

**Florida Department of Health Discharge Planning Webinar  
September 11, 2012**

>> BONNIE GAUGHAN-BAILEY: Good afternoon and welcome.

[Slide No. 1]

This is the Florida Department of Health Discharge Planning Webinar.

Before we get started, please place your phones on mute. Questions may be submitted using the chat feature. And direct questions and comments to the participant named "questions" if you have signed in to the webinar.

And direct questions and comments to the participant named "questions" in the Webinar.

[Slide No. 2]

Once again, good afternoon. My name is Bonnie Gaughan-Bailey. I'm the Community Resilience Manager for the Florida Department of Health, Bureau of Preparedness and Response. I will be your moderator for today.

But first and foremost, today's an anniversary, an anniversary that we will never forget. We will never forget those who lost their lives on 9/11.

I would like to read a small excerpt from a letter by the 9/11 memorial president, Joe Daniels, commemorating the 11th anniversary of 9/11 and it follows: Despite the unimaginable tragedy of 9/11 itself, this day is also about the spirit of unity that came in the aftermath.

It showed us that the best of humanity can

overcome the worst fate and the worst hate. It gives us hope for the future.

[Slide No. 3]

The purpose of today's webinar is to inform participants of the discharge planning process for clients and shelters and the varied uses of the Discharge Planning Guide after a disaster.

We will discuss how community partners can work together and use this guide to improve local planning, discharge planning, as well as to better understand the roles of various agencies when it comes to sheltering, discharge planning and other resources after an event.

The objectives of the presentation focus on increasing understanding and importance of planning for discharging clients in shelters and the roles and responsibilities of all of us when it comes to discharge planning.

[Slide No. 4]

The presenters for today: Pam Damitz from the Department of Elder Affairs.

Kathi Chisolm, also with the Department of Elder Affairs.

Bernard Hudson with the Agency for Health Care Administration and Martha Hicks with the Florida Department of Health.

[Slide No. 5]

Once again, if you have questions, use the chat feature to submit a question or comment any time during the presentation.

We will be taking questions at the end of the presentation.

You'll want to hover your mouse over the graphics at the top middle of your screen until the "chat" button appears. Click on the "chat" button and a window will open. Direct all questions and comments to the participant named "questions." We will remind you of that feature later in the broadcast.

Your questions will be compiled based on the total conversation for today. If we do not get to all questions, we will post them after the broadcast with the answers, and all registered participants will receive the link.

[Slide No. 6]

As an introduction into the topic, Discharge Planning is a process that facilitates moving a person from one level of care and service to another. Or moving from one hospice setting to another, or moving someone from a temporary or sheltering setting back to the community for more permanent residence and placement.

While individual plans will be based on a person's need and available resources, local plans for the process should be ready for activation at any time. Think about the multiple dangers that someone could face after a disaster.

There is no way that we could ever pull together ad hoc and impromptu to take care of such diverse needs. That's why the plans must be in place, as well as understood and exercised, so everyone understands their roles.

To provide another example, if translating a local planning, is that we should start thinking about discharging clients when you open a shelter. Then, prior to discharge, the client may need new community services and resources. There may have been unexpected changes to a client's life, possibly to their health status.

The purpose is to accomplish actions necessary to find civil placement, stand-in or substitute accommodations for a person being released from a temporary shelter or healthcare setting.

To help with Discharge Planning, the Discharge Planning Resource Guide provides information for local officials, discharge planning teams, Special Needs Shelter managers and others working with displaced persons.

It contains community resource listings and contact information, background information, such as statutes, other technical information, summaries of the various roles of different agencies, as well as other resources to assist as a single-reference document to facilitate moving persons back into the community.

This Guide is the result of a wonderful collaboration among many state agencies and organizations.

It is through the Interagency Committee for Special Needs Shelters that this guide is updated every two years. And with every update presents new opportunities.

With the July 2012 update, we have added county supplements. Think of it as a grab-and-go section for each county. If you don't want to look through the entire document, go straight to your county and grab and go. Information on how to obtain the Guide online will be discussed later in the broadcast. You will find lots of informational contact slides after each presentation.

I would like to remind folks to please use the mute feature and make sure that your phones are on mute. And we really appreciate that.

Now, let's get started with our program.

[Slide No. 7]

To start our program, the Florida Department of Elder Affairs Emergency Coordinating Officer, Pam Damitz, will be talking with us.

Prior to her work with the Department of Elder Affairs, she served 17 years in law enforcement.

Pam will explain the impacts of discharge planning after a disaster.

>> PAM DAMITZ: Hello, everyone and good afternoon. Like to thank you for participating in this webinar.

[Slide No. 8]

I'd like to begin by explaining the support roles

that the Department of Elder Affairs has with the State Emergency Operations Center during a disaster.

The Department of Elder Affairs supports six emergency state functions, which include ESF-8, which is health and medical, through discharge planning and staff as needed. ESF-9, which is search and rescue. We provide information only as needed.

ESF-11, which is food and water. We also provide information only as needed.

ESF-14, which is public information. We provide staff for the EOC as needed.

ESF-15, volunteers and donations. We assist as needed. And one of those roles is to assist in meeting the Florida Emergency Information Line, better known as the FEIL line.

Our main support role is with ESF-6, which is mass care. For that ESF, we provide staffing for the EOC when needed and also provide assistance in the Disaster Recovery Centers.

[Slide No. 9]

The role of the Florida Department of Elder Affairs in relation to Special Needs Shelter discharge planning teams is outlined in Florida Statute 381.0303, section (2)(e), that of Special Needs Shelters and explains how the role of Department of Elder Affairs is to convene

and coordinate those multi-agency Special Needs Shelter discharge planning teams.

[Slide No. 10]

How are these multi-agency Special Needs Shelter discharge planning teams initiated? They could be initiated one of two ways.

The first way would be through the Secretary of Elder Affairs, who can convene a team when it's deemed appropriate and necessary.

The second requires local emergency management officials, once all local resources have been exhausted.

That request comes through a mission request from EM Constellation, which alerts state emergency management officials that a discharge planning team is needed.

[Slide No. 11]

The mission request put into EM Constellation by local emergency management officials should contain the following information: The number of clients at the Special Needs Shelter that need discharge planning assistance.

The location of the Special Needs Shelter or shelters.

A dedicated line for that shelter.

The duration of operations or the anticipated date of closure for the shelter.

A shelter contact person with contact phone numbers.

And also a local emergency management point of contact or the official that is requesting the mission, to include a direct telephone number for them.

[Slide No. 12]

Any additional information that can be provided in the mission request about the clients in need of discharge planning will be very helpful. This information may help us determine which agency should be involved in the initial response for evaluation of the clients needing assistance.

[Slide No. 13]

Each multi-agency special needs discharge planning team shall include at least one representative from the following agencies.

Those agencies are: The Department of Elder Affairs, the Department of Health, the Department of Children and Families, Department of Veterans' Affairs, Division of Emergency Management, Agency for Health Care Administration, and Agency for Persons with Disabilities.

[Slide No. 14]

That list is not all-exclusive because the Secretary of Elder Affairs may request assistance from additional agencies or may determine that assistance from specific agencies on the list is not necessary, depending on the nature or circumstances surrounding the disaster.

[Slide No. 15]

The multi-agency Special Needs Shelter discharge



planning team lead will be designated by the Department of Elder Affairs.

The team lead will be from CARES, which is Comprehensive Assessment and Review for Long-Term Care Services.

It could be from LTCOP, which is the Long-Term Care Ombudsman Program or from the AAA or ADRC, which are the Area Agency on Aging and the Aging and Disability Resource Centers.

If a member from one of those groups is unavailable to serve as team lead, a team lead from another agency may be designated by the Secretary of Elder Affairs.

[Slide No. 16]

The Emergency Coordinating Officer for the Florida Department of Elder Affairs will be contacted once a request for a multi-agency special needs shelter discharge planning team is requested through the Emergency Operations Center.

The DOEA ECO will then contact CARES to conduct an initial assessment at the shelter to determine the needs of the clients.

If we are aware of additional needs at this time, appropriate agencies may accompany CARES and others may be added as needed.

This is when it's very important that the initial mission request, when it comes in, has as much information as you can provide so that we can determine if, in the

initial assessment, if it's appropriate to send other agencies in rather than waiting until later.

[Slide No. 17]

Once the needs are determined, the appropriate agencies will be contacted to initiate the multi-agency special needs shelter discharge planning team.

That would be in addition to those individuals who are already in the shelters conducting the assessment.

Once a team is deployed into the shelters, the Department of Elder Affairs ECO will coordinate the team until it is dismantled and update and also close the mission in EM Constellation.

[Slide No. 18]

Currently the model of a multi-agency special needs discharge planning team only applies to Special Needs Shelters.

And remember, as Bonnie also pointed out, discharge planning starts at admission, so as much information as you can get at admission is going to be very helpful to emergency management officials in determining who needs to be a part of these teams.

[Slide No. 19]

I want to thank you for participating today. Please feel free to contact me for any further information, and I have my name and contact information on the screen. Have a wonderful afternoon.

>> BONNIE GAUGHAN-BAILEY: Thank you, Pam, for your discussion on the role of multi-agency teams.

[Slide No. 20]

Next we have Kathi Chisolm. She's the CARES disaster preparedness point of contact for the Florida Department of Elder Affairs. She will provide insight into the unique role of CARES team in discharge planning.

Thank you, Kathi.

>> KATHI CHISOLM: Thank you, Bonnie, and good afternoon everyone.

[Slide No. 21]

Before we review how to request CARES' assistance at Special Needs Shelters after a disaster event, I want to tell you a little bit about CARES.

As Pam has stated, CARES stands for the Comprehensive Assessment and Review for Long-Term Care Services. And we are Florida's federally mandated pre-admission screening program for nursing home applicants. There are two components to the Medicaid eligibility process.

The medical component, which is handled by CARES, and the financial component, which is handled by the Department of Children and Families.

The CARES program emphasizes different approaches that make it possible for someone to remain in their home with home-based services or in an alternative community

setting such as an assisted living facility.

CARES has been around for quite sometime. It started as a pilot program in 1982 and was expanded throughout the state in 1986.

CARES is operated by the Department of Elder Affairs through an interagency agreement with the Agency for Health Care Administration.

We have 19 CARES field offices throughout the state, and each of our field offices include registered nurses, assessors, administrative support staff and office supervisors.

If you would like to read more about the CARES program, an article that recently appeared in the DOEA elder update was attached to yesterday's e-mail from Gail LaRosa.

As I said earlier, CARES is Florida's federally mandated pre-admission screening program for nursing home applicants. But we do many other things.

As Pam pointed out just a few minutes ago, we also serve as an integral part of the multi-agency special needs shelter discharge planning team lead, along with LTCLT and the AAAs, which are also known as the ADRC.

Now, let's move on to the flow chart requesting CARES assistance at Special Needs Shelters after a disaster event.

[Slide No. 22]

This first slide just gives you acronyms you might

not be familiar with, and I would point out that ECO is Emergency Coordinating Officer, but EOC is the Emergency Operations Center. Sometimes we get those two things confused.

[Slide No. 23]

Okay, we have a disaster happen in the state of Florida. It can be a hurricane, it can be a fire, it could be a tornado. Some sort of a disaster event.

The Governor issues Emergency Order Declaring State of Emergency. At this point, the Governor would request the Presidential Declaration as well.

[Slide No. 24]

Next, request for assistance in Special Needs Shelter is made by the county EOC after receiving a request from the Special Needs Shelter unit team leader or the shelter manager.

And as Pam stated earlier, as much information as you can possibly give us would be very helpful because our teams will be made up from different groups.

You may have people 18 to 59. You may have people 50 and over. And they may have complex medical needs. If you can give us as much information as possible, it would be very helpful.

The county EOC inputs Request for Assistance in EM Constellation as a mission.

[Slide No. 25]

The state EOC in Tallahassee assigns mission in EM Constellation to ESF-8.

ESF-8 then contacts the DOEA ECO, who advises CARES central office POC -- which at this point, me -- by e-mail, if possible, of the mission number and any assignment details that you might have.

At that point, the CARES central office POC advises the Regional Program Supervisors, the Deputy Bureau Chief, the Bureau Chiefs and the Statewide Community-Based Services Director of the mission number and any additional information regarding mission details.

[Slide No. 26]

At that point the RPS advises the local CARES supervisors of the request to assist, gives the mission number and details to the CARES supervisor and any other pertinent information regarding the Special Needs Shelter client.

The RPS notifies the CARES POC in Tallahassee by e-mail, if possible, of the availability and assignment of staff to assist in Special Needs Shelter discharge planning.

Okay, we've gone through the shifts, and at the close of the shift in the Special Needs Shelter, the local CARES staff updates his or her CARES supervisor of the status of the client and any unmet needs or requests for funding.

The CARES supervisor advises the RPS of status of

clients and any unmet needs and/or requests for funding in their daily report.

[Slide No. 27]

The RPS then provides the CARES supervisors' daily report to the central office POC, who provides the report to the DOEA ECO by e-mail if possible.

The DOEA ECO inputs unmet needs and/or requests for funding in EM Constellation under the appropriate mission number.

So for the first couple of slides, all the information is being pushed out to the field, and these last couple of slides, all the information is coming back from the field.

Any unmet needs and/or requests for funding is coordinated by DOEA ECO with the Department of Health ESF-8 using the mission number and details in EM Constellation.

[Slide No 28]

After everything is done and all the clients have been discharged, the DOEA ECO will close out the mission.

[Slide No. 29]

Our contact information can be found at our Web site and our CARES directory, you can download that so you have the names of the supervisors and the addresses and phone numbers for all of our offices.

Thank you very much for participating in this webinar.

>> BONNIE GAUGHAN-BAILEY: Thank you. Once again, if you have questions, look for, or direct questions and comments to the participant named "questions" in the chat feature.

Thank you, Kathi, for that perspective on CARES. Explained a very complicated process and in a nice flow chart and we all appreciate that.

[Slide No. 30]

Next, Bernard Hudson. Bernard Hudson has worked in Health and Human Services programs for 10 years, with a focus in data analysis. Bernard is currently the Alternate Emergency Coordinating Officer for the Agency for Health Care Administration and the Long-Term Care Unit Manager. He's responsible for regulation of long-term care and facilities, including skilled nursing facilities, intermediate care facilities for the developmentally disabled, prescribed pediatric extended care facilities, transitional living facilities and homes for special services.

Bernard will discuss the discharge planning role of the Agency for Health Care Administration.

Thank you, Bernard.

>> BERNARD HUDSON: Good afternoon. Thank you for joining us today. I will discuss the Agency's role as it pertains to emergency preparedness.

[Slide No. 31]



Just a little background. The Agency for Health Care Administration was established to locate the state's health financing, regulatory and planning activities into one organization.

It is the chief health policy and planning entity for the state, and our mission is better health care for all Floridians.

[Slide No. 32]

The major roles and responsibilities of the Agency is to license, regulate and oversee. We license and regulate managed care plans and health care facilities.

We oversee the services provided to eligible Medicaid recipients and we publish health care data and statistics.

[Slide No. 33]

As it pertains to emergency response, the Agency is a supporting partner to the Department of Health and the Emergency Support Function 8. We also staff the Emergency Operations Center as requested during an emergency.

[Slide No. 34]

The Agency supports ESF-8 through contact with health care facilities, which include residential and 24-hour care facilities.

The system by which we do this is our Emergency Status System, and we refer to it as our ESS system, which is an online system to track facility status. Currently we

have about a 95% enrollment rate, where we have 4,868 facilities that are currently enrolled in ESS.

[Slide No. 35]

This ESS participation includes a wide number of facilities, which are hospitals, inpatient hospices, intermediate care facilities, nursing homes, crisis stabilization units, dialysis facilities, residential treatment centers, and you see the list goes on and on.

And as you can see, the percentages on this list are pretty close to 100% for all providers, with a few that we have to continue to work with to get them into full compliance.

[Slide No. 36]

Now, so the question may be, well, what does ESS do? For those of you who are not familiar with it, ESS tracks the emergency status and impact for those providers that we regulate. It also assists in us prioritizing the activities and the responses to those providers who are impacted during an emergency.

It also serves as a resource for the Emergency Operations Center where we can run reports of requests and needs from this system.

[Slide No. 37]

Now, in the ESS system, we have both pre-storm and post-storm activity. The pre-storm activities, we would like to have information such as the evacuation status,

which will include the destination. We would like to have that entered.

Special residents' characteristics. If there are some facilities that have residents that have special needs, such as oxygen, ventilator dependent, dialysis dependent, we need to know that information because these types of providers will need to get immediate assistance to help those residents who require these services.

We also want to know about the census and the number of available beds, which from time to time may be male and female oriented.

So this information can be entered also.

[Slide No. 38]

Now, after the storm, we'd like to know about power status. If you are impacted by an emergency, do you currently have power?

Was there any type of structural damage?

What's your evacuation status?

If you left, is your facility safe to return to?

That's the type of information that we would like to have.

We also want to know about available beds and whether or not the provider needs anything or any specific requests can be entered through this system.

[Slide No. 39]

For the comprehensive emergency management plans,

there are eight providers that have specific emergency management planning criteria.

Those provider types are adult day care centers, ambulatory surgery centers, home medical equipment providers, home health agencies, hospices, hospitals, nursing homes and nurse registries.

[Slide No. 40]

Now, as it pertains to facility capacity, under our health care licensing Statute 408.821, it allows the provider to temporarily exceed licensed capacity to act as a receiving facility. But it can only do this for up to 15 days. Anything in excess of 15 days has to have prior approval by the Agency.

[Slide No. 41]

As it pertains to home care providers, there's a bit of clarity I'd like to add to this particular slide.

It says the comprehensive emergency management plan for home health agencies and nurse registries shall include the means by which -- and this should say they will continue, because both home health agencies and nurse registries have to continue to provide staff to perform the same type and quantity of services to their patients who evacuate to Special Needs Shelters that were being provided to those patients prior to the evacuation.

Now, that's barring any type of natural disaster that may preclude those individuals who provide those

services from being able to get to those patients.

[Slide No. 42]

Next, you have some information, contact information and also resource information. The Emergency Status System's Web site is listed here. The Agency's Web site is listed.

Our emergency resource site, where you can go and find those comprehensive emergency management planning criteria listed is also here.

And I have numbers for each one of the licensing units here at the Agency, so if you have a particular question or anything that would fall into these areas, this is the type of information for those particular units that you can make contact with to see if you can get your issue resolved.

[Slide No. 43]

I'd like to say thank you, and please feel free to contact me at the information listed should you have any questions.

>> BONNIE GAUGHAN-BAILEY: Thank you, Bernard.

[Slide No. 44]

Next, we will have Martha Hicks. Martha Hicks is the Region 1 Special Needs Shelter Consultant and Vulnerable Population Coordinator with our Escambia County Health Department. In her role with Special Needs Shelters, she's responsible for a 10-county area in the panhandle. She will

share with us how Region 1 used the Discharge Planning Guide during an exercise. But beyond that, the valuable considerations learned for improving the planning process.

Martha.

>> MARTHA HICKS: Good afternoon everybody.

This is Martha Hicks, and I'm the Special Needs Shelter Consultant for Region 1.

[Slide No. 45]

What prompted us to design the tabletop exercise on discharge planning was a 2010 hurricane planning initiative report that identified several gaps in shelter discharge planning.

For example, plans, process, contracts, memorandums of understanding did not exist or they were inadequate.

There were no solutions to relocating persons when the shelters closed, and we have a good example.

Hurricane Ivan, during Hurricane Ivan, when we closed the shelter, there were 26 people left waiting to be discharged. They had no homes to go to safely. Other gaps included state discharge teams were lacking event experience. We didn't have discharge teams at that time.

And re-entry plans for those who wanted to go back home, they lacked information, if there was electricity, if there was access to food, water, how they could get home and if their home was able to accept them.

[Slide No. 46]

The exercise was designed on Homeland Security Exercise & Evaluation Program. The participants of the exercise were able to take a tour of one of the Special Needs Shelters in the region, and this was in Santa Rosa County.

Then later, we followed with our exercise. For best practice, we utilized the team approach participation versus an individual planning the tabletop. And we had distributed, prior to the exercise, the Discharge Planning Resource Guide 2011 at that time.

We made sure we had adequate copies during the exercise for people to review their own resources. We also were very, very fortunate to have 31 persons representing eight out of ten counties in Region 1.

The entire tabletop exercise was highlighted by five scenarios. The scenarios were a good variety of people that you could find in Special Needs Shelter.

[Slide No. 47]

We kept it very simple, with just four tabletop objectives. One was to gain a heightened awareness of the need for advance discharge planning. That's what we wanted our participants to do, become aware of the needs. We also wanted them to identify and prioritize the response activity.

We asked the participants at the end of the

exercise to name at least two steps of the Florida Department of Elder Affairs process. That was the process that Kathi Chisholm described to everybody earlier in this exercise. And we asked the participants also to list at least three resources available, whether they were local or state resources. So these were easy, attainable, measurable objectives.

[Slide No. 48]

I have a few pictures to show you.

Our first school was Bennett Russell Elementary School in Santa Rosa County out in Milton, Florida, brand new school. It was just built in 2011. And at that time, there was an exercise, the Santa Rosa County Health Department conducting on Special Needs Shelters.

[Slide No. 49]

And here you will see the next picture, how the Special Needs Shelter was set up. It can hold up to as many as 100 cots. That day there were 90 cots were set up, and our participants of the exercise were impressed by looking how a Special Needs Shelter looks like.

We were very grateful to the Santa Rosa County Health Department allowing us to take a tour of their Special Needs Shelter.

[Slide No. 50]

Following their tour, then we moved on to the Santa Rosa County Emergency Operations Center out in Milton,



Florida, out on Pine Forest Road.

And there we were able to proceed with about two-hour tabletop exercise that we all learned an awful lot out of that.

[Slide No. 51]

We certainly realized that there were a lot of challenges, challenges by having to send people home after a discharge process, but what mostly we found out to be a priority of these challenges were that several agencies lacked an understanding of their roles and responsibilities for creating contracts, billing and making agreements or preparing memorandum of understanding with our other agencies.

And the other challenge there was just as particularly important was, the mechanism of reimbursement was unclear, and I think sometimes it still is unclear, how and who, or how Medicaid is going to pay.

Medicaid waiver, how it's going to pay. Medicare, health insurance, or other coverage that the residents might can have while they're needing temporary placement.

I think Bernard today kind of gave us some good information about who's going to pay what and how, and I really appreciate the speakers because this is going to make it so much easier for future exercises to understand these two big challenges.

[Slide No. 52]

Our recommendations at the end of the exercise and a few days later, we realized that there were two major issues.

One, to start discharging residents out of the shelters as early as 6:00 a.m.

This we felt will give the shelter team leader or the shelter manager to get in contact with the ESF-8, which is health and medical, and they can start getting the mission numbers through EM Constellation and get the discharge team on board so that they can start sending people home before all the agencies close after 5:00. So that's a very, very important recommendation.

And the second one was a modification in the Elder Affairs process.

Instead of notifying the Special Needs Shelter Consultants, we requested the Elder Affairs consider having the shelter manager contact the EOCs, ESF-8 desk and say we have more people that they need to go home for discharge and we are pressing discharge team on board and request a mission number.

So these two recommendations went real well. We took over a year to get it done, but we nevertheless feel very comfortable that we accomplished that.

I want to really come back again to the five scenarios that we have. All five took quite a while of time, but we had such an intelligent group of participants,

all of them were in some way connected with residents in the region, so all five scenarios were good.

[Slide No. 53]

The first was a typical scenario that you may find at the shelter, an 80-year-old female with chronic obstructive pulmonary disease who was on a concentrator because she needed oxygen and she was brought to Special Needs Shelter.

But now she finds herself unable to go home because she lost her house from the wind surge of the hurricane. She didn't have a lot of money, obviously living on Social Security and Medicare, and the question was, who is going to rebuild a new house for her? Are we needing to take her to a long-term care? We need to put her temporarily somewhere else?

So the group was asked to participate and give responses, and they were very, very good. They considered all her mobility problems, her breathing problems, her pet dog that she had home and the fact that she was very slow walking and so forth. However, we came up with some very good responses. They determined -- they wanted to really determine first the client's wishes.

Did she want to go to long-term care or did she want to kind of stay in another facility or in a temporary home? Or some area that it wouldn't be a nursing home,

because we had to take into consideration her wishes.

The other issues that came up was, if she was placed in the temporary placement, would she need some type of support? Would she be needing community resources?

However, if she wanted to go to long-term care, then we would have to call in the CARES supervisor, who is -- we have one in Region 1 and lucky for us, she happened to be attending this tabletop exercise.

So, therefore, she talked about comprehensive assessment review for long-term care and maybe this person needed some level of care to be decided whether she could stay alone or she needed to actually be placed in a long-term care facility.

So to make a long story short, all of those were taken into consideration and we came with some decisions at the end that she needed other referrals if she wished to stay in the community, from other sources. That was solved real easy.

[Slide No. 54]

The next case management, which I really will go to the last one, we wanted to have someone -- we needed a person with disabilities who is young and therefore, in the fifth and last scenario, we had a 26-year-old blind resident who had a service dog with him in the shelter, in the Special Needs Shelter, but he could not go home. He had no relatives to assist him. His home was flooded. And he

required temporary placement for two, three months until the carpets were removed and reinstalled.

Obviously, his home was all flooded; therefore, the timeframe could be even longer if they had to do mold treatment, treatments for his home. So we again put this scenario before the participants. They were able to respond appropriately. We had just about every county participating. And their responses, some answers were, let's put him in the hotel. Let's call the American Red Cross to help him. And all of those were good resources, until we really learned a lesson here.

We had the CARES, the Comprehensive Assessment Supervisor, who was attending, and she quickly spoke up and said, well, I don't know about placing a blind person this young in a hotel.

My best estimate would be to place him in a group home with younger people similar to his age. Maybe with a buddy system, he can get acclimated and learn the facility temporarily, and possibly later, we can hook him with other sources, bring him braille reading while he's waiting for his home to be repaired. Maybe we can connect him with a center for independent living and/or get him, by the way, some other orientation to future environment and maybe connect him with blind services.

So I think all the scenarios were very, very good.

We had outstanding response, overwhelming good response from our participants in the exercise.

[Slide No. 55]

What we learned, we did have evaluations that we collected, and we had a summary that we shared with other people.

The few responses I'm going to give you here, that we learned the role of available local and state partners and what resources are available and how to access them. The process, which Kathi described earlier to you, how to request assistance from the Elder Affairs through the CARES program.

But we also found out that the comprehensive assessment review for long-term care supervisor's job just begins right at the discharge planning and goes on. It is just never ending for them. But the biggest part and the best lesson learned was that we understood and we learned that this is a multi-agency, multi-disciplinary teamwork, that working together, we could discharge the clients through some suitable places.

[Slide No. 56]

In summary, I just hope that most of you who have your computers up front can see the cover of the Discharge Planning Resource Guide. This was revised this year for 2012, and they did an outstanding job.

In summary, what I covered today is what we

accomplished was actually an awareness of discharge planning through that tabletop exercise.

We identified our challenges. We implemented two improvement recommendation steps. And we recognized the need for regional discharge planning exercises for the rest of the state.

And I also would highly, highly recommend that everybody utilizes the 2012 Discharge Planning Resource Guide before, during and after disaster. But I want you to keep it by your table or your desk because it is a plethora of helpful resources in our state of Florida.

I want to thank you all for attending this program.

[Slide No. 57]

If anyone has questions about the exercise or needs information, please feel free to contact me. My number is here. And I am at the e-mail Martha\_Hicks@doh.state.fl.us.

Thank you for attending this program.

>> BONNIE GAUGHAN-BAILEY: Okay. Thank you, Martha. Thank you for that look at the Discharge Planning Resource Guide and how you put it into action, and I really enjoyed your local perspective.

More than just having a guide on the shelf, even opening it up and sifting through it to find the information you need, as with any training process, exercising what you

have learned really brings it home and creates many opportunities for improvement. And you provided the scenarios.

Thank you for talking us through the scenarios, that we could all think about the many needs of different clients that we can all see in shelters and with needs to assist. And also the lessons learned, how things could be improved in the future. I think that that's also critically important and really appreciated your insight.

Thank you.

[Slide No. 58]

Okay, some may say "All clear?" But we will say when the "All Care" is given. This is a summary slide for you.

Shelter staff, just like when you're doing intake and you're triaging clients that come in, plans for the entire sheltering process are taken into account and possible unmet needs that may have to be addressed once the shelter closes. Shelter leaders that need further assistance go through local ESF-8s. They can verify client destination, make sure that everyone is safe.

Local ESF-8 works with partners within their local Emergency Operations Center to help make those plans, whatever the plans may be that support the client. And with that, when additional help is needed, shelter staff, they go up the chain and they submit a request for additional



guidance and assistance.

[Slide No. 59]

Shelter deactivation.

Deactivation is not complete until the last person has been delivered safely to their home or other arranged location. It may be necessary to retain some persons until further arrangements can be made. This would also be a planning consideration for staff as well. Shelters do not close until all clients have left the facility and have plans. Advanced planning and exercising with partners, as was mentioned earlier, help make the task easier. As we're all planning our exercises for this next year coming up, maybe this is the perfect time to start thinking about discharge planning.

And it sounds like you've got some resources that if you are looking for some injects, or some scenarios that you could use for discharge planning or sheltering, we've got some good subject matter experts.

All right.

[Slide No. 60]

Top ten uses for the Discharge Planning Resource Guide.

Number 10, utilize as local community partner directory. You'll have contact information, addresses and more.

Number 9, share partner agency information in

newsletters and at staff meetings. You'll find from the Discharge Planning Guide that it gives you background as well as contacts. Find what you need.

Number 8, develop exercises or scenarios.

Number 7, provide during staff refresher training.

Number 6, use as a resource during local whole community planning sessions.

FEMA has recently issued the whole community concept and a supportive guide that goes into further explanation.

But it's a reality check for all of us to be thinking about the various partners that need to come to the table, maybe nontraditional partners, but for planning for the whole community. And how can we make our local communities more resilient?

Number 5, serve as impetus for including discharge planning in local emergency plans. Checks and balance.

Okay, number 4, can be used for providing orientation for new staff. Once again, it has wide-reaching contacts and information.

Number 3, refer to when building new coalitions. You won't find names in there, but you will find the contact information for where these different organizations are located and then you can make your own contact.

Number 2, exercise the process of shelter

closings.

And number 1, activate as resource during shelter closing.

The top ten. All right.

[Slide No. 61]

We have some time now for questions. You may continue to submit questions. If we do not get to all of your questions, remember, we will be compiling the questions and the answers and putting them on our Web site and then sharing the link with all who have registered for this webinar.

Okay. We've got a crew here that are working on questions. And we will go ahead and take our first question.

>> VALERIE BEYNON: Thank you, Bonnie. This is Valerie Beynon from Vulnerable Populations in the Community Resilience Unit.

The first question has come it and it's for Pam.

And someone has asked, will vulnerable populations other than elders be served by the multi-agency special needs shelter discharge planning team?

>> PAM DAMITZ: And the answer to that question is yes. All vulnerable populations that are in Special Needs Shelters will be served until that shelter is closed and all the clients' needs are met.

The purpose of the multi-agency special shelter

discharge planning team is to have representatives from agencies across the board that can serve the needs of those clients in those shelters. So it's not just for elders. It will be for everyone that's there.

>> VALERIE BEYNON: All right, thank you, Pam.

Bonnie, this next question is for you.

What can I do if I notice something needs to be changed or updated in the Resource Guide?

>> BONNIE GAUGHAN-BAILEY: Okay, well, thank you.

And we know that changes will occur and we do a major update every two years.

But if there is something that needs to be updated, please report any changes needed to the Guide to the Department of Health contact from which you received your registration information. And that will be Gail LaRosa.

Additionally, this can be done by completing the Discharge Planning Resource Guide feedback form on the Department of Health discharge planning Web page.

Important updates and changes will be posted on the Web page. We can prepare change notices as we make changes to the Guide and we can alert people of the changes.

You can also use the spaces on the county supplement or use the posted Microsoft Word version on the county supplement to make changes for your location. Think about that county supplement as a document to modify, to make it what you need.

>> VALERIE BEYNON: Great, thank you, Bonnie.

Our next question, we're back to Pam again.

Is a minimum number of clients needing assistance required before the multi-agency special needs discharge planning team can be requested?

>> PAM DAMITZ: No, there is no minimum. The only requirement would be that even if it's just one client in the Special Needs Shelter. The only requirement would be that the local resources would be exhausted first.

Even if it is one client that needs assistance, as long as the local resources have been exhausted, then a mission can still be requested through Emergency Operations Center just for that one client.

And we would send out someone from CARES to do the assessment, and if we can determine in the beginning, based on the information received, that another agency would also be helpful, based on that person's needs, we would send them out to them also.

>> VALERIE BEYNON: Great. Thank you, Pam.

And we have another question here. This one is for Bonnie again.

I'm a shelter leader. Once I submit a request for assistance to the county EOC, is my responsibility over?

>> BONNIE GAUGHAN-BAILEY: Really, the responsibility's over when there are no clients left. And then the shelter can close.

>> VALERIE BEYNON: Excellent. We have a follow-up question to that.

How can I connect with my local planner so I can be involved in the local discharge planning?

>> Well, I would suggest that they look up the Department of Elder Affairs CARE regional office. And there are some links that were provided in the PowerPoint presentation. Additionally, you can call the local health department and ask for a key contact in sheltering.

You can also contact local emergency management and say that you want to be involved in sheltering and discharge planning.

>> VALERIE BEYNON: Okay, that's great. Thank you, Bonnie.

Once again, if you have any additional questions, feel free to use the chat feature on the Web access at this time.

And we have another question that has come in.

Has anyone had experience this year with home health agencies providing care during the sheltering operation?

Bernard, is that something that would be in your neck of the woods?

>> BERNARD HUDSON: Well, we haven't -- I think it's more geared for providers and whether or not they've had experience with that.

I don't have our representative from our home care unit, so we wouldn't be able to provide a response on that one.

>> VALERIE BEYNON: Great. Thank you, Bernard.

Once again, feel free, we're still taking questions. You can go ahead and use the chat feature on your WebEx.

Okay. With that previous question, if anybody else has had experience with that, feel free to go and use the chat feature at this time to go ahead and let us know about that.

We'll go ahead and post the answer to that question later on on the Web site. And we'll be giving you a link to that Web site at the end of this presentation.

We have another question from Paul. This has come in and this is a multi-question.

How can discharge planning help a client arriving at a Special Needs Shelter pre-storm who exceeds capability of the shelter?

And the second part of that is, can this process provide payment to nursing home or hospital to shelter the client?

>> Okay. The first half of that, how can discharge planning help a client arriving at a Special Needs Shelter -- this pre-storm -- who exceeds capability of the shelter?

Well, in that intake process and with the client

coming into the Special Needs Shelter, the client would be assessed, and it sounds to me, based on this question, that if their health status exceeds the capability of the shelter, then the shelter manager and leader would be working to find the best place for this person to stay safe and maintain their health status.

>> All right.

>> Bonnie?

>> Yes?

>> Paul Morrison in Manatee. I asked that question.

>>BONNIE GAUGHAN-BAILEY: Okay.

>> PAUL MORRISON: This assumes that we're unable to find a place that will take them and we're looking for additional assistance.

I understood -- understand this has happened during Debby in Region 4 and it happened to us in Manatee during Isaac.

We spent five hours trying to place a single resident, and so, ultimately, we would love to have access or would like to know if we could get access to this program, if not for the assistance of who can take them, but for the assistance of who will pay for it?

>> Okay. Sounds like certainly, Paul, working through your, your ICS structure, that seems like that would take -- it would take a village, so it sounds like that



would be another mission request that would have to go back to the EOC to see what could be done to find services and care for this client.

But as far as the payment goes, certainly when we're trying to place someone in a nursing home or other health care facility, they're going to be looking for, is there a Medicare payment?

Is there a Medicaid payment or is there other insurance available?

There's Florida Statute reference that is in the Discharge Planning Guide that provides some additional detail that you may want to refer to. And that applies when there is a declared Presidential emergency.

Anything else to add on that? Okay.

>> BONNIE GAUGHAN-BAILEY: All right. Final questions? Okay.

[Slide No. 62]

Well, thank you for your participation.

You have some Web sites here for additional information.

I encourage you to please take the evaluation, please note the link and if you go to the evaluation and you would like a certificate of appreciation for your attendance, there is a section where you can complete the information and we will send you a certificate of attendance for this broadcast.

>> Excuse me, Bonnie?

>> Yes.

>> It's Kathleen in Collier. We did submit two more questions. Do you have time to take them?

>> Oh, we didn't receive them. Go ahead and ask.

>> Well, the first one is, what is the expected turnaround time for a CARES rep to be deployed once a request is actually sent in to EM Constellation?

>> Once it is received by the EOC here, it would probably be within 12 to 24 hours, depending on the impact area and the seriousness of the disaster.

But you could expect various persons out there in that time period.

>> Okay, and my second part of the question is, if you all are bombarded with requests, are they managed on a first-come, first-serve basis or how is that going to be managed?

>> PAM DAMITZ: It's going to be based on -- this is Pam speaking -- it's going to be based on the, like Kathi said, the scope of the disaster.

If we're going to have -- if we do have a catastrophic event and do have a lot of different requests, we're going to have to take them as they come in. But it would probably be a situation where if we had one area that was a lot more devastated than another, that that one may get a little bit of priority.

But everybody's going to be, as those requests come in, they're going to be filtered to me and as they're filtered to me as they come in, they will be -- a discharge planning committee will be convened and sent to both locations for evaluation.

>> Thank you.

>> Bonnie?

>> Yes.

>> This is Bob.

I also submitted a question and evidently you didn't get it. It's a question for Bernard.

When ESS is activated, will AHCA mandate that nursing homes and ALFs enter data?

>> BERNARD HUDSON: Yes, all of those identified provider types will be required to enter data into ESS when an event is activated.

>> Okay, thank you.

>> Okay.

We're pulling up the chat feature and make sure that we took care of everybody.

All right, I think we've taken care of that.

I want to thank everyone for participating. You will be notified when the questions and the answers are posted on the Web site. And I want to thank you very much for your participation today.

Have a great day.