Long-Term Care Mutual Aid Plan
Full-Scale Exercise

After-Action Report/Improvement Plan

May 26, 2022

Central Virginia Health Care Coalition
830 East Main Street, Richmond, VA 23219

Eastern Virginia Healthcare Coalition
1104 Madison Plaza, Chesapeake, VA 23320

EXERCISE OVERVIEW

Exercise Name	EVHC and CVHC LTC MAP Full-scale Exercise
Exercise Dates	April 26, 2022
Scope	This was a full-scale exercise executed over approximately seven hours. The scope of this exercise was limited to the Eastern and Central Virginia Healthcare Coalition Regional Healthcare Coordination Centers (RHCC) and clinical administrators and emergency managers at long-term health care facilities in each coalition region.
Mission Area(s)	Preparation and Response
Core Capabilities	• Foundation for Healthcare and Medical Readiness • Continuity of Healthcare Service Delivery • Medical Surge
Objectives	1. Evaluate the ability of a Disaster Struck Facility to complete and utilize Long-Term Care Mutual Aid Plan (LTC MAP) evacuation forms or an electronic record transfer for each resident during a facility evacuation. 2. Assess the ability of a Long-Term Care Facility to conduct a "slow out" evacuation utilizing transportation assets from LTC MAP partners for residents that do not require ALS or BLS transport, in coordination with the RHCCs. 3. Demonstrate the ability of the participating RHCCs to coordinate Long-Term Care Facility bed availability during a single-facility evacuation. 4. Evaluate the ability of the evacuating facility, accepting facilities, and RHCC to accurately track residents throughout the evacuation process. 5. Evaluate the ability of both evacuating and accepting facilities to provide timely updates to their respective RHCC when requested or necessary.
Threat or Hazard	Power outage
Scenario	An unexpected and prolonged power outage at a Skilled Nursing Facility in Williamsburg, VA, combined with a high heat index, forced the evacuation of 73 residents from a Disaster-struck Facility (DSF) to a number of Resident-accepting Facilities (RAF).
Sponsors	Virginia Hospital and Healthcare Association, Eastern Virginia Healthcare Coalition (EVHC) and Central Virginia Healthcare Coalition (CVHC)

Exercise Name	EVHC and CVHC LTC MAP Full-scale Exercise
Exercise Participants	Appendix A lists the participating agencies and facilities.
Exercise Summary	The exercise began at 9:00AM with an inject to the clinical administrator from maintenance indicating there is a severe power outage that will last for 3-4 days. This power outage necessitated a slow-out evacuation of 73 residents from Williamsburg Landing. Williamsburg Landing notified EVHC's Regional Healthcare Coordination Center (RHCC) who subsequently created an alert and event in Virginia Healthcare Alerting and Status System (VHASS). The RHCC asked LTC facilities in the Eastern Coalition to post in the VHASS event log and update the LTC Status Board their bed availability and transportation capabilities. EVHC RHCC's then notified the CVHC in order to expand the options for Williamsburg Landing. Williamsburg Landing started coordinating with RAFs located within both coalition regions to determine which residents should go where. The first residents, played by small plush animals with a resident tag, departed around 10:15 AM and arrived at the first RAF a little over an hour later. The last residents left Williamsburg Landing around 3:30 PM. Due to the late hour of the day, the last three transports of residents occurred virtually. Ultimately, all 73 residents arrived at their new location. The exercise ended at 4:02 PM. A total of 37 facilities participated in the exercise with 10 facilities accepting residents. In order for any given facility to receive credit for the exercise, they must have provided an update in the VHASS event log with bed availability and updated the LTC status board. This exercise identified five Areas for Improvement and one Strength (Best Practice) to update the LTC MAP and Coalition Emergency Operation Plans (EOP).

Exercise Name	EVHC and CVHC LTC MAP Full-scale Exercise
Points of Contact	Matt Colmer Eastern Virginia Healthcare Coalition Exercise and Training Coordinator 1104 Madison Plaza Chesapeake, VA 23320 (757) 963-0632 Ext. 325 mcolmer@vaems.org Megan Middleton Central Virginia Healthcare Coalition Preparedness, Exercise and Training Coordinator (804) 723-0511 Ext. 5 Megan.Middleton@central-region.org

ANALYSIS OF HPP CAPABILITIES

Aligning exercise objectives and Hospital Preparedness Program (HPP) capabilities provides a consistent taxonomy for evaluation transcending individual exercises to support preparedness reporting and trend analysis. Table 1 lists the exercise objectives, aligned core capabilities, and performance ratings for each core capability as observed during the exercise and determined by the evaluation team.

Ratings Definitions

Performed without Challenges (P): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws.

Performed with Some Challenges (S): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws. However, opportunities to enhance effectiveness and/or efficiency were identified.

Performed with Major Challenges (M): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s), but some or all of the following were observed: demonstrated performance had a negative impact on the performance of other activities; contributed to additional health and/or safety risks for the public or for emergency workers; and/or was not conducted in accordance with applicable plans, policies, procedures, regulations, and laws.

Unable to be Performed (U): The targets and critical tasks associated with the core capability were not performed in a manner that achieved the objective(s).

The Analysis of Core Capability section highlights strengths and areas for improvement as they relate to each exercise objective and associated core capability.

Exercise Objective	HPP Capability	(P)	(S)	(M)	(U)
1. Evaluate the ability of a Disaster Struck Facility to complete and utilize Long-Term Care Mutual Aid Plan (LTC MAP) evacuation forms or an electronic record transfer for each resident during a facility evacuation.	**HPP Capability 3** Continuity of Health Care Service Delivery		X		
2. Assess the ability of a Long-Term Care Facility to conduct a "slow out" evacuation utilizing transportation assets from LTC MAP partners for residents that do not require ALS or BLS transport, in coordination with the RHCCs.	**HPP Capability 3** Continuity of Health Care Service Delivery		X		
3. Demonstrate the ability of the participating RHCCs to coordinate Long-Term Care Facility bed availability during a single-facility evacuation.	**HPP Capability 3** Continuity of Health Care Service Delivery		X		
	HPP Capability 4 Medical Surge		X		
4. Evaluate the ability of the evacuating facility, accepting facilities, and RHCC to accurately track residents throughout the evacuation process.	**HPP Capability 1** Foundation for Healthcare and Medical Readiness		X		
	HPP Capability 3 Continuity of Health Care Service Delivery		X		
5. Evaluate the ability of both evacuating and accepting facilities to provide timely updates to their respective RHCC when requested or necessary.	**HPP Capability 1** Foundation for Healthcare and Medical Readiness		X		
	HPP Capability 3 Continuity of Health Care Service Delivery		X		

Table 1. Summary of Core Capability Performance

ANALYSIS OF CORE CAPABILITIES

Exercise Objective 1 – Evaluate the ability of a Disaster Struck Facility to complete and utilize Long-Term Care Mutual Aid Plan (LTC MAP) evacuation forms or an electronic record transfer for each resident during a facility evacuation.

Capability 3: Continuity of Healthcare Service Delivery
Objective 6: Plan for and coordinate healthcare evacuation and relocation
Activity 1: Develop and implement evacuation and relocation plans

Critical task: An LTC MAP Resident Evacuation Form or alternative method of medical record transfer is completed on behalf of each evacuation resident.

Area of Improvement 1 – Resident Tracking Forms

Observation – the Virginia Resident/Medical Record/Staff/Equipment Track Sheet was completed for 10 residents but not used for the evacuation of residents. Instead, the DSF and RAFs used an electronic record transfer system.

Discussion – The LTC Mutual Aid Plan advocates use of the Virginia Resident/Medical Record/Staff/Equipment Track Sheet to track residents, medical records, and equipment as the residents leave the DSF. As indicated in the MAP, a single sheet should be completed for each RAF receiving one or more residents. Use of the Track Sheet was not feasible in the timeframe given to evacuate residents. Clinical personnel needed to focus on evacuating residents by assessing their needs, ensuring medicine and equipment accompanied the residents and coordinating transport. The administrative side of the evacuation became a liability especially when it came to writing down all required information.

Recommendation – Develop a short form that reduces the amount of administration time taken away from caring for residents. This would be most practical and efficient in the absence of an electronic record transfer system.

Area of Improvement 2 – Coalition Staffing Support to Impacted Facilities

Observation 1 – Exercise Planning Team Members from both coalitions transitioned from controllers to players in an effort to support the DSF evacuation. The Team Members facilitated evacuation solutions on behalf of the DSF and RAFs. This transition helped tremendously and allowed the DSF to successfully complete the exercise.

Observation 2 – A staff member from CVHC followed representatives from one of the RAFs back to their facility after the resident was picked up at the DSF to assist clinical staff with the transition of one of the DSF residents. The RAF assigned a large contingent of staff to be ready and accept the relocated residents ensuring all were settled

and needs met upon arrival at the RAF; specifically they had one clinical person assigned to each resident.

Discussion – the exercise was not designed to have an Exercise Planning Team Member become a player. However, the DSF had limited staffing available the day of the exercise, and demonstrated limited understanding of the evacuation process, the electronic record transfer system and VHASS. With primary clinical staff caring for residents, there remained little to no assistance with administrative duties. The Exercise Planning Team Members were available to assist the DSF.

For this type of emergency, the LTC MAP does not indicate a coalition member shall deploy to support the DSF. One of the purposes of the LTC MAP is to provide staffing support, as necessary, to a DSF or RAF, whether evacuating, surging and sheltering residents above licensed bed capacity, or sheltering-in-place. The LTC MAP neither states where the staffing support could come nor does it encourage requesting staffing support. In accordance with the Activation Algorithm in Appendix A, the closest request for staffing support corresponds to asking the RHCC for assistance with identifying facilities with availability. The Algorithm neither indicates nor implies Coalition staff should deploy to a DSF to help with their administrative needs. No Coalition should deploy to either a DSF or RAF without express request for support.

Recommendation – review each coalition's Emergency Operations Plan to clarify roles, responsibilities and expectations regarding supporting directly a DSF evacuation. There exists capacity within the coalitions to support the DSF and RAFs with their administrative needs during an evacuation, thus, allowing clinical staff to focus on resident care. Coalition staff have the unique ability to leverage existing relationships with RAFs to expedite communication and establish potential evacuation solutions. Language within the LTC MAP should explicitly encourage DSFs and RAFs to reach out to their coalitions for staffing support on-site. Additionally, exercises of this scope would improve understanding and increase capacity at all facilities.

Exercise Objective 2 – Assess the ability of a Long-Term Care Facility to conduct a "slow out" evacuation utilizing transportation assets from LTC MAP partners for residents that do not require ALS or BLS transport, in coordination with the RHCCs.

Capability 3: Continuity of Healthcare Service Delivery

Objective 6: Plan for and coordinate healthcare evacuation and relocation

Activity 2: Develop and implement evacuation transportation plans

Critical tasks

- The RHCCs can gather, compile, and share information regarding the type, capability, and availability of LTC-owned transportation assets in the region.
- 100% of evacuating residents who do not require ALS or BLS transport are able to be moved utilizing LTC-owned transportation assets.

- Residents who require BLS or ALS transport are identified, and alternative arrangements are made.

Area of Improvement 3 – VHASS Event Thresholds

Observation – the EVHC RHCC created an event in VHASS upon notification by the DSF. The RHCC sent out an alert and the event initially to the Eastern Coalition and subsequently forwarded the event to CVHC. The alerts notified individual healthcare facilities, their assigned leadership and critical partners via text message and email.

Discussion – The LTC MAP relies on VHASS as a primary method of communication. As a secure, web-based emergency management system, VHASS coordinates and streamlines individual and regional healthcare responses to all hazards. The LTC MAP does not define when, or to what extent, an alert should be created; neither does VHASS. The important point here is when should an event be created and when should supporting facilities be notified.

Recommendation – The LTC MAP should include, if not specifically, but at least generally, criteria upon which VHASS event creation should be established. The criteria should include consideration for notifying facilities in neighboring coalitions. Solutions for evacuating residents should not lie solely within the DSF's coalition alone.

Exercise Objective 3 – Demonstrate the ability of the participating RHCCs to coordinate Long-Term Care Facility bed availability during a single-facility evacuation.

Capability 3: Continuity of Healthcare Service Delivery
Objective 6: Plan for and coordinate healthcare evacuation and relocation
Activity 1: Develop and implement evacuation and relocation plans

Capability 4: Medical Surge
Objective 2: Respond to a Medical Surge
Activity 2: Implement Out-of-hospital Medical Surge Response

Critical tasks

- The RHCCs collect information on the bed types required by the evacuating facility and the availability of those bed types in the region within the target timeframe.
- The RHCC can send regional bed availability to the Disaster Struck Facility within the target timeframe.
- The RHCC can provide the Disaster Struck Facility with accurate contact information for the receiving facilities' coordination centers or designated liaisons.

Areas for Improvement 4 – RHCC Staff, Roles and Responsibilities for LTC Evacuations

Observation – each of the two Coalitions had varying levels of staffing support at their respective RHCCs. Based on the staffing differences, one coalition was able to provide

regular updates of resident movements in the event log in VHASS; the other coalition was not able to keep pace due to a smaller number of RHCC staff.

Discussion – the LTC MAP does not require or direct how a Coalition's RHCC is staffed; this remains the responsibility of each Coalition's leadership.

Recommendations

- Including the aforementioned direct staff support to a DSF or RAF, Coalition staff should further examine, and subsequently train on, within their respective EOPs RHCC staff responsibilities and roles for all-hazards.
- All Coalitions should look at the possibility of a part-time incident management team with capability of supporting the DSF, all RAFs and the RHCC(s), as needed and requested.

Exercise Objective 4 – Evaluate the ability of the evacuating facility, accepting facilities, and RHCC to accurately track residents throughout the evacuation process.

Capability 1: Foundation for Healthcare and Medical Readiness
Objective 4: Train and Prepare the Healthcare and Medical Workforce
Activity 2: Educate and Train on Identified Prepared and Response Gaps

Capability 3: Continuity of Healthcare Service Delivery
Objective 6: Plan for and coordinate healthcare evacuation and relocation
Activity 2: Develop and implement evacuation transportation plans

Critical tasks

- The Disaster Struck Facility and all Resident Accepting Facilities cross-check forms to verify all residents are accounted for.
- All facilities provide their respective RHCCs with copies of tracking forms as outlined in the LTC MAP.
- RHCCs coordinate to ensure each has a complete and accurate record of resident transfers.

Strengths 1 – Virginia Resident Emergency Evacuation Board

Observation – the exercise players opted to use an alternate electronic transfer record for tracking the movement and placement of evacuated residents. The Virginia Resident Emergency Evacuation Board (Board) had not been used before in an exercise of this type or scope. The Board proved valuable by tracking resident movement more efficiently and alleviated significant administrative paperwork.

Discussion – the Board provides a central cloud-based location to access all electronic resources required in an LTC evacuation. Strategically placed along the top, the Board included tabs for Just-in-time training, a link to VHASS, the complete Dashboard to track LTC resident evacuation progress, a reference to the LTC MAP in PDF format, and the

exercise Participant Feedback form. The Dashboard tab allowed resident information to be entered or edited using forms on the left including key metrics about the residents displayed in color and an enhanced, filterable indicator/chart/table/text section. Multiple buttons at top right allow LTCs to quickly search for essential information.

Overall, exercise participants found the dashboard useful, beneficial and a strong upgrade over the Virginia Resident/Medical Record/Staff/Equipment Track Sheet.

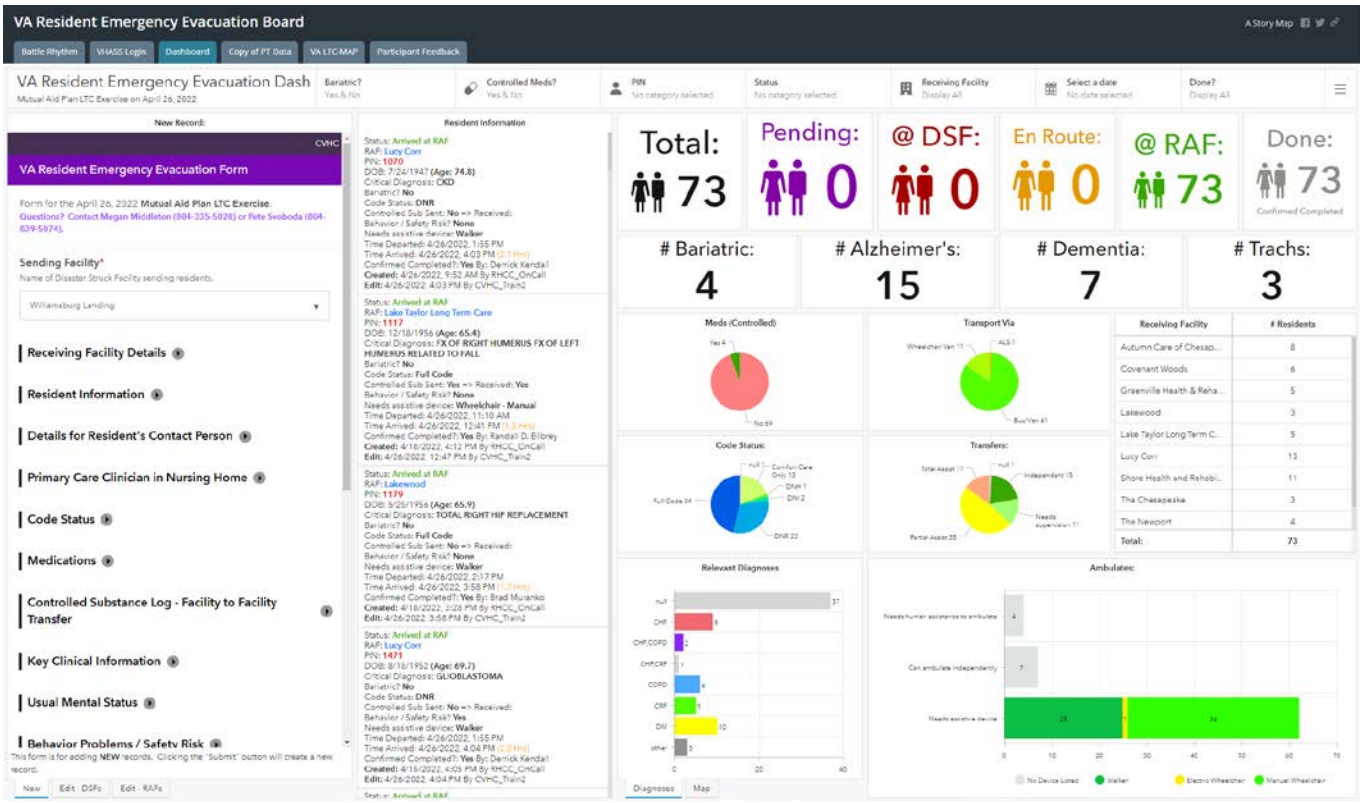

Figure 1. Screen shot from the VA Resident Emergency Evacuation Board displaying the final picture of the transferred residents.

Recommendations – identified as a Best Practice, facilities welcomed its application for future exercises and events and made recommended recommendations along the following categories. Additionally, the Virginia Hospital and Healthcare Association is encouraged to adopt this platform, or something of similar nature, to replace the Track Sheet as the primary method of tracking residents. The Track Sheet can remain a secondary approach in the absence of accessibility to the Board.

- Training – many players expressed the need for more training after having never used the Board before the exercise. Others expressed some confusion on how to use it but once they did, the application became more intuitive.

- Process Guide – the LTC MAP includes an evacuation Activation Algorithm designed to help make evacuation decisions easier and more straightforward. The

same type of flowchart should be created for the Board. The flowchart would allow for easier organization.

- Tailor site to the end user – exercise players expressed the time needed to perform data entry in the application adds a burden to the evacuation process, which could be remedied with a pared down version. Furthermore, the Board should be more intuitive and simplistic. Polling facilities in the exercise in order to see what they want will help tailor the application for future evacuations.

Exercise Objective 5 – Evaluate the ability of both evacuating and accepting facilities to provide timely updates to their respective RHCC when requested or necessary.

Capability 1: Foundation for Healthcare and Medical Readiness
Objective 4: Train and Prepare the Healthcare and Medical Workforce
Activity 2: Educate and Train on Identified Prepared and Response Gaps

Critical tasks

- 100% of participating LTC-MAP Facilities respond to request for bed availability information within the required timeframe.
- 100% of participating LTC-MAP Facilities are able to provide information on their available transportation assets as requested by the RHCC.
- 100% of participating LTC-MAP Facilities respond to attempts to collect additional information in a timely manner.

Area for Improvement 5 – Establish Multiple Points of Contact

Observation – at the onset of the exercise, most facilities, including the DSF, provided a single point of contact to coordinate the tracking and transport of residents. Later in the exercise, some single contacts were not available and a secondary contact had not been identified, thus, delaying the evacuations. Furthermore, RHCCs needed to reach out to RAFs to confirm data entered in VHASS was accurate. However, when the primary contact was unavailable, confirmation was delayed.

Discussion – the LTC MAP emphasizes facilities should develop an Incident Action Plan (IAP) and include a communication plan. As noted in the LTC MAP, facilities used cell phones, radios and the internet as primary methods of communications. If the primary method or methods become disabled, inoperable or unavailable, a secondary method should be established.

Recommendations

- Facilities should review their Emergency Operation Plans to determine if multiple methods and representatives (either by name or position) are identified and update accordingly to include at least three names or positions. These names and positions should be relayed via VHASS, cell phone or radio

during the course of the evacuation immediately upon notification. All names and contact numbers should also be verified in VHASS.

- Furthermore, there is a need to develop and implement training to address the execution of an IAP along with reinforcing the understanding and use of ICS to facilitate an orderly evacuation.

IMPROVEMENT PLAN

Obj	Capability	Area for Improvement	Corrective Action / Recommendation	Primary POC	Start Date	Target Date
1	Continuity of Healthcare Service Delivery	Resident Tracking Forms	Develop shorter form	Matt Marry – VHASS	May 26, 2022	December 31, 2022
2	Continuity of Healthcare Service Delivery	Coalition Staffing Support to Impacted Facilities	review EOPs to clarify roles, responsibilities and expectations LTC evacuation	Steve Parrot – CVHC / Carolyn Malloy – EVHC	May 26, 2022	July 31, 2022
2	Continuity of Healthcare Service Delivery	VHASS Event Thresholds	Established event threshold criteria in VHASS	Matt Marry – VHASS	May 26, 2022	December 31, 2022
3	Medical Surge	RHCC Staff, Roles and Responsibilities for LTC Evacuations	Examine and train on, responsibilities and roles for all-hazards events	Steve Parrot – CVHC / Carolyn Malloy – EVHC	May 26, 2022	July 31, 2022
3	Medical Surge	Incident Management Team	Examine possibility of staffing an IMT on part-time basis	Steve Parrot – CVHC / Carolyn Malloy – EVHC	May 20, 2022	December 31, 2022
4	Continuity of Healthcare Service Delivery	Virginia Resident Emergency Evacuation Board	1. More training 2. Process guide 3. Simplify for end user 4. Adopt Board into practice in VA	CVHC – Megan Middleton / Matt Marry – VHASS	May 26, 2022	December 31, 2022
5	Continuity of Healthcare Service Delivery	Establish Multiple Points of Contact	Review, update EOPs with more POCs.	DSFs and RAFs	May 26, 2022	June 30, 2022
5	Continuity of Healthcare Service Delivery	Incident Action Plan	Training on IAP development	DSFs and RAFs	May 26, 2022	December 31, 2022

APPENDIX A: EXERCISE PARTICIPANTS

The following is the list of organizations who participated in the exercise based on their response to bed availability in VHASS the event log and an update on the LTC status board.

Participating Organizations
Regional Healthcare Coalitions
Central Virginia Healthcare Coalition (CVHC)
Eastern Virginia Healthcare Coalition (EVHC)
Skilled Nursing Facilities (Disaster Struck Facility)
Williamsburg Landing
Skilled Nursing Facilities (Resident Accepting Facilities – CVHC)
Chesterfield County – Galloway Intermediary Care Facility (ICF)
Covenant Woods
Greenville Health and Rehabilitation Center
Hiram Davis Medical Center
Lakewood Manor
Lucy Corr
Pine Forest ICF
Skilled Nursing Facilities (Resident Accepting Facilities – EVHC)
Atlantic Shores
Autumn Care of Chesapeake
Beth Sholom
Birchwood Park
Consulate of Norfolk
East Pavilion
Harbor's Edge
Holiday House
Indian River ICF
Kentucky Avenue ICF
Lake Taylor Transitional Care Hospital
Moore House
Patriots Colony
Rappahannock Westminster Canterbury
Riverside – Mathews
Riverside – Sanders

Riverside – Smithfield
Riverside – The Gardens at Warwick Forest
Riverside – Warwick Forest
Shore Health and Rehab
Southeastern Virginia Training Center
Thalia Gardens
The Chesapeake
The Newport
Waterside Health and Rehab
West Neck ICF
Western Tidewater CSB
Westminster Canterbury on Chesapeake Bay
Westmoreland Rehab

APPENDIX B: RESPONSE BREAKDOWN

Facility	Location	Event Response	Gender Preferences	Behavior	Vent	Bariatric	Transportation Confirmed	Status Board Response	Accepted Residents
1	Chesapeake	Yes	Yes				Simulated	Yes	Yes
2	Mechanicsville	Yes					Yes	Yes	Yes
3	Emporia	Yes	Yes					Yes	Yes
4	Norfolk	Yes		No	No	No	Yes	Yes	Yes
5	Henrico	Yes					Yes	Yes	Yes
6	Chesterfield	Yes	Yes				Yes	Yes	Yes
7	Parksley	Yes	Yes				Simulated	Yes	Yes
8	Newport News	Yes		No	No	No	Yes	Yes	Yes
9	Newport News	Yes	Yes				Simulated	Yes	Yes
10	Virginia Beach	Yes	Yes				Yes	Yes	Yes

APPENDIX C: PARTICIPANT FEEDBACK

The following feedback is taken verbatim from Participant Feedback Forms and has been collated by similar topic or theme.

Dashboard / LTC Tracking Forms

- Inputting Residents
  - I believe that if we were in an actual emergency, the length of time that it would take to manually input each resident into the portal would be too great. I believe that there needs to be a way to trim down what is requested in the actual portal. Much of the information about the resident can be found on the face sheet, med list and H&P, which we would be sending with the residents. Would it be possible to upload these documents to the portal? I believe only key info needs to be added like DNR status and some of the critical diagnosis like bariatric, peg tube, trach etc.
- More training on dashboard for those that have never used before.
  - More training on how to use the dashboard. This was my very first exposure to dashboard.
- Dashboard – confusing on where to enter data as a RAF
  - More training for RAFs on the dashboard
- Battle Rhythm Printing
  - I was unable to print the Battle Rhythm instructions properly. Only the section showing on the screen would print when using Chrome Version 100.0.4896.127 (Official Build) (64-bit). Having a PDF available for download and/or printing would be nice.
- Flow Sheet
  - I believe that there should be a flow sheet for an evacuation. It was hard to picture each step that needed to take place. I.e., multiple steps needed when the resident was assigned an alternate location, when the location picked them up and when they arrived. I believe that a 30000-foot flow sheet would help the facilities stay organized.
- Data entry
  - Once started, the data entry seemed to flow, and everyone began realizing what to look for and where. My concern would be for the DSF who would truly be dealing with so much more than the data entry. I feel the prep from the DSF, which had to be cumbersome, was well thought out and executed. Although is there a simple way to load an excel sheet, or have campuses using one daily, that would mimic the sheets on the board that could be uploaded from a facility?
- Dashboard development
  - Overall, make them more intuitive and simplistic. Approach their development from an end-user perspective. Users in the MVP facilities may have limited IT experience and likely no prior dashboard exposure in a stressful environment.
    * Balance the critical data with the 'like to have' data
- Field pull-down needs clearing

    - In order for the pull-down menu to show properly the previous data needs to be cleared first.
- Help Desk for troubled users (me) during event
    - Amy Green was a WONDERFUL help! But, having never used the dashboard before...I almost felt I could have used more help or training before the event

VHASS

- In the event that having a liaison on site is not possible, we need to find a way to communicate confirmation of the number of residents/residents evacuating, versus the number the RAF says they can take.
    - Ensure VHASS contact information is up to date. This would enable us to speak to someone at the RAF directly, in the event someone in their ICC is not available.
- VHASS Utilization and Familiarity
    - Provide additional training both internally and externally based upon users. Specific training on updating bed availability for facility users. Specific training internally for EVHC staff on various status boards and ideal messaging.
- We should be able to track Assisted Living Facility bed availability in VHASS
    - Communications between the Eastern and Central RHCCs was strong and consistent. Using RIOS to create a talk group is very beneficial.
      Also, having a liaison travel to the facility is a great practice. It allows us to have real-time updates when facility personnel are too busy to provide updates. It also enables us to provide a more robust level of assistance to the facility.
- Event Log Enhancements
    - A way to filter the Event Log to show only pertinent information would be nice. Constantly scanning the event log for replies to my messages or new messages from the DSF is tedious. A way to set filters would be nice.
- There were some discrepancies between the number of beds available entered on the LTC VHASS status board by the RAF, and the number they entered in the VHASS Event Log.
    - Provide training to LTCFs on entering information on the status board, and to RHCC / Coalition staff on how to read and interpret the information on these status boards. Train RHCC and Coalition staff to call the RAF to confirm numbers.
      Determine a tiered approach for sharing confirmed bed availability from one RHCC to another. We tried a variety of methods, settling on the VHASS Event Log as our primary means of communicating this information. Is there a better or more efficient method?

Communication

- Communication
    - While I know there were some missed and dropped calls, in a real situation this will only be increased. We supplied numbers and names of individuals who were participating and expecting calls, and we still had issues. What we may need to

provide are emergency contacts as a backup in a true crisis. An emergency contact list per campus.

- Establishing and Continuing Communications with DSF
    - Initial communications were established with the DSF. DSF POC information was provided as well as good contact phone number. DSF POC via phone number was unavailable after initial contact was made. Lesson learned: Need to establish good primary, secondary and tertiary communication platforms at the beginning of incident if contact is lost utilizing primary method of communication.
- Communicate with RAFs when they have been selected to receive pts
    - Develop a liaison to facilitate this communication; Let RAFs know how they will be communicated with when this occurs (by phone, msg in Event Log or other method)
- Alternate facility contacts
    - I believe that it would be helpful to have the ability to print out a list of facilities in the coalition with their associated contact numbers. If you do not have this, you are constantly flipping back and forth between all the portals that are open. balancing internet and verbal interactions
    - Coalition staff attitudes. Positive, helpful, collaborative, willing to learn, accept criticism.
- Send appropriate pts to receiving facility
    - We indicated we could take only standard pts and were sent 2 bariatric pts and many with behavioral and safety issues
- Identifying EVHC RHCC Action Items Outside of RFA
    - Identify list of action items for EVHC RHCC to take based upon incident type as well as if actions should be taken regardless of if it is requested from the DSF.
- Portable radios
    - Clarify/develop statewide radio ops plans (How will the RHCCs communicate with each other across the state? How will on scene staff from the coalitions communicate with their RHCC? CVHC seems 'robust' compared with other regions.) Rename various radio channels to avoid confusion. ('RHCC Ops' vs WAVEs 'RHCC Ops'). Future VSP/STARS reformatting should be engaged.
- Balancing internet and verbal interactions
    - How can coalitions assist at the scene better? Coaching, interjecting when appropriate, helping organize, etc. More TTXs, ICS training (In a very brief (<3 hour) format that is site specific.), internal coalition staff training, etc.

Staffing

More staff involvement

- With Seaside and Harbourway combining to one unit (Atlantic Shores) a few years ago several staff members dropped off of the VHASS site and were not replaced in the combined one. For this exercise I realized we required more than just one person to monitor the site as I was trying to go about my day and monitor the site to see if we needed to pick up any residents. Resolution: I have signed up

two additional staff members on the VHASS site so that we all can monitor in times of emergencies.

- Staffing Concerns
    - During this exercise it was determined we had more beds available than staff that could care for the additional residents. I originally updated the board with the availability we had for open beds, but on the event, log listed the number of residents we could take on safely per staffing we had. Question....could I have listed the number of residents I could take without additional staffing needs AND the number I could take if the facility evacuating the residents could send staff with them? I did receive a call from your team and updated / corrected my board.

Strengths

- The coalition being on site was critical.
- The coalition was supportive.
- Intermediates were great for calling and connecting, but I feel there would be more calls made to them from all campuses rather than waiting to be contacted. In a true crisis most people who are willing to help will want to reach out...especially if they feel they need to take action.
- Robust technology: IT platforms, radios, backups, etc.
- Knowing, training with facility staff, other agencies. Sharing information, lessons learned. Open to new ideas.
- The coalition has a great program that helps train all facilities to look at their emergency plans and to practice possible real-life scenarios. These exercises are extremely helpful as they truly get you looking for weaknesses in one's plan.
- Although, our facility did not receive any residents the dashboard looked very organized and a great way to safely track residents to ensure no one gets lost.
- Great teamwork from RAF's nurses in admitting the new residents and placing them in appropriate rooms during the exercise
- Good reception from Williamsburg Landing when driver arrived and seemed to be an organized process there
- More training on using the dashboard. This looks like a great tool to use in an actual event.
- Good communication established between EVHC RHCC and CVHC RHCC. Multiple platforms established, utilized, and monitored.
- CVHC RHCC Establishing platform to share bed availability information with EVHC RHCC
- VA Resident Emergency Evacuation Board seemed overwhelming at first, but quickly became my best friend. I found it intuitive and easy to use.
- More training on the new dashboard. It was a very valuable asset but was overwhelming at first. More exercises of this nature so that we become more comfortable with the tools would be beneficial. Separate training sessions for DSF and RAF might make learning easier. Online videos that could be viewed at any time as a refresher would be helpful. The Zoom support was excellent and appreciated. I found this exercise very helpful and informative. I appreciate all the hard work that went into the endeavor. Thank you.