Upgrade Emergency Planning For Nursing Homes, CMS Told

BY ALICIA AULT
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After reviewing nursing homes' emergency plans and outcomes of evacuations and sheltering for the last two hurricane seasons, the Health and Human Services Department's Office of Inspector General has suggested that the Centers for Medicare and Medicaid Services strengthen federal emergency management standards for long-term care facilities.

Of the 16,125 nursing homes inspected nationwide in 2004 and 2005, 94% met federal standards for emergency plans, and 80% met those standards for emergency training, the OIG said.

The rates were similar for the 2,526 facilities in the Gulf states of Alabama, Florida, Louisiana, Mississippi, and Texas, according to the OIG's report. But it found in many cases that nursing home administrators and staff did not follow their own plans, or lacked transportation or other resources to effect those plans in a crisis.

The office reviewed state survey data for emergency preparedness and interviewed nursing home staff and administrators and local authorities in nine counties across the five affected states. The OIG took an in-depth look at plans from 20 nursing homes caught in hurricanes Ivan in September 2004, Katrina in August 2005, Rita in September 2005, and Wilma in October 2005, and compared those plans to provisions required by state law.

All 20 homes ran into challenges, whether they evacuated or not. All administrators said evacuation was not necessarily the best course of action as it could cause physical and mental stress. They also cited transportation contracts that weren't honored, complicated medication needs, and host facilities that were not available or prepared to receive evacuees.

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Homes where patients were sheltered in place did not have as many problems overall but still had staffing and supplies issues.

At 5 of the 20 homes, administrators said they deviated from the prepared plan because the plan wasn't up to date or did not address their situation.

Six of the homes did not have instructions on how to evacuate to an alternative site, 9 did not have any guidance on how to determine whether to evacuate or shelter in place, and 11 did not have any instructions on how to return to the homes after an evacuation.

Still, Dr. John Morley, director of the division of geriatric medicine for St. Louis University, said there is a need for an additional plan, saying this is an issue that "goes beyond a local plan and expecting nursing homes to do everything themselves." He said "local police, emergency units, and everyone needs to be involved."

The reality is that evacuation plans have to go beyond the facility because "if something goes wrong, it will affect" the entire area, Dr. Morley said. A facility may plan to use local buildings in an extended outage, but if there is a major disaster, "you probably have to move to another county." Dr. Morley said the issue is not only having a plan and following it but "knowing when to evacuate," given the risks of moving such a vulnerable population.

Indeed, during Katrina, facilities that did not evacuate were criticized, and others that tried to move to Houston had tragic deaths, Dr. Morley noted. He said emergency planning falls apart in older populations, including those in home care and hospice care, because "no one is very interested. We're an ageist society—we don't like old people so we don't plan for them. Then, we get all upset when things go wrong."

Dr. Morley also stressed the need for an "electronic database" to help track patients as part of disaster preparedness.

The challenge of evacuations was underscored in the Sept. 21 grand jury indictments against two nursing home owners in New Orleans' St. Bernard Parish. The Katrina surge flooded the one-story facility to the ceiling in 20 minutes. The owners, Mabel and Salvador Mangano, were charged with negligent homicide in the drowning of 35 residents. However, they have maintained their innocence, saying they were worried that frail residents wouldn't survive the ordeal of an evacuation. ■

Contract Must Detail All Responsibilities When Hiring Physician Extender Personnel

DALLAS — When hiring a physician extender, be sure to spell out all responsibilities in the contract, Dr. Raymond Blackburn said at the annual meeting of the National Medical Association.

"You must delineate in their contract every little detail that you want them to do so that when any dispute comes up it's there," said Dr. Blackburn, a Dallas dermatologist who employs two physician assistants.

A good contract should include a listing of all the duties expected of the physician extender, from performing history and physicals to returning patient calls and handling refills, he said.

Furthermore, consider specifying the physician extender's work hours ahead of time, he recommended.

Extenders need to know if they will be responsible for making after-hours patient calls, working weekends, and staying until the last patient has been seen each day. "I find that's very important because that's not going to be at the same time everyday," Dr. Blackburn said.

Benefits should also be detailed in the contract, he continued. For example, physicians should outline what they will cover in terms of health insurance, paid holidays, vacations, continuing education, sick days, professional-organization dues, medical liability coverage, and retirement.

The average starting salary for a physician assistant (PA) across all medical specialties is about $65,000 a year. And a PA with 6 years of experience averages about $70,000, Dr. Blackburn said. A PA in a busy specialty practice can bring in gross revenues between $600,000 and $700,000 a year.

–Mary Ellen Schneider

Hospice Enrollment Cuts Final Hospitalizations

BY DOUG BRUNK
San Diego Bureau

One-quarter of nursing home residents who enrolled in a hospice program for end-of-life care required hospitalization in the 30 days prior to their deaths, compared with 43% of residents who did not enroll in a hospice program, results from a large analysis have shown.

The finding provides further evidence that offering hospice as an end-of-life option for nursing home residents is beneficial, lead study author Pedro L. Gozalo, Ph.D., said in an interview.

"Prognosis is the big problem: when to figure out whether a person is close to death or not," said Dr. Gozalo, of the Center for Gerontology and Health Care Research in the department of community health at Brown University, Providence, R.I. "Some medical directors feel more aggressive about trying to cure people at the end of life than others. In the end, it's always a matter of personal belief from the medical director's perspective as to whether the person is still at a stage where life can be prolonged substantially. But once it's clear that the person is entering the last stages in life, then hospice appears to be a valid alternative that can save unnecessary hospitalizations."

He and his associate, Susan C. Miller, Ph.D., used Minimum Data Set and Centers for Medicare and Medicaid Services files to review the records of 183,742 nursing home residents in Kansas, Maine, New York, Ohio, and South Dakota who died between 1995 and 1997 (Health Services Research 2006;doi:10.1111/j.1475-6773.2006.00623.x). These states were chosen because they represent the kind of wide variation in hospice enrollment seen from state to state. "For example, Maine has a totally different utilization pattern than New York, even though they are relatively close geographically," Dr. Gozalo said. "The same goes for Kansas and Ohio. We felt that [these states] represented a good sample of the overall states."

Of the 183,742 nursing home residents in the study, the majority (169,127) did not enroll into hospice during their last 30 days of life, while 14,615 did. As expected, the rates of hospice enrollment varied widely and were as follows: 12.5% in Ohio, 11.6% in Kansas, 6.6% in New York, 5.4% in South Dakota, and 2.4% in Maine. Almost twice as many hospice residents had do-not-hospitalize and do-not-resuscitate orders and had diagnoses of cancer, compared with nonhospice residents (47% vs. 22%, respectively).

Compared with nonhospice nursing home residents, those who enrolled into hospice were more likely to live in a nursing home that was for-profit and part of a chain, had a higher private-pay/Medicare-pay ratio, had a lower percentage of nonwhite residents, and had a special care unit; in addition, it was more likely that their nearest hospice provider was for-profit and/or based in a hospital.

The researchers also found that in the 30 days before death, 26% of the hospice patients (3,730) and 43% of the nonhospice patients (73,410) were hospitalized.

When they adjusted for characteristics that might influence a patient to select hospice care, Dr. Gozalo and Dr. Miller found that about one-quarter of the hospice patients chose it because they preferred less-aggressive care. "That means the brunt of the observed effect is real," not solely influenced by one's preference for hospice care, Dr. Gozalo said.

"It would benefit medical directors to enter into cooperative agreements with hospice providers, to refer people to hospice early enough so that they can take advantage of these benefits," he concluded.

The researchers acknowledged certain limitations of the study, including the fact that it did not distinguish hospice treatment by its length of exposure and that the data came from only five states.

The study was funded by the Agency for Healthcare Research and Quality. ■

Explaining Health Care Terms

Brochures that define the common terms that are used in the diagnosis and treatment of breast cancer, heart disease, and diabetes are available to help patients better understand their conditions and medical care.

For more information, and to obtain sample copies of the brochures, contact the Medical Library Association by sending an e-mail to info@mlahq.org.