High-Utility Tabletop Exercise Concepts for ODP Service Providers



Pennsylvania
Department of Human Services

These tabletop exercise concepts are designed for the **Office of Developmental Programs** (**ODP) service providers, Administrative Entities (AEs), ODP regional offices, and provider leadership**. Each exercise is structured to test practical capabilities rather than simply review emergency plans. The emphasis is on **continuity of supports, individual health and safety, regulatory decision-making, communication, workforce resilience, and recovery**.

Concept 1: The Extended Cyberattack — Administrative & Payment Disruption

Focus Area: Business Continuity, Service Delivery, Financial Resilience

Scenario

A sophisticated ransomware attack disrupts critical state and provider systems. HCSIS, billing-related systems, email, electronic records, and other administrative platforms become unavailable. The outage is initially expected to last **72 hours but extends to 14 business days**.

Providers cannot reliably submit claims, access critical records, verify authorizations, communicate through normal channels, or confirm current information for some individuals.

As the outage continues, providers begin reporting payroll concerns, medication-record access problems, staffing difficulties, and uncertainty about authorizations and billing.

Key Discussion Points

Service Continuity

- What services must continue regardless of system availability?
- What information does the provider need immediately to operate safely?
- What paper/manual processes are available and who can authorize them?
- How are critical individual needs identified when electronic records are unavailable?

Financial Continuity

- At what point does an extended outage become a provider financial emergency?
- How will providers maintain payroll, purchase medications, obtain food, and pay essential vendors?

- What mechanisms exist for communicating billing and payment contingencies?

Documentation & Compliance

- What documentation must be maintained manually?
- How will providers reconstruct records after systems return?
- How do providers distinguish between required documentation and information that can be reconstructed later?

Communication

- What happens if normal email and electronic communication are unavailable?
- What is the provider's backup communication tree?
- How are individuals, families, staff, AEs, ODP, and emergency partners kept informed?
- Who has authority to issue operational guidance to staff?

High-Value Injects

1. **Day 2:** A provider cannot access an individual's electronic medication information.
2. **Day 4:** Payroll is approaching and the provider is uncertain whether claims will be processed.
3. **Day 7:** A staff member reports that a critical individual-information document may have been lost.
4. **Day 10:** A rumor circulates that providers should stop certain services until systems are restored.
5. **Day 14:** Systems begin returning but contain incomplete or inconsistent information.

Exercise Success Measures

Participants should leave with:

- A defined **manual operations procedure**.
- A documented **minimum-information-needed-to-operate** list.
- A provider/AE communication redundancy plan.
- A process for **reconstructing records and documentation**.
- A clear escalation threshold for financial and operational distress.

Concept 2: Extreme Weather & Provider Grid Failure — Health, Safety & Relocation

Focus Area: Emergency Preparedness, Individual Safety, Regional Coordination

Scenario

A severe winter storm produces prolonged power outages across a Pennsylvania region. Temperatures remain below freezing and multiple provider-operated homes lose electricity and heat.

Several individuals rely on oxygen, powered medical equipment, refrigeration for medications, mobility equipment, or other electrically dependent supports.

The outage is initially projected at 24 hours but expands to **72+ hours**.

At the same time:

- Roads become difficult to travel.
- Some staff cannot report to work.
- Fuel becomes difficult to obtain.
- Cellular communications become intermittent.
- Local emergency management is prioritizing hospitals and other critical facilities.

Key Discussion Points

Individual Health & Safety

- Which individuals are most vulnerable to extended power loss?
- Does the provider have a current list of individuals requiring electricity-dependent supports?
- How long can each critical support continue without power?
- Who determines when an individual must be relocated?

Relocation

- Where can individuals safely go?
- How does the provider identify available alternate locations?
- How are medications, records, equipment, mobility devices, and essential personal items transferred?

- How is continuity maintained if individuals are temporarily placed somewhere other than their normal residence?

Workforce

- What happens when scheduled staff cannot reach the home?
- Can staff remain safely at the location?
- What is the provider's process for extended shifts, relief staffing, transportation, meals, and rest?

Regional Coordination

- How does the provider communicate its status to the AE and county emergency management?
- How are priority restoration needs communicated to utilities?
- What information should be shared with PEMA/local emergency management without compromising individual privacy?

High-Value Injects

1. **Hour 12:** Generator fuel is available for only another 18 hours.
2. **Hour 24:** Two scheduled staff members cannot reach the home.
3. **Hour 30:** An individual's oxygen equipment requires reliable electricity.
4. **Hour 42:** A second provider home requests emergency staffing assistance.
5. **Hour 60:** The local emergency manager asks whether the provider has individuals who should receive priority evacuation or power restoration assistance.
6. **Hour 72:** The provider must decide whether to continue operating in place or relocate several individuals.

Exercise Success Measures

Participants should identify:

- Their **individual-level power outage risk list**.
- A defined **relocation trigger**.
- Backup staffing and transportation options.
- Emergency communication methods.

- A process for coordinating with county emergency management and other providers.
- Gaps in generator, fuel, medical equipment, transportation, and alternate-location planning.

Concept 3: The Workforce Collapse — Staffing Shortage & Service Capacity Crisis

Focus Area: Workforce Resilience, Continuity of Care, Provider Capacity

Scenario

A contagious respiratory illness spreads rapidly through a provider's workforce during the winter. Within five days, **30% of direct-support professionals are unavailable** because of illness, exposure, transportation problems, or family obligations.

Several additional employees are expected to become unavailable.

The provider operates residential and community-based services for individuals with varying levels of medical, behavioral, and daily-support needs.

The provider's normal staffing model is no longer sustainable.

Key Discussion Points

Prioritization

- Which services must be protected first?
- Which supports can be reduced, consolidated, delayed, or temporarily modified?
- How does the provider prioritize when every individual has legitimate needs?

Staffing

- What is the provider's minimum safe staffing level?
- Which employees can be reassigned?
- What cross-training exists?
- How are managers, nurses, supervisors, administrative employees, or other qualified personnel incorporated into emergency staffing?

Individual Risk

- Which individuals cannot safely tolerate a reduction in staffing?

- Which individuals have medical, behavioral, communication, or mobility needs requiring specialized personnel?
- How are individuals and families informed about temporary changes?

Provider-to-Provider Coordination

- Can providers share qualified staff?
- What resources can the AE or regional office help coordinate?
- Can individuals temporarily receive support in another location?

Workforce Sustainability

- How does the provider avoid exhausting the remaining workforce?
- What is the plan for food, transportation, rest, mental-health support, and relief staffing during a prolonged event?

High-Value Injects

1. **Day 1:** 15% of direct-support staff call off.
2. **Day 3:** Absenteeism reaches 30%.
3. **Day 4:** The only staff member qualified to support a high-risk individual becomes unavailable.
4. **Day 5:** Two residential programs require emergency staffing assistance simultaneously.
5. **Day 6:** A staff member has worked excessive hours and reports being unable to safely continue.
6. **Day 7:** The provider must decide which services can be modified while maintaining individual health and safety.

Exercise Success Measures

Participants should establish:

- A **minimum staffing threshold** for critical services.
- A system for identifying **critical individuals and critical staffing competencies**.
- A prioritized staffing allocation process.
- Cross-training and backup staffing gaps.
- A workforce fatigue-management strategy.
- Clear escalation criteria for requesting AE/ODP assistance.

High-Utility Feature: This exercise can be run without a disease-specific scenario. The same framework works for **flu, COVID-19, transportation disruption, mass staff resignation, severe weather, or another event that removes a large portion of the workforce.**

Concept 4: The Provider Failure — Sudden Loss of a Critical Service Provider

Focus Area: Continuity of Care, Individual Protection, Transition & Regional Capacity

Scenario

A major provider suddenly announces that it cannot continue operating one or more services because of a combination of financial distress, workforce shortages, and operational problems.

The provider initially indicates that it can maintain services for **30 days**.

Within 72 hours, however, the provider reports that it may be unable to continue several residential and community-based services.

Affected individuals include people with complex medical, behavioral, communication, mobility, and daily-support needs.

The region has limited provider capacity and few immediately available residential alternatives.

Key Discussion Points

Immediate Safety

- How does the AE determine which individuals are at greatest immediate risk?
- What information is required to safely transition each person?
- How are medications, equipment, transportation, behavioral supports, and natural supports maintained?

Continuity of Care

- What happens if there is no immediately available replacement provider?
- Can another provider temporarily assume responsibility?
- What services can be maintained while a permanent solution is developed?

Individual Choice & Rights

- How are individuals and families involved in decisions?

- How are preferences, relationships, routines, community connections, and other person-centered considerations protected during an emergency transition?

Provider Capacity

- How many individuals can nearby providers realistically absorb?
- What happens when every available provider reports that it is already at capacity?
- How can regional resources be coordinated rather than handled independently by individual providers?

Regulatory & Administrative Coordination

- What decisions must be escalated to the AE, ODP regional office, or other authorities?
- What emergency flexibility may be necessary?
- How are temporary arrangements documented and monitored?

High-Value Injects

1. **Day 1:** Provider announces a potential service closure affecting 20 individuals.
2. **Day 2:** The provider reports that several employees have resigned.
3. **Day 3:** Three individuals require immediate alternative arrangements.
4. **Day 4:** Nearby providers report that they have no available capacity.
5. **Day 5:** A family objects to moving an individual far from their current community.
6. **Day 7:** One proposed receiving provider cannot accommodate the individual's specialized support needs.
7. **Day 10:** The provider announces that it cannot guarantee continued service beyond 72 hours.

Exercise Success Measures

Participants should identify:

- A **provider-failure escalation protocol**.
- A process for identifying individuals requiring immediate intervention.
- A regional **capacity and resource picture**.
- Critical information needed for safe transition.
- A strategy for maintaining individual choice and person-centered planning during an emergency.

- Communication responsibilities among the provider, AE, ODP, individuals, families, and other stakeholders.

Recommended TTX Design: Make the Exercise Produce Something

For maximum utility, each exercise should end with a **concrete operational product**, rather than simply a discussion of what participants "would do."

Exercise	Primary Product
Cyberattack	**72-Hour Manual Operations & Communication Plan**
Extreme Weather	**Individual Relocation & Power-Dependency Decision Tool**
Workforce Collapse	**Critical Staffing & Service Prioritization Matrix**
Provider Failure	**Provider Failure / Service Transition Playbook**

Common Exercise Questions

Use the same six questions throughout each TTX:

1. **What do you do first?**
2. **Who has authority to make that decision?**
3. **What information do you need?**
4. **Who needs to know?**
5. **What happens if your first solution fails?**
6. **What would you need from the AE, ODP, county emergency management, or another provider?**

These questions keep the exercise focused on **actual decision-making and resource gaps**, rather than turning the TTX into a review of written emergency plans.

Suggested Exercise Series

Rather than conducting four unrelated exercises, the concepts can form an **ODP Provider Resilience TTX Series**:

Visual Decision Aids



Figure 1. ODP Provider Resilience TTX Series Roadmap — frames the four exercises as a progressive resilience sequence from systems continuity to service-network continuity.

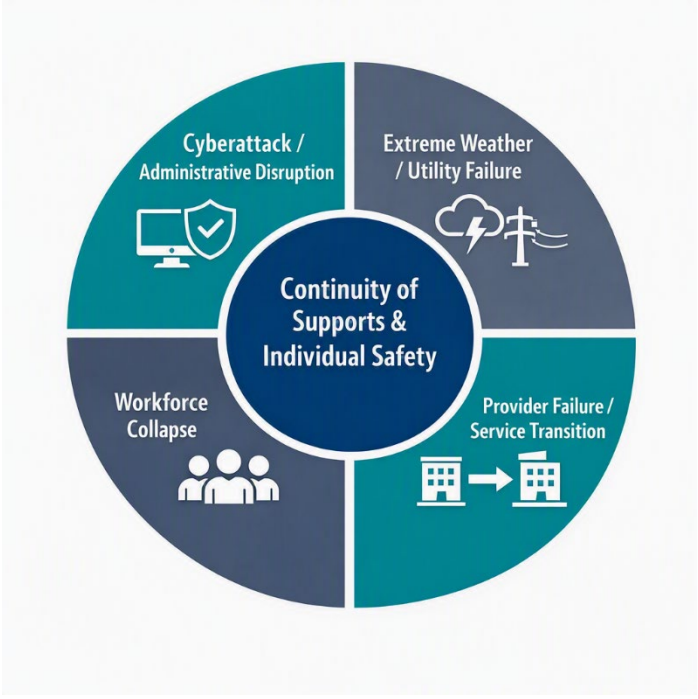


Figure 2. Four-Risk Scenario Wheel — summarizes the core disruption types addressed by the series and connects them to continuity of supports and individual safety.

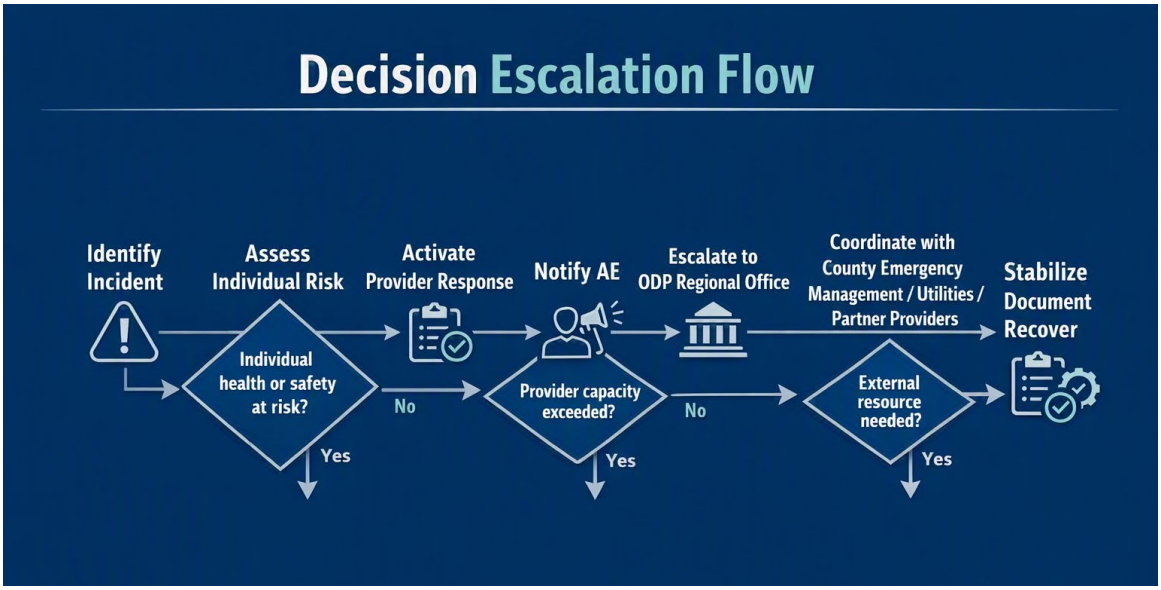


Figure 3. Decision Escalation Flow — illustrates when providers move from internal response to AE, ODP regional office, county emergency management, utilities, and partner-provider coordination.

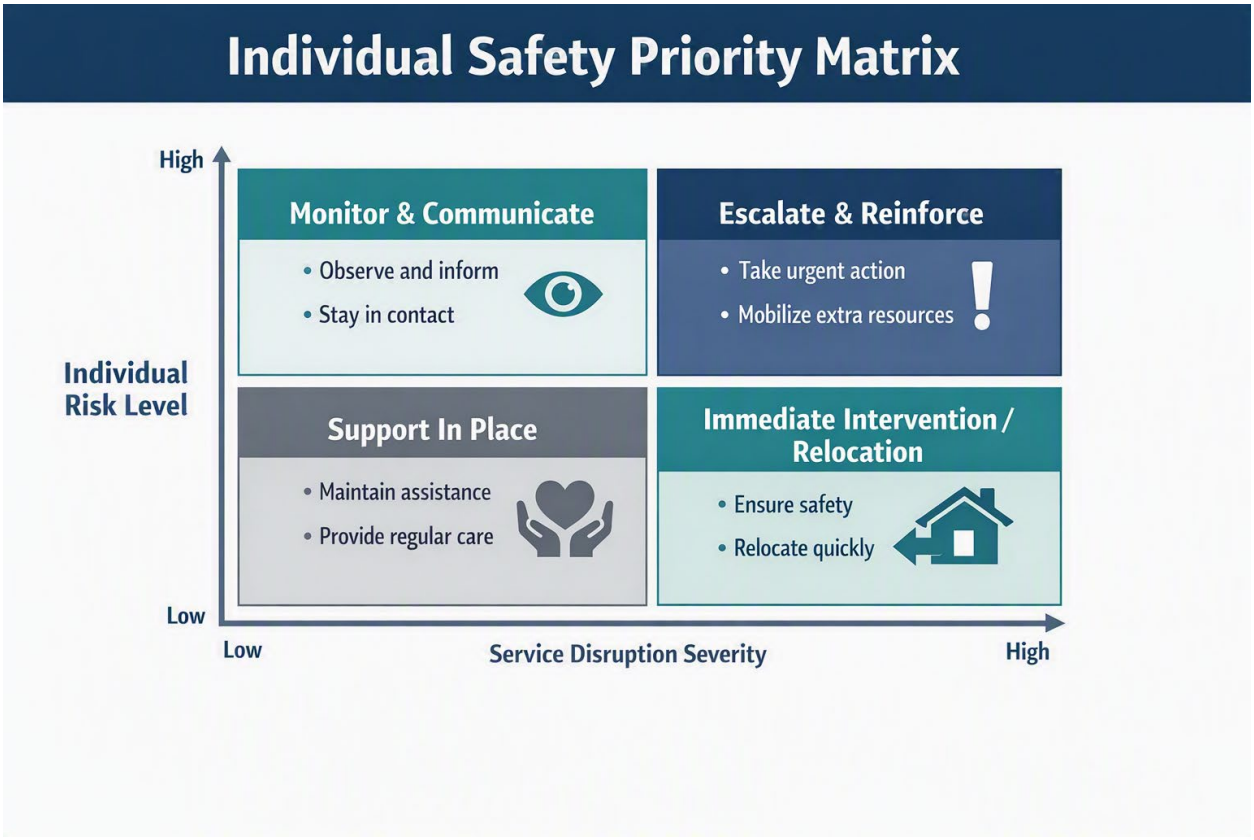


Figure 4. Individual Safety Priority Matrix — helps participants prioritize interventions by comparing individual risk level with the severity of the service disruption.

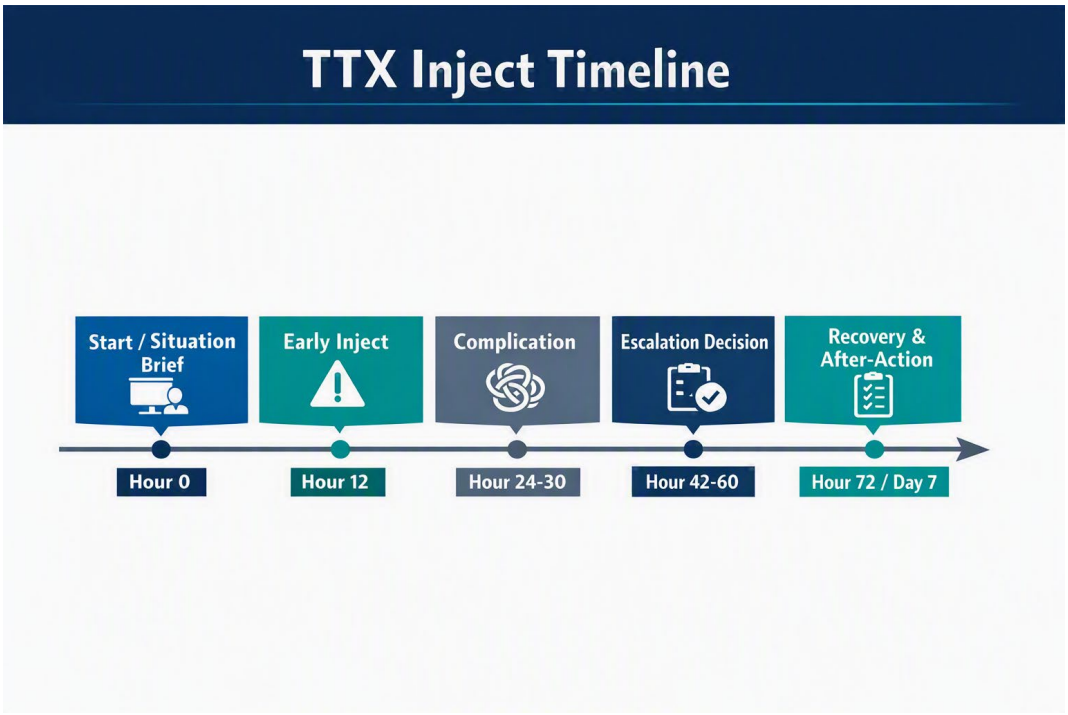


Figure 5. TTX Inject Timeline — shows how exercise information can unfold over time, moving participants from the initial situation brief through complications, escalation, recovery, and after-action learning.

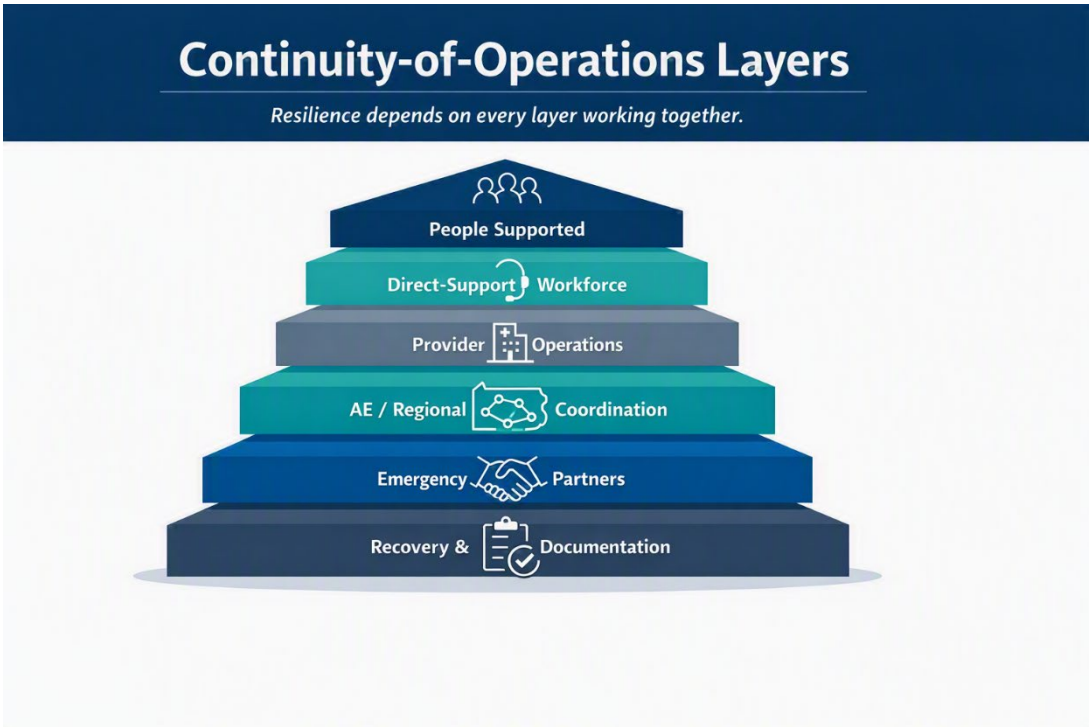


Figure 6. Continuity-of-Operations Layers — shows how individual safety depends on coordinated resilience across people supported, the direct-support workforce, provider operations, AE/regional coordination, emergency partners, and recovery documentation.

TTX 1 — Be Ready to Operate: Cyberattack / loss of administrative systems
↓
TTX 2 — Keep People Safe: Extreme weather / loss of utilities
↓
TTX 3 — Keep Staff Available: Workforce collapse
↓
TTX 4 — Keep Services Going: Provider failure / regional capacity crisis

The progression moves from **systems → safety → workforce → continuity of the service network**, giving providers an increasingly comprehensive view of resilience.

The strongest implementation approach would be to use the **same provider organization and fictional individuals across all four exercises**. Information learned in one exercise can then become a vulnerability carried into the next, creating a realistic **continuity-of-operations storyline** rather than four disconnected tabletop discussions.