Emergency with an 1135 (Social Security Act) waiver could have eliminated this requirement to move them directly into Long Term Care to support hospital decompression
3. Medicaid eligible patients – Appropriate actions were taken to enable certain relief on Pre-Admission Screening and Resident Review (PASRR) and Ascend, the contractor who

⁴ See Attachment 1

⁵ See Attachment 2

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administers the PASRR process for Connecticut. Challenges were encountered when it was believed by acute care hospitals that the waiver or relief then enabled hospitals to eliminate key documentation such as W-10 forms and this was not the case as those were still required. An overall communications issue that was addressed between DPH, the hospitals and the LTC-MAP

- i. Respite Care – Many of the patients were paid for under a Respite Care provision. A respite care resident still requires PASRR and a W-10. Respite care usually refers to length of time the resident is in the nursing home (less than 7 days) and is usually utilized for a break, or “respite”, for the at-home primary caregiver.
4. Private Insurance patients – A process was established by some Admissions departments at LTC facilities to quickly negotiate with the insurer to enable their insured to be placed in the LTC facility for 3 – 5 days, or until power was restored at their home address
5. Private pay – In these situations, there were some acute care hospitals that provided guaranteed pay to the LTC facilities to take these patients to open hospital beds and decompress. This was on a case by case basis and should be reviewed if there could be a standard process here for this to take place for any of the above patients in the absence of a patient/resident meeting admission criteria and having acceptable documentation. Private pay was typically 3 – 5 days length of stay, or until power was restored at their home address

Note:

These private contracts with acute care hospitals had a varying price per day ranging from fixed all inclusive daily rates to the facility’s Medicaid rate. This was dependant on the complexity and care needs of the resident

Observed Strengths

- Generosity of Long Term Care – Mutual Aid Plan participant facilities in assisting the communities and hospitals
- Coordination and creativity provided by volunteer staffers at the LTC Coordination Center
- Willingness of DPH/FLIS to work with the Region 3 agencies to find solutions
- Partially successful regional collaboration with CT-DPH/FLIS and CT-Department of Social Services (DSS) in resolving issues inhibiting patient flow from the hospitals to the LTC facilities
- Collaborative approach with private insurance payment sources

Areas for Improvement

- Pre-event development of protocols and procedures for completing LTC admission waivers
- Clarification of emergency sheltering protocols for the LTC facilities
- Developing the process for implementing transfer of individuals among the facilities participating in the LTC-MAP
- Developing the concept of regional medical shelters

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Analysis:

Following Storm Alfred, the biggest challenge facing Region 3 from a public health/medical perspective was the appropriate management of so-called “boarders” at the Acute Care Hospitals (ACH) and the community shelters. ACHs saw their emergency departments being overrun with boarders seeking shelter who had minimal medical needs and who normally were self-sufficient at home. Early on in the event, some of these individuals were sent to community shelters by the hospitals, only to have those shelters call 911 or other transportation services to take these same individuals back to a hospital. LTC facilities were willing to provide some relief to the hospitals, but without the identification of a payer source, and with admission vs. sheltering concerns, the LTC-MAP was not able to achieve its full potential as an effective regional surge resource.

Confusion about policies and regulations, and a perceived reluctance on the part of state authorities to find ways to circumvent certain regulations for the benefit of the region’s residents, led to limited success in Region 3 in managing this group of unfortunate citizens. Discussions with DPH regarding state and federal waiver processes, especially for Medicare and Medicaid (Federal 1135 waivers), were informative and helpful, but DPH appeared hesitant to make any requests for relief. During after action reviews conducted in Region 3, considerable discussion occurred regarding the decision by DPH not to declare a state public health emergency, as both hospitals and LTC facility operators believed that such a declaration may have facilitated relief from the burdens of regulation that inhibited an effective regional response.

As noted later, under Section 319 of the federal US-HHS Public Health Service Act, the US Health and Human Services (HHS) Secretary or a designee can waive or modify certain Medicare, Medicaid, and Health Insurance Portability and Accountability Act (HIPAA) requirements by declaring a federal Public Health Emergency (PHE). This PHE declaration may be made whether or not a Presidential declaration of emergency under the terms of the Stafford Act has been made. However the issue is complicated by the fact that, under the terms of the Social Security Act (SSA), Section 1135 waivers require both a Presidential Stafford Act declaration/ National Emergency Act and a Public Health Declaration by the Secretary of HHS to be invoked; at that point, HHS regional coordinators can assist local as well as state officials in obtaining 1135 waivers.⁶ At the time of this incident, none of this was clearly understood by or adequately explained to regional response agencies and institutions, and confusion limited an effective regional response to the boarders’ issue. In any case, CT received the Presidential declaration of emergency upon the request of the Governor, but did not receive a declaration of Public Health Emergency from HHS as it was not requested.

It is noted that in CT Region 5, a regional medical shelter utilizing an alternate care site opened by Danbury Hospital was successfully implemented, reducing some of the boarders’ burden on the Region 5 hospitals and community shelters. The Region 3 RESF 8 solicited support from the region’s hospitals to implement a similar facility in Region 3, but the severity of the storm’s impact on the hospitals precluded that possibility. One regional hospital approached the officials of the community in which it is located and asked for assistance in identifying a location to serve as an alternate care site at which a regional shelter operation could be established. Due to perceived concerns about liability, the town refused to allow the establishment of a regionally operated shelter that included medical operations. Similarly, a Region 3 RESF 5 solicitation to the Region 3 communities asking any of them to open a regional medical shelter was met with considerable reluctance and concerns about town liability.

⁶ As posted on the US HHS website <http://www.phe.gov/Preparedness/legal/Pages/phe-ga.aspx#11>

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Nevertheless, clearly there has been established a need for an entity such as a regional medical shelter, able to operate in a time of disaster, within the spectrum of the CT healthcare system. Citing the Region 5 success as a best practice then, there is a clear opportunity to engage both regional and state agencies in a process to implement a statewide plan and protocols for the operation of regional medical shelters. That process must include a discussion regarding ways to modify or waive those regulations and policies that inhibit local flexibility in meeting the exigencies of a disaster.

It is noted that under DPH leadership, a statewide workgroup developed a draft plan entitled *“Regional Emergency Supportive Care Shelter Operations and Planning Guidance”* that addresses the pertinent issues, but that document has not received the support of the appropriate state agencies for its use as a template for further discussion leading to a workable statewide plan. It is time to revive this effort.

Recommendations:

- 3.1 Establish statewide taskforce to review the *“Regional Emergency Supportive Care Shelter Operations and Planning Guidance”* document and determine feasibility of implementation
- 3.2 Examine the development of a Regional Shelter system, or;
- 3.3 Authorized agencies of the State of Connecticut provide proper guidance and assistance in the sheltering of individuals with certain medical needs
- 3.4 Examine best practices from other States in sheltering those with medical needs and waiver processes
- 3.5 In collaboration with state and federal agencies, develop and provide training on a statewide plan to activate and operate regional medical shelters
- 3.6 Determine if hospitals and LTC facilities should pre-negotiate rates to support the rapid decompression of the hospitals in the absence of the ability for patients or “medical sheltered” community to go anywhere else.

Section 4

Conclusions:

Development of the LTC-MAP and use of the plan when needed is a regional success story that needs to be told. The success of this initiative is borne from the buy in and confidence it has developed from the LTC community, the Region, and the State (primarily DPH). Like all plans, it is not perfect and the experiences detailed in this AAR provide great clues for improvement. Implementing recommendations in the quest for improvement comes with a price or requires longer term capital budget planning and expenditures. However budgets alone should not deter the examination of how best to mitigate or buy down risk going forward.

There are opportunities for the LTC-MAP to hone the necessary skills in resource management and coordination. There are opportunities for Region 3 / CREPC to enhance their operations and coordination efforts. And hopefully the State will examine how they responded to both TS Irene and Storm Alfred. Without the honesty and openness needed for self-examination we are doomed to commit the same mistakes as was evidenced by the utility companies' response to both storms. The State of Connecticut needs to commit and follow through on corrective actions highlighted in exercise After Action Reports and Improvement Plans from the past three (3) years in Region 3. Storm Alfred is not the first time these Areas for Improvement have not been observed at both the State and sub-state Regional level and it is hoped that all stakeholders accept their respective responsibility to correct where correction is needed and appropriate.

The areas for improvement yielding the greatest effect for preparedness and response include:

- For the plan itself, ensure all stakeholders are familiar with the plan and trained adequately on reporting and plan implementation.
- Build a more effective process to share critical information in a timely and accurate way, then train and exercise on it. This process should include a critical assessment, by the state, of *their* WebEOC system. It simply lacks protocols for use. If there is no resource, or will, at the state level to develop those protocols then it would make sense to halt the "waste" of money on a system not being used to its full potential. WebEOC is a powerful tool and when used to that full potential it can become THE platform for developing that common operating picture among all stakeholders.
- Hone the vendor process. It is essential that LTC facilities can get the things they need when needed.
- Address the total sheltering question; what is the role of LTCs in community sheltering and hospital decompression when they are overwhelmed with "boarders"? How can private organizations afford to support these state and community efforts?
- Development of processes, and better understanding of, the appropriate waivers for payer identification whereby pre-event, stakeholders can provide the highest level of care necessary for those in need. This would include alternative assessment requirements and treatment / care option short of a "full waiver" process.
- In conjunction with DEMHS, Regional outreach to municipal Chief Executive Officers and Emergency Management Directors emphasizing strength and value of regional plans and processes. This would include updating training and education to the Region 3 Regional Emergency Support Plan (R-3

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RESP) and working in collaboration with DEMHS in the coordination of resource requests and logistics support and management.

These efforts will enhance the process that currently exists resulting in better care, better support and less confusion the next time a large scale regional incident occurs. The cost of not doing anything may be hard to measure, but it should be considered and should include the deterioration of a good process and lack of support needed by citizens when they most need it. The responsibilities are primarily those of the local jurisdictions and the State, but they must recognize they have regional and local networks across the State ready, willing and able to assist. Let's not blow this opportunity.

Attachment 1
STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: Facility: _____
Address: _____
Town: _____, CT Zip _____

WAIVER CONSENT AGREEMENT

(Facility Name): _____, (Facility) hereby stipulates and agrees as follows:

WHEREAS, the above-referenced Facility has been issued a License to operate a health care institution under Connecticut General Statutes (Statutes) §19a-490 by the Department of Public Health, State of Connecticut (the Department); and

WHEREAS, on October 29, 2011, pursuant to §28-9 of the Statutes, the Governor of the State of Connecticut declared a state of emergency due to the impact of Storm Alfred; and

WHEREAS, the Facility has requested a waiver pursuant to §19-13-D8t(c) of the Regulations of Connecticut State Agencies (Regulations) citing the specific regulation(s) for which the waiver is requested, the reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon enforcement of the regulation(s), the specific relief requested; and any documentation which supports the waiver; and

WHEREAS, the Department's consideration of this request is based on consideration of the factors listed in §19-13-D8t(c)(3) of the regulations; and

WHEREAS, the Facility agrees to the conditions set forth herein.

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NOW THEREFORE, the Department acting herein and through Barbara Cass, Section Chief of the Facility Licensing and Investigations Section (FLIS), and the Facility, acting herein and through _____, the Facility's officer authorized to sign this Consent Agreement on behalf of the Facility, hereby stipulate and agree as follows:

1. In the event of a surge of patients presenting to the Facility during the October 29th declared state emergency, necessitating admission to the Facility beyond its current licensed capacity, the Facility may increase its bed capacity by ten (10) percent of the licensed capacity provided all of the conditions contained in this Agreement are met.
2. The Facility shall make provisions to manage the increase in bed capacity to provide appropriate care at all times including but not be limited to the following requirements:
 - a. Provide a safe and comfortable environment;
 - b. Compliance with Infection Control standards;
 - c. Communication mechanism for all patients;
 - d. Provisions for adequate food and supplies;
 - e. Provisions for patient privacy;
 - f. Provide staffing to meet the health and safety needs of the patients; and
 - g. Notification to the local Fire Marshal of the increase in licensed bed capacity.
3. This Consent Agreement shall remain in effect for thirty (30) days from final signature unless otherwise specified by the Department.

The parties hereto have caused this Consent Agreement to be executed by their respective officers and officials, which Consent Agreement is to be effective as of the later of the two dates noted below:

Date: _____ By: _____

Date _____ By: _____

Barbara Cass, R.N
Section Chief
Facility Licensing & Investigations Section

Attachment 2

BLAST FAX 11-1-11

TO: All Nursing Home Providers

FROM: Barbara Cass, R.N., Section Chief
Facility Licensing and Investigations Section
410 Capitol Avenue
Hartford, Connecticut, 06134

DATE: November 1, 2011, 1700 Hours

SUBJECT: ADMISSION TO NURSING HOMES/PASRR Requirements
CONSENT AGREEMENT TO SURGE LICENSED BED CAPACITY
GENERATOR UTILIZATION AS OF 11/1/11

ADMISSION TO NURSING HOMES/PASRR Requirements : As hospitals attempt to decompress, many issues have surfaced regarding PASRR requirements. The Department of Social Services has provided the following guidance to hospitals and nursing homes as it relates to pre-admission screening:

1. All Nursing Facility applicants need a PASRR screen prior to admission to the nursing facility.
2. Effective until November 5, 2011, the Department of Social Services will not require a level of care determination for Medicaid recipients whose stay is 7 days or less who are admitted as a result of needs that could not be met in the community because of the winter storm.
3. Effective November 6, 2011, the existing PASRR and Level of Care requirements rules shall be followed.
4. Any person with a Positive Level I screen coming into the Hospital Emergency Department is being reviewed by Ascend for a seven (7) day emergency exemption. This exemption allows placement absent the level of care determination and the Level II assessment. However, it is the Nursing Home's responsibility to notify Ascend if the admission will exceed seven (7) days regardless of the payor source.
5. For Medicaid recipients, if the stay will exceed the seven (7) days a level of care determination must be submitted by the nursing home.
6. If they do not meet level of care after 7 days, Medicaid payment will cease.

CONSENT AGREEMENT TO SURGE LICENSED BED CAPACITY: Nursing homes have been significantly impacted with requests for admission in an effort to assist with the decompression in the hospitals. While we are aware that many of you are at licensed capacity, we are providing a waiver opportunity to

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nursing homes that may be interested in surging. A consent agreement permitting surge that must be signed by the facility designee is attached. The procedure will be timely and is as follows:

1. Review and sign attached consent agreement and forward electronically to Barbara.cass@ct.gov;
2. Initiate telephone call to Barbara Cass at 860-637-2714 requesting desire to surge;
3. The waiver committee will immediately convene telephonically (regardless of time) and a decision will be determined;
4. Barbara Cass will notify the facility telephonically with the decision and if approved, scan back a signed copy of the consent agreement; and
5. Should the request be made off hours and while DPH staff are remotely assisting with the request, an approval will be provided through email with the signed consent agreement scanned to the facility on the next business day.

GENERATOR UTILIZATION AS OF 11/2/11: If you are on generator power on November 2, 2011, please respond to **facsimile number 860-707-1832 by Tuesday 11/2/11, 10:30 AM.**

Please respond only if currently on generator power and indicate if there are any issues associated with accessing generator fuel.

It is very important that you respond, so that further planning can be made if necessary.

Should you have any questions, please call 860-509-7400 and ask to speak to a supervisor.

Attachment 3



AUTHORITY TO WAIVE REQUIREMENTS DURING NATIONAL EMERGENCIES

Sec. 1135. [42 U.S.C. 1320b–5] (a) Purpose.—The purpose of this section is to enable the Secretary to ensure to the maximum extent feasible, in any emergency area and during an emergency period (as defined in subsection (g)(1))—

(1) that sufficient health care items and services are available to meet the needs of individuals in such area enrolled in the programs under titles XVIII, XIX, and XXI; and

(2) that health care providers (as defined in subsection (g)(2)) that furnish such items and services in good faith, but that are unable to comply with one or more requirements described in subsection (b), may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.

(b) Secretarial Authority.—To the extent necessary to accomplish the purpose specified in subsection (a), the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify the application of, with respect to health care items and services furnished by a health care provider (or classes of health care providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of titles XVIII, XIX, or XXI, or any regulation thereunder (and the requirements of this title other than this section, and regulations thereunder, insofar as they relate to such titles), pertaining to—

(1)(A) conditions of participation or other certification requirements for an individual health care provider or types of providers,

(B) program participation and similar requirements for an individual health care provider or types of providers, and

(C) pre-approval requirements;

(2) requirements that physicians and other health care professionals be licensed in the State in which they provide such services, if they have equivalent licensing in another State and are not affirmatively excluded from practice in that State or in any State a part of which is included in the emergency area;

(3) actions under section [1867](#) (relating to examination and treatment for emergency medical conditions and women in labor) for—

(A) a transfer of an individual who has not been stabilized in violation of subsection (c) of such section if the transfer arises out of the circumstances of the emergency;

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(B) the direction or relocation of an individual to receive medical screening in an alternative location—

(i) pursuant to an appropriate State emergency preparedness plan; or

(ii) in the case of a public health emergency described in subsection (g)(1)(B) that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan or a plan referred to in clause (i), whichever is applicable in the State;

(4) sanctions under section [1877\(g\)](#) (relating to limitations on physician referral);

(5) deadlines and timetables for performance of required activities, except that such deadlines and timetables may only be modified, not waived;

(6) limitations on payments under section [1851\(i\)](#) for health care items and services furnished to individuals enrolled in a Medicare+Choice plan by health care professionals or facilities not included under such plan; and

(7) sanctions and penalties that arise from the noncompliance with the following requirements (as promulgated under the authority of section 264(c) of the Health Insurance Portability and Accountability Act of 1996^[131] (42 U.S. C. 1320d-2 note)—

(A) section 164.510 of title 45, Code of Federal Regulations, relating to—

(i) requirements to obtain a patient’s agreement to speak with family members or friends; and

(ii) the requirement to honor a request to opt out of the facility directory;

(B) section 164.520 of such title, relating to the requirement to distribute a notice; or

(C) section 164.522 of such title, relating to—

(i) the patient’s right to request privacy restrictions; and

(ii) the patient’s right to request confidential communications.

Insofar as the Secretary exercises authority under paragraph (6) with respect to individuals enrolled in a Medicare+Choice plan, to the extent possible given the circumstances, the Secretary shall reconcile payments made on behalf of such enrollees to ensure that the enrollees do not pay more than would be required had they received services from providers within the network of the plan and may reconcile payments to the organization offering the plan to ensure that such organization pays for services for which payment is included in the capitation payment it receives under part C of title XVIII. A waiver or modification provided for under paragraph (3) or (7) shall only be in effect if such actions are taken in a manner that does not discriminate among individuals on the basis of their source of payment or of their ability to pay, and, except in the case of a waiver or modification to which the fifth sentence of this subsection applies, shall

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be limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. A waiver or modification under such paragraph (7) shall be withdrawn after such period and the provider shall comply with the requirements under such paragraph for any patient still under the care of the provider. If a public health emergency described in subsection (g)(1)(B) involves a pandemic infectious disease (such as pandemic influenza), the duration of a waiver or modification under paragraph (3) shall be determined in accordance with subsection (e) as such subsection applies to public health emergencies.

(c) Authority for Retroactive Waiver.—A waiver or modification of requirements pursuant to this section may, at the Secretary’s discretion, be made retroactive to the beginning of the emergency period or any subsequent date in such period specified by the Secretary.

(d) Certification to Congress.—The Secretary shall provide a certification and advance written notice to the Congress at least two days before exercising the authority under this section with respect to an emergency area. Such a certification and notice shall include—

(1) a description of—

(A) the specific provisions that will be waived or modified;

(B) the health care providers to whom the waiver or modification will apply;

(C) the geographic area in which the waiver or modification will apply; and

(D) the period of time for which the waiver or modification will be in effect; and

(2) a certification that the waiver or modification is necessary to carry out the purpose specified in subsection (a).

(e) Duration of Waiver.—

(1) In general.—A waiver or modification of requirements pursuant to this section terminates upon—

(A) the termination of the applicable declaration of emergency or disaster described in subsection (g)(1)(A);

(B) the termination of the applicable declaration of public health emergency described in subsection (g)(1)(B); or

(C) subject to paragraph (2), the termination of a period of 60 days from the date the waiver or modification is first published (or, if applicable, the date of extension of the waiver or modification under paragraph (2)).

(2) Extension of 60-day periods.—The Secretary may, by notice, provide for an extension of a 60-day period described in paragraph (1)(C) (or an additional period provided under this

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paragraph) for additional period or periods (not to exceed, except as subsequently provided under this paragraph, 60 days each), but any such extension shall not affect or prevent the termination of a waiver or modification under subparagraph (A) or (B) of paragraph (1).

(f) Report to Congress.—Within one year after the end of the emergency period in an emergency area in which the Secretary exercised the authority provided under this section, the Secretary shall report to the Congress regarding the approaches used to accomplish the purposes described in subsection (a), including an evaluation of such approaches and recommendations for improved approaches should the need for such emergency authority arise in the future.

(g) Definitions.—For purposes of this section:

(1) Emergency area; emergency period.—An “emergency area” is a geographical area in which, and an “emergency period” is the period during which, there exists—

(A) an emergency or disaster declared by the President pursuant to the National Emergencies Act^[132] or the Robert T. Stafford Disaster Relief and Emergency Assistance Act^[133]; and

(B) a public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act.

(2) Health care provider.—The term “health care provider” means any entity that furnishes health care items or services, and includes a hospital or other provider of services, a physician or other health care practitioner or professional, a health care facility, or a supplier of health care items or services.

^[131] See Vol. II, P.L. 104-191, §264(c).

^[132] P.L. 94-412.

^[133] P.L. 93-288.

