Improving Disaster Planning in Nursing Homes and Home Health Agencies.

Host: Loretta Jackson Brown

Moderator: Mary Leinhos, PhD

Presenters: David H. Howard, PhD and Sarah C. Blake, PhD(c)

Date/Time: May 8, 2012 2:00 pm ET

Coordinator:
Welcome and thank you for standing by. At this time all participants are in a listen-only mode. After the presentation we will conduct a question and answer session. At that time if you'd like to ask a question dial star 1 on your touchtone phone. Today's conference is being recorded, if you have any objections you may disconnect at this time. I would now like to introduce your host, Miss Loretta Jackson-Brown. You may begin.

Loretta Jackson-Brown:
Thank you, (Holly). Good afternoon. I'm Loretta Jackson-Brown and I'm representing the Clinician Outreach and Communication Activity, COCA with the emergency communication system at the Centers for Disease Control and Prevention. I am delighted to welcome you to today's COCA Webinar: Improving Disaster Planning in Nursing Homes and Home Health Agencies. We are pleased to have with us today Dr. David Howard and Miss Sarah Blake here to discuss strategies to incorporate nursing homes and home health agencies into community-wide disaster planning.

You may participate in today's presentation by audio only, via Webinar or you may download the slides if you are unable to access the Webinar. The PowerPoint slide set and the Webinar link along with the audio number can be found on our COCA Webpage at emergency.cdc.gov/coca. Click on COCA Calls, the Webinar link and slide set can be found under the call in number and call passcode.

At the conclusion of this session the participant will be able to accomplish the following: discuss preparedness levels among nursing homes and home health agencies, describe the unique obstacles facing nursing homes and home health agencies in responding to disasters and identify opportunities to improve disaster preparedness planning for nursing homes and home health agencies.

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Our moderator for this Webinar is Dr. Mary Leinhos. Dr. Leinhos is a Scientific Program Officer with the Extramural Research Programs in the Office of Public Health Preparedness and Response at the Centers for Disease Control and Prevention. She serves as Project Officer to four of the Preparedness and Emergency Response Research Centers. Prior to this role she was involved in several CDC activities related to emergency preparedness to include planning and executing workshops on genomics and acute public health investigations, providing emergency operation center ethics desk coverage and input during the pandemic influenza exercise and the 2009 H1N1 response. She has also provided guidance for protection of human subjects and regulatory compliance in investigations related to emergency response.

Again the PowerPoint slide set and Webinar link are available from our COCA Webpage at http://emergency.cdc.gov/coca/ . At this time please welcome Dr. Leinhos.

Mary Leinhos:
Thank you very much, Loretta. Today's presenters hail from one of the nine Preparedness and Emergency Response Research Centers, which you already mentioned, or PERRCs as we call them for short, which are all funded by CDC. The nine PERRCs conduct research examining the structure, capabilities and performance of public health systems for preparedness in emergency response. The first seven PERRCs were funded in 2008 and two more were funded in 2009.

Our presenters today come from the Emory University PERRC which focuses on the comparative analysis of public health systems to produce practical and sustainable outcomes that serve to improve our nation's public health systems in the event of a disaster.

First on deck today will be David Howard. Dr. Howard is a faculty member in the Department of Health Policy and Management at Emory University. Trained as a health economist Dr. Howard employs economics and statistics in his research to better understand physician decision making and its implications for public policy.

Dr. Howard received his doctorate in health policy from Harvard University in 2000. His current areas of research include the impact of patient's life expectancy on the use of cancer screening and the responsiveness of practice patterns to comparative effectiveness research. Dr. Howard has acted as an advisor or consultant to MedPac, the American Cancer Society, the Division of Transplantation in the Department of Health and Human Services and the Institute of Medicine. David's co-presenter today will be Sarah Blake. Sarah Blake is an associate faculty member in the Department of Health Policy and Management at the Emory University Rollins School of Public Health. She has over 15 years of experience conducting program evaluation and health services research. Her work focuses on access to care for vulnerable populations including the uninsured, low income women and children and the elderly. Miss Blake is also a member of Emory's PERRC where she serves as the qualitative lead for the research project that our presenters will be discussing today. Miss Blake is also the co-principal investigator for a CDC-funded study to examine the influenza vaccination practices of nursing homes in Florida, Georgia and Wisconsin. She is completing her doctoral degree in public policy at Georgia State and holds a masters degree in public policy from the George Washington University.

Please join me in welcoming our presenters for today's topic, Improving Disaster Planning and Preparedness in Nursing Homes and Home Health Agencies. David, would you like to get us started?

David Howard:

Thanks, Mary. So this is a project we've been working on for four years to examine disaster preparedness in nursing homes and home health agencies of course generously funded by the CDC. We're mostly going to talk about our work in nursing homes. There are about 15,000 nursing homes and about 1.5 million nursing home residents at any point in time. Of course the health status and conditions of nursing home residents makes them extremely vulnerable to any disaster related disruptions in medical care, food, shelter and water. And the same is true of the between 1.7 and 2.8 million persons served by home health agencies. Many have very severe chronic conditions and require daily or near daily assistance to remain functional and independent in the community.

At various points in time the issue of preparedness in nursing homes and problems related to preparedness in nursing homes have been in the news. St Rita's Nursing Home was in St. Bernard's Parish outside of New Orleans. And despite being urged to evacuate prior to Hurricane Katrina and having a disaster plan that described in detail the process for evacuating the owners, Sal and Mabel

Mangano decided not to evacuate. The facility was hit by I guess what you could call a flash flood and many residents died during the storm. I believe they were the only healthcare workers or people in the healthcare industry to actually formally be criminally indicted following Hurricane Katrina.

And I thought the trial and some of the issues that were raised by the trial were very interesting and helped to motivate our work. So during the trial the defense called an expert who is a former public health physician. He said the bottom line on it all is that there's no evidence-based proof that you actually save lives by evacuating patients from nursing homes.

And so the defense tried to rebut the prosecution's argument that it was automatic that they should have evacuated - should have evacuated during the storm. In fact evacuation is fraught with difficulty; it can be extremely disruptive to residents. And the defense correctly raised the point, although I don't know if it was the correct course of action in this particular case, that it's not always clear that evacuating is the right thing to do. And there's no evidence that it actually saves lives on an average.

The defense also raised the point that the state did not act according to its plan. So prior to Katrina – actually relatively shortly before Katrina the state had revised its emergency operation plan and part of the revision stated that the Department of Transportation would, quote, direct evacuation and sheltering of persons with mobility limitations which would include persons in nursing homes.

In response Governor Blanco said that the Department was - as the name implies - the Department of Transportation it wasn't - preparedness and emergency response wasn't really a core function and that the three-month period that elapsed between when the plan was revised and when Hurricane Katrina struck was not enough time to really be able to put the plan into operation and develop the resources to be able to carry out the plan.

And that it was alleged that the state responded that St. Rita's never called for help. And that the owners of St. Rita's Nursing Home had actually rejected explicit offers to send busses to evacuate. But I think the experience of St. Rita's is interesting both because it was something that put this issue in the national agenda but also illustrates the importance of better understanding nursing homes' ability to respond to disasters and how that interacts with state plans and capabilities.

More recently nursing home preparedness was in the news not - maybe last week or the week before. In the aftermath of Katrina the Office of Inspector General in the Department of Health and Human Services issued a report describing poor preparedness planning among nursing homes. And several weeks ago they released a follow up report entitled Gaps Continue to Exist in Nursing Home Emergency Preparedness and Response During Disasters that basically said although all nursing homes have

disaster plans that the disaster plans continue to show some areas of weakness.

Among these are they list transportation contracts for evacuation that may not be reliable. There is minimal collaboration with emergency management officials. And a number of other issues that they identified in the previous report had not fully been addressed in the nursing homes that they visited and audited. As you'll see in our findings we - many of these issues came up as well as we'll describe later on.

So our project examined preparedness in nursing homes and home health agencies. We focused primarily on three states which are Georgia, Florida and California. And we selected these states both because of geographic proximity to ourselves as well as the fact that they are subject to different types of disasters but are disaster-prone states. And in these states we entered into a number of discussions with local preparedness planners, with officials at state nursing home associations. We also interviewed nursing home administrators and then conducted a survey of a large number of nursing home administrators in the state.

So my colleague, Sarah Blake, is going to talk about what we found when we sat down and had thorough detailed discussions with nursing home administrators about their plans vis-à-vis preparedness and their capabilities for responding during disasters. Sarah.

Sarah Blake:
Thanks, David. So our research design was based on a mixed methods approach. I'm going to discuss the qualitative methods, as David mentioned, and some of the findings and then let David discuss our quantitative findings from the survey.

So the goal of our qualitative approach was to examine the disaster preparedness capabilities and experiences of both nursing homes and home health - and personal care agencies as these agencies are the least studied and serve a growing medically vulnerable population. The secondary goal of our qualitative component of our research was to inform the development of a nursing home and home health provider surveys.

Two qualitative methods were used; informant interviews and document reviews. We interviewed a total of 17 nursing home administrators and 21 home health and personal care administrators via telephone and in person. Our interviews consisted of 10 nursing homes in Georgia and seven in San Diego, California. Our document reviewed consisted of a review of disaster plans from all nursing homes that we interviewed as well as any memoranda of agreement or understanding as well as contracts that were shared by the nursing homes. We recruited administrators from these 17 nursing homes using the help of state agency associations. Interviews took place both face to face and by phone. And they lasted

generally about one hour. And informants were not paid for their participation.

So I'm going to review some of the major interview domains that were covered with our qualitative interviews. First the interviews addressed disaster preparedness policy development and that included how nursing homes developed their disaster plan, what the plan addresses as well as any other policies they may have had around disaster preparedness and whether this included directives that nursing homes followed from their corporate headquarters. We also addressed disaster preparedness training, training of administrative staff as well as regular clinical staff and patients or clients. Our interviews also addressed disaster preparedness planning and coordination with outside agencies; agencies with related - related to preparedness, public health, nursing home agencies as well as hospitals and other community partners.

And we asked in our interviews about nursing homes and whether they had any disaster or emergency experience and specifically whether they evacuated their nursing homes. And then we generally asked nursing homes - administrators to share with us any lessons learned they had from these experiences. Just briefly about our analysis interviews - interviews were professionally transcribed and reviewed and cleaned by research team members. Coding by two research team members began with a set of deductive codes and led to the development of an initial code book.

We used inductive coding that produced additional codes and were applied consistently to all the data. And then descriptive analysis was performed and initial results were presented via case studies and thematic summaries. And then we conducted a comparative case analysis.

So let's begin briefly to discuss some of our major findings with our nursing home interviews. The first has to do with pre-disaster policy development. We found that all of our nursing homes in the study had a disaster plan in place. Most nursing homes developed their disaster plans with internal staff, senior staff. And these disaster plans took an all-hazards approach. Many of the nursing homes that we interviewed also adapted their disaster plans from a corporate template. Pre-disaster planning occurred with very little input from outside agencies such as emergency management officials, fire departments or public health.

When we asked about training we found that most training occurs in the form of drills, especially fire drills. Some of our facilities in the study reported taking part in tabletop exercises and other state or county-run trainings. Provider associations in each of the states conducted a lot of the training. These were nursing home associations in particular. We also found that government-affiliated nursing homes conduct more training than private or independent nursing homes.

When we asked about communication with outside agencies nursing homes reported that they were more

likely to have regular communication pre-disaster with fire and police departments. They had less established relationships with emergency management officials. We also found that communication with other area nursing homes about disaster preparedness was hampered by competition and really the lack of opportunity to collaborate. Communication among nursing homes did improve post-disasters. Many nursing home administrators expressed to us the lack of awareness of outside resources that they could use in terms of communicating during or after a disaster.

Communication with staff was also addressed in our interviews. Staff members are informed of disaster preparedness policy usually at orientation, through employment materials as well as emergency or during disaster drills. Staff members from most of our nursing home agencies are expected to report for duty during the emergencies or disasters but oftentimes their own family or personal responsibilities or overall lack of availability during these events have prevented their availability. Some facilities have made provisions for staff's family to stay in the facility during an emergency or disaster.

We also addressed communication with family during our nursing home interviews. We found that most nursing homes informed family members about their disaster preparedness policies once upon admission. Family members are expected to take residents during a disaster or during the evacuation. Less family involvement was indicated in our interviews in facilities that served lower income families.

Transportation, also as David mentioned, not only was a problem in New Orleans but continues to be a problem - a challenge to many nursing homes in our study. Most nursing homes contract with ambulances or school buses for transportation in cases of evacuation. Some of the nursing homes in our study did have their own facilities or vehicles. Interestingly enough some of the nursing homes during their experiences with disasters reported using unusual vehicles including a hearse. One nursing home had used a U-Haul truck. And agreements were in place by some nursing homes with companies just to move equipment and supplies such as medical charts, etcetera, during an evacuation. Administrators acknowledged the potential to have ambulances and school buses either commandeered by the county or not available due to overlap in company's commitments.

In terms of the evacuation and the shelter and place experiences of our nursing homes we found that informal relationships with other administrators and disaster preparedness officials played key roles in the evacuations that did occur. Facilities that were in areas under constant threat of a disaster appeared to be more prepared than those that are not.

Now we'd like to highlight two cases of nursing homes' experiences with disaster preparedness. In the next two examples both cases where a wildfire was the disaster. You will see the difference in not only how the nursing home communicated or did not with public preparedness officials but also with their

experiences with transportation and ways the nursing homes had to work creatively with the community, residents' families and other nursing homes to get help during the disaster.

We'll start with an evacuation story from Georgia. A little bit of background of this particular story. In the spring of 2007 there was a wildfire in South Georgia. The wildfire started by a tree falling on a power line. Due to the extreme draught conditions at the time and the low humidity and high winds a fire erupted and spread quickly throughout this area of the state. The wildfire burned for more than two months and destroyed over 100,000 acres of land making it the largest wildfire in the history of the state. It was also the costliest estimated at about $150 million. Over 6000 people were forced to evacuate including residents, schools and businesses. One nursing home came within hours of having to evacuate and this is their story. This nursing home was notified by the county EMA to review disaster plan and to get ready. School buses and ambulances assured through agreements with the county EMA were unavailable. The buses commandeered by the state to help bring school children home, 10-12 county ambulances were held to help other community members. Only one ambulance was available to this nursing home to transport their more than 20 ambulatory patients. Churches volunteered their buses and the nursing home ended up hiring moving trucks to move equipment and supplies. After complaints about the EMA were made by the community as well as residents' families finally ambulances were brought in from nearby counties.

Now to give a contrast I'm going to give you a story from California. Again this is a wildfire in the fall of 2007 in San Diego, California. In San Diego at this time there was a series of wildfires that burned over 500,000 acres during one week in the San Diego region. Nearly 1 million people evacuated, 2180 homes were destroyed and nine people died. The cost of containing this wildfire was estimated to be at over $10 million. One nursing home that contributed to this story and that was in our study had a very interesting and yet different experience from the Georgia nursing home that we interviewed. Fourteen nursing homes in San Diego evacuated over 1200 residents during this 2007 wildfire. Many of these medically fragile residents were evacuated to non health facilities such as Qualcomm Stadium and Del Mar Fairgrounds while unaffected nursing homes reported available beds and the ability to provide care and aid.
The nursing home in our study was forced to evacuate its residents though it had transportation agreements with private ambulance companies. But unfortunately the ambulances were commandeered by the county EMA. Personal relationships with other nursing home administrators guaranteed that this nursing home residents - this nursing home - the residents - had a place to stay. The medical operations center in San Diego eventually contacted this nursing home and provided eight ambulances although it was hours after the evacuation was ordered. Nursing homes that accepted transferred patients reported staffing challenges including just simply staff that did not show up, not enough staff as well as staff that were ill prepared to assist high demand patients such as Alzheimer's patients. Repatriation was also a challenge and took time and money.

Out of the 2007 San Diego wildfires the Area Coordinator's Model was developed. I'm going to discuss this model just a bit. We have written an article about this model that should appear soon in the Journal of Disaster Medicine and Public Health Preparedness. The Area Coordinator Model was developed by the San Diego nursing home administrator after the October 2007 wildfire. This model was initially developed as a bed-tracking system. It was eventually formed to foster extensive communication and collaboration between nursing homes on emergency preparedness polices and procedures particularly around mutual aid, evacuation and sheltering of nursing home residents. Seven area coordinators, or ACs, represent between 10 and 17 nursing homes each within their region representing a total of 91 skilled nursing facilities in the greater San Diego region. All ACs work together closely with the San Diego Office of Emergency Services and all area coordinators also volunteer monthly with the San Diego Medical Operations Center. The San Diego Area Coordinator Model is currently being adapted to fit other models of care such as residential care and assisted living and has the potential to be successful - a successful model in other parts of the country.

Let me just turn now to the findings from our qualitative work on home health care and personal care agencies. Similar to the nursing home findings we've learned a great deal about these agencies' preparedness policy development or lack thereof. We found that in terms of the pre-disaster policy development most agencies did not have a formal disaster plan in place. Unlike the nursing homes which all did have a disaster plan nursing homes are not encouraged or required to have a formal disaster plan in place and most simply did not. Home health agencies affiliated with the hospital were most likely to have one. Little to no pre-disaster planning existed and policies were really more informal in nature.

In terms of training there is little to no training that occurs within home health or home care agency staff. Administrators of hospital-affiliated agencies report taking part in NIMS online training program. Agency representatives reported knowing about disaster preparedness from self-directed learning such as doing online searches or reading articles in the paper. There was certainly a desire for more formal disaster preparedness training that was expressed by home health and personal care agency administrators.

Our next finding relates to disaster preparedness perspectives. We found interestingly enough that home health care and personal care agencies view the concept of a disaster quite differently. Home health agencies view a disaster as a highly unusual, large-scale event that disrupts normal functioning of the agency such as a hurricane, a tornado, an epidemic, even a terrorist attack. Personal care agencies view a disaster as something small-scale, personal or business-related disruptions that might include an employee not showing up for a shift or a client falling down while in the care of the agency. Maybe the client's water has been shut off. That is the more small-scale conceptualization of a disaster held by most personal care agencies.

We found also a lot of differences in terms of responsibilities and expectations with home health and personal care agencies. Home health agencies considered their role to be strictly about providing medical care and thus rely more on family members to be available to help during a disaster.

Personal care agencies, on the other hand, which are more likely to spend more time in a client's home on a daily or weekly basis and therefore they're prepared to take a more active and more first-hand role in assisting clients during a disaster. Several of the home health agency administrators that we talked to indicated that they would not even take on a new client if that new client did not have a family member or other nearby - other person nearby that could serve as a caretaker during an emergency. In general these agencies do not assume total responsibility for care during an emergency or disaster. Agencies maintain a strong dedication to client care and a willingness to work through the disasters.

So now I'm going to turn it over back to David and let him discuss the results from our nursing home survey.

David Howard:
Thanks. So we conducted a survey of nursing homes in Florida, Georgia and California to kind of help flesh out some of the points that were raised during the interviews and also gather data from a larger number of nursing homes.

So we sent a survey to 498 nursing homes of which 296 responded to the survey. We were obviously concerned about non-response bias in this context. Our responder is going to be primarily nursing homes that are less prepared or not as well prepared as non responders - or excuse me, are better prepared than non responders. However when we compared responders and non responders on a number of characteristics available in the online nursing home compare database they were very similar so that lessened our concern about response bias in this case.

And so here's some data about kind of disaster plans and drills. Almost all nursing homes surveyed conduct a disaster drill with most conducting two per year. And these do not include routine fire drills. A lot of preparedness efforts for nursing homes have been focused on the use of disaster plan templates and dissemination of templates. So some states are disseminating templates. Many nursing home associations at the state level have focused their disaster plan and preparedness-related activities on dissemination templates. So we were interested in how widely are these templates being used. Of the nursing homes we surveyed over half are using a template from a corporate office, 17% are using a template from a nursing home association and 27% - about - a little less than 1/3 are not using a template. I think there are positive and negative aspects to the movement to disseminate templates. On

the one hand going through the exercise of filling out a template may make - may be a good vehicle for administrators to consider various aspects of disaster planning that they would not consider on their own. Going through a template can prompt administrators to reflect and consider the issues that may arise that they may not have otherwise been aware of. However all too often there is a feeling that merely by completing a plan or a template that that equates to adequate preparedness and that's certainly not the case. So it's important not only that nursing homes have a good plan but the plan be grounded in reality and sound expectations of the resources and capabilities that are going to be available during a disaster.

We're very curious to what degree did nursing homes coordinate their actions or coordinate preparedness planning with government officials and other local bodies that are going to be important during an emergency and helpful in allowing a nursing home to either evacuate or shelter in place during a disaster. And we were surprised; a very large - well more than half of the nursing homes had had some contact with the local or state emergency management office so that was encouraging to see. Many had also talked to a fire department and then large numbers had talked to various other agencies and officials. And of course these categories are not mutually exclusive. However, only 59% of respondents, and that's this result right here, only 59% of respondents had discussed disaster planning with residents' families. Now during a disaster the nursing home maintains responsibility for residents. The families don't necessarily have a formal role.

However, informally families can be very important in helping to evacuate residents or providing care during shelters or even providing emotional support to residents. And of course families are very - during a disaster will be very concerned about what's happening to their loved ones. And it's good that they know that there's a plan in place and what that plan is particularly if evacuation is necessary.

We asked nursing homes about their ability to shelter in place. So I'm not going to put up all of the results here but these are just some of the ones that we found more interesting. Eighty percent of the respondents had a generator. And that generator - in 80% of the nursing homes that had a generator the generator was able to provide support for resident critical care functions. And in almost all cases it was able to provide emergency lighting.

There are various recommendations out there about how many days nursing homes should be able to shelter in place and how many days supply of food and water they should have. The Department of Health and Human Services and the Center for Medicare and Medicaid Services recommends a - I believe a 3-10 day supply. The state of Florida recommends I think at least a seven-day supply. But many state regulations specify that nursing homes have to have at least a two to three-day supply but not necessarily more than that so there's the recommendation and what's in the regulations.

We found that about half of the nursing homes have a two to three-day supply of food and that - we found similar results for water. And then 22% have a four to six-day supply and about 1/3 have more than week's supply of food. And so these types of results should be of interest to local preparedness planners when they think about what - how they might need to step in during a disaster that goes longer than two to three days. Many nursing homes will run out of food and if they're not able to get resupplied that is going to be problematic. Here are the results about the water supply and the source of water supply.

Also asked about evacuation plans and we found this result interesting that 76% of respondents listed an ambulance service as one of their transportation vendors for evacuation. Again the responses for all these different types of transportation are not mutually exclusive. During a small-scale disaster use of an ambulance service is not likely to raise any issues. But during a larger-scale disaster where ambulances may be called on to transfer or evacuate hospital patients, disaster victims where ambulances may be commandeered by FEMA or state emergency management officials the reliance on ambulances to evacuate nursing home patients may prove problematic.

And so it's important that nursing homes have reasonable expectations about what types of resources will and will not be available during a large-scale disaster and plan accordingly. And our results and echoing the findings of the report from the Office of the Inspector General suggests that there is room for improvement in this case.

We asked about where are nursing homes going to evacuate, where are they going to take their residents if they have to evacuate. Most are going to evacuate to a sister facility which would be a nursing home in the same corporate or chain umbrella. About 1/3 lists a non-sister facility as evacuation destination. The only slightly troubling result here is that 17% listed a hospital as an evacuation destination. And while this might be reasonable for hospital-based skilled nursing facilities for community nursing homes this could prove problematic in that during a disaster the demand for hospital care may increase; hospitals may be reluctant to accept new patients. And it may be difficult to - this may be difficult to get nursing home residents admitted to a hospital or for the hospital to have excess capacity to shelter nursing home residents. And so it's important that hospitals and nursing homes talk to one another and set expectations about the capacity that will be available during a disaster.

Interestingly many hospital surge capacity plans - these are plans that hospitals or states may have to create capacity in the hospital during a disaster that creates a sudden surge in demand for the hospital's resources among victims of an accident, victims of a disaster or people who are suffering from pandemic influenza call for hospital patients – existing hospital patients to be discharged to nursing homes or skilled nursing facilities. That again may prove problematic if nursing homes are struggling to take care of their existing residents. They're not going to want to accept new residents. So I think there's a lot of dialogue

that could take place between nursing homes and hospitals with regard to who is going to be able to accept new patients and in what circumstances are facilities just going to say we're trying to take care of all our existing patients; we're not going to be able to accept new admissions.

Skip over [slide] - we ran some regressions looking at the impact of various hospital characteristic - sorry, nursing home characteristics on preparedness. I think I'm going to skip over those. I'd like to talk a little bit about our - another project we're doing also with the CDC on immunization for seasonal influenza vaccine in nursing homes. And some of the results are very germane to our work on preparedness so I just wanted to highlight those. What we're doing is going into nursing homes in Florida, Georgia and Wisconsin and collecting data both on resident and staff vaccination rates. And what this table shows is staff vaccination rates from 11 facilities in Georgia. The second column shows the proportion of staff who receives season influenza vaccines. The third column shows the proportion of staff who received the H1N1 vaccine in 2009. And then the last column shows the number of staff in each facility. While many of these facilities have relatively high resident vaccination rates there is some evidence - and accumulating evidence - to suggest that influenza vaccine is of limited or greatly diminished efficacy among older and immunocompromised individuals. So vaccinating staff is really important for reducing the transmission of influenza.

And what we see here is that on average only about half of nursing home staff are receiving the season influenza vaccine every year and less than half receive the H1N1 vaccine. So these results have obvious implications for preparedness and suggest that improving staff vaccination rates is a major target for improvement both for reducing the transmission of seasonal influenza vaccine as well as being able to respond to any future pandemic.

So just going through, you know, trying to step back now and thinking about some of the conclusions or broader lessons that we can draw from our work on preparedness in nursing homes and then to a lesser degree home health agencies.

The first item that is based on our research and also previous experience with disaster is that disaster plans are not enough. There's a great deal of emphasis on getting the nursing homes to fill out plans, to write better plans, to use templates. And that's all important but just having a disaster plan does not insure preparedness or the ability to respond during a disaster. And there's a nice little blurb in a report from - I believe it was a report from the State of Louisiana following Hurricane Katrina that talked about the paper plan syndrome; that talked about how there's a tendency to believe that disaster preparedness can be accomplished merely by the completion of a written plan. It creates the illusion of preparedness in cases when planning assumptions are not

valid, plans are created - not created based on inter-organizational perspective, plans were not accompanied by the provisions or resources to carry out the plan. And end users were not involved in the planning process. And so I think this is very, very relevant to the case of nursing home preparedness and many of the issues that we have raised earlier and also that were raised in the Office of Inspector General report.

The second broad conclusion is just - relates to the importance of setting expectations both for nursing homes and all the actors that are involved in preparedness planning in a community about what can they expect to happen during a disaster, what types of resources will and will not be available. So this is particularly true for nursing homes in the case of transportation vendors during a disaster. We've heard - and we're certainly not the first to raise this point that both ambulance companies and even commercial bus companies may be overextended during a disaster. They might have contracts with multiple nursing homes or multiple hospitals and nursing homes. And during a disaster they're not going to be able to honor all of those contracts.

And we've talked also about the case of evacuation destination that during a small-scale disaster a hospital might be able to accept nursing home residents but during a larger-scale disaster that might not necessarily be a reasonable evacuation destination. So I think one of the major roles here that local preparedness planners can fill is to get these parties together and to set expectations about what types of help they can expect and that's a major benefit of the San Diego Coordinator's Model that Sarah talked about earlier is that it begins those conversations among nursing - at least in the case of San Diego - among nursing homes as to what they can and can't expect.

The third point is something I raised recently. Just be cautious about using nursing homes as alternate care sites or as spillover sites to create hospital surge capacity. Many states' surge plans call for nursing homes to be used as a secondary care site during disasters. I don't think nursing homes are going to be comfortable with expectation particularly if they're under stress and have difficulty caring for their existing residents.

And the fourth item is it's important to integrate nursing homes and home health personal care agencies into community plans and recognize the interconnectedness that exists within the healthcare system between home health agencies, nursing homes and hospitals. In some cases – and I think this is starting to change - although hospitals are characterized as healthcare facilities nursing homes and home healthcare agencies because many are for profit businesses are characterized as businesses and not involved in the larger healthcare system planning that goes on around preparedness. I know a number of communities in states have started to change the

way they look at nursing homes - change the way they look at nursing homes with respect to preparedness but that's an important development that needs to take place nationwide.

And so with that that's all the - that's all the, you know, the broad conclusions I wanted to raise from our work. I'll just turn it over to Sarah. Sarah, do you have any other additional points that you wanted to address before we respond to questions?

Sarah Blake:
No that's it. Thanks.

Mary Leinhos:
Well thank you very much, David and Sarah. We really appreciate your presentation. And we would like to open up the line now for questions as well as take any that folks submit via the Webinar. Give folks a moment to dial in. Loretta, would you like to remind people how they can ask - to ask a question?

Coordinator:
Certainly. Again if anyone does have a question please make sure to press star 1. Make sure your phone line is not muted and record your name clearly. Again that's star 1 to ask a question. And if your question or comment is answered you may press star 2 and be removed. And we'll give it just a moment.

Loretta Jackson-Brown:
And while we're waiting for the first audio question I see where we do have several questions through the Webinar. But I do want to add that Dr. Howard and Sarah mentioned several additional resources. Those resources are available on that COCA call Webpage for today's call. So if you go to emergency.cdc.gov/coca click on COCA Calls and then look for the May 8 call. And then go down to Additional Resources and you'll see the CDC Preparedness Resource for Long Term Acute and Chronic Care Facilities. You will also find the HHS Office of the Inspector General report about Gaps Continue to Exist in Nursing Home Emergency Preparedness and Response During Disasters. And there you will also find the Centers for Medicare and Medicaid Services Emergency Preparedness Checklist Recommended Tools for Effective Healthcare Facility Planning.

Mary Leinhos:
Thank you, Loretta. So I see we have a couple of questions on the Webinar link so I will read the first question that came in and turn it to our presenters to answer.

So the question is from (Heidi Barsness) and she says, "So I work in a home care agency. We have talked about this time and time again. What is our staff's responsibility if there is a tornado or disaster; if our client is not able to get to a lower level or an interior room, for example. Is it your staff's responsibility to staff with a client or get themselves safe? Would it be abandonment if you're safe and left the clients to get themselves safe?"

David, do you have some thoughts you'd like to share about that?

David Howard:
Yes, I mean, so this is the, you know, with nursing homes the lines of responsibility are very clear because nursing homes, you know, patients are residents in nursing homes. So it's very clear that nursing homes will maintain responsibility for residents during a disaster. In the case of home health the lines of responsibility are not always so clear. And we have just, you know, there's a - I think it's fair to say there's a lack of consensus and that lack of consensus may hamper disaster planning and obviously creates all sorts of liability concerns about the, you know, what happens and the responsibilities of home healthcare workers during a disaster.

Sarah, do you have anything to add?

Sarah Blake:
No. I think that, like you said, David, the line is unclear. I think it's - where home health agencies also struggle most of them - did with this issue that we - when we raised it with them. I think they work it out on a case by case basis and do the best that they can.

Mary Leinhos:
Thank you both. I see a couple of people - it looks like they raised they hand but didn't actually type a question into the box. (Carrie Zaleski) and (Carol Thornton) as well as (Tracy Claire). I don't know if they're on the phone line if they want to get in the queue or if they want to retype a question into the Web box?

Coordinator:
I currently just have (Linda Scott) in the queue. So if anybody else wants to ask a question please do make sure that your phone line is not muted and then press star 1 and record your name. Otherwise I won't be able to let you know that your line has been opened. So would you like me go ahead and open (Linda)'s line up?

Mary Leinhos:

Yes please. Thank you, Operator.

Coordinator:
You're welcome. And, (Linda), your line is open.

Linda Scott:
Great. Thank you for an excellent presentation. I actually have kind of a two-part question. One of the things that we run into in Michigan when we're working - and we've been trying to support our nursing homes in emergency preparedness for several years. And the first part is that we get challenged by our nursing homes in trying to do inventive planning that would be good for the facility but stretches the limits of their perception of subjecting them to some (F) tag or some federal compliance problems in their emergency preparedness plan. And I just wondered if in your discussion with any of the nursing homes you had gotten that information is the first part of my question. And that really dovetails into how is this information being shared at the national level with CMS? Because again I think that it's important that they have to have a plan but the quality of the plan and the ability to think inventively at least is what we're hearing in Michigan. Thank you.

Sarah Blake:
I can respond to that. This is Sarah. I think inventively is a good idea. Nursing homes that we talk to are often overburdened with so many different responsibilities, you know, including but of course outside their emergency preparedness responsibilities. I think San Diego is a great example of how to be, you know, inventive and resourceful. And that being, you know, a network - you know, basically there was a champion at the nursing home who wanted to learn from the disaster, you know, the disaster of the wildfire. And, you know, encouraging nursing homes to work together, to communicate, to set up, you know, whether it's an advisory committee or an Area Coordinator's type model takes a little bit of that burden away from them but also gives them that opportunity to engage and to facilitate communication with other nursing homes and to learn from each other.

So I think, you know, that is one way you can be inventive in terms of helping nursing homes figure out what they need to do. I think, you know, the nursing homes that we talked to also echoed a lot of concern over just not having the resources. Many felt that their disaster plans, while in place were probably something that they hadn't looked at for quite a while, you know, knew that they needed to sort of refresh their memories about the disaster plans. But I think encouraging the nursing homes to, you know, use what resources they can and to really kind of facilitate access to their sister agencies and so forth will help them sort of move forward and

being better prepared.

David Howard:
And this is David. Nursing homes are certainly skittish about new regulations and requirements. We've found that in many states the nursing home associations are taking a very active role in preparedness and that may help to overcome some objections. I don't know what the case is in Michigan but that might be a good venue for contacting and working with nursing homes.

Linda Scott:
Great, thank you.

Mary Leinhos:
In terms of whether we've shared this on the federal - with CMS I think was your - other part of your question is that correct?

Coordinator:
I just put her - (Linda), if you want to call back in; I thought you were finished. You said thank you.

David Howard:
Yes, this is David. Yes, that was part of the question. We are - the survey results are going to be published in the American Journal of Disaster Medicine. I don't know when it's coming out. So we're publishing many of the pieces of our work. We are writing little, you know, writing up the results in newsletters. I don't know that we've have formal contact with CMS but we certainly consulted them when we were developing the survey. And I think that's a good idea to try to follow back up with them.

Coordinator:
And we do have another question from (Lawrence Heidenberg), your line is open.

Lawrence Heidenberg:
Hi. I'm from the State of New Jersey, Department of Health. I'm in our Emergency Preparedness Division as opposed to the division that handles our licensing of long term care facilities. One thing we've found going back to the folks from Michigan is that having our division that does not handle anything involving licensure or licensing actions work cooperatively with facilities in objectively reviewing plans, helping develop exercises, helping to bridge the gap between the healthcare industry and the emergency management sphere including the local offices of

emergency management and all of the responding agencies has paid off tremendously in our area primarily because we've found that everyone is now coming together. And we've developed templates. We've developed actually multi-county agreements that are being opened up slowly statewide so that a facility that is signed on with every facility in one county can now access other counties that have signed into similar agreements so that we're slowly but surely trying to develop a statewide network. Because all of the participants in a very active healthcare facilities committee involving both acute and long term care they've all agreed that on a day to day basis, yes, they're competitors. The second that a disaster hits they have come to the realization and have actually gone through real world event disasters that they stop being competitors and just start doing what's right for the residence, the patients, the community overall. We've had exceptional success. And I'm pleasantly shocked at how well everybody is actually playing together in the sandbox.

David Howard:
That's great to hear. And, sorry, what's your name again?

Lawrence Heidenberg:
My name is Lawrence Heidenberg.

David Howard:
Okay great. Thank you.

Coordinator:
And I'm showing no further questions on the phone.

Mary Leinhos:
Great, thank you very much, Operator. We have several more questions in the queue on the Webinar so we'll go ahead and go through those starting with the ones that came in earlier.

First one is from (Joan Flynn). She asks, "Do our presenters know, and if so can they share any information on the status of CMS's regulations for emergency preparedness in nursing homes?" She had seen on the regulatory agenda that these regulations were scheduled for a proposal but haven't gone - she hasn't received a definite answer from CMS as to when that would be happening.

David Howard:
I don't know. I know that, you know, they recently revisited the conditions and participation for

dialysis centers. And those - the new regulations included a number of preparedness related requirements. But I haven't heard anything about that.

Mary Leinhos:
Thank you, David. I guess we'll all stay tuned to see what happens. A related question from (Patricia Ford): "Are there any specific guidelines from CMS regarding home care agencies for disaster planning such as disaster drills, how-to's, etcetera?"

David Howard:
I haven't run across any.

Mary Leinhos:
Thank you, David. Now our next question is from (Larry Graff). He says, "Is the Red Cross prepared to accommodate some nursing home residents who are mobile who might be evacuated to shelters such as schools, churches, etcetera?" That's an excellent question.

David Howard:
Some facilities did list special needs shelters and schools as an evacuation site although I think in many cases that would probably be a secondary evacuation site. The issue, Sarah, you can speak up. But I don't believe the issue of the Red Cross providing assistance has come up.

Sarah Blake:
Not in direct - direct assistance to nursing homes. I think it's just as you said, David, that it's likely that Red Cross officials and staff assisted and do assist nursing home residents that have been evacuated to special needs shelters. But we've not found any of the nursing homes that we have spoken to that indicated any kind of informal or even formal relationship with the Red Cross.

Mary Leinhos:
Thank you both. I'm aware that the Red Cross has been doing some pilot programs with community resilience. And perhaps they are working more directly with specific communities to help them figure out how they might provide accommodations for at-risk individuals such as those in nursing homes. So it might be worth taking a look at the Red Cross Website and see what they're up to these days.

Our next question comes from (Kelsy Blackburn). "How do you increase long term care facilities' participation related to disaster preparedness? Ohio has offered funding, supplies, free

trainings, even developed a regional workshop and our attendance continues to be minimal. Most of the participating facilities are those who have actually experienced disasters first hand. Do the presenters have any ideas about how to address this challenge?"

David Howard:
We've seen at the Georgia Healthcare Association that session - and also attended the annual meeting of the Kentucky Healthcare Association - that sessions on disaster preparedness were relatively well attended. But of course you do always worry that those who are attending are going to be the best prepared. You know, again nursing home associations might be able to do outreach to facilities in a way that government cannot. And so that's the best suggestion I have. But other than that it can be hard to engage people.

Mary Leinhos:
Thank you, David. Sarah, do you have anything to add?

Sarah Blake:
Just, you know, you - as David said we've had good experience in seeing Georgia's participation from nursing homes at these annual conferences. It would have to incorporate some sort of incentive for probably the nursing home to participate. And that may be monetary; it could be something in terms of some sort of, you know, credentialing. It would have to be something that would be worthwhile to the facility to participate. I think once you get them engaged you will probably likely keep them engaged. But I think that initial engagement is challenging.

Mary Leinhos:
Thank you, Sarah. Let's check in with the operator again. Are there any callers on the line?

Coordinator:
There are no questions.

Mary Leinhos:
Okay thank you. We do have one more in here - in the Webinar. And I also got a question – somebody was asking for the person from Ohio to - if they would repeat - maybe if you could type in again and tell us who you were. There was some curiosity about where you were at.

We have a question from (Merritt Carnahan). "What expectation does CMS have regarding following the CMS task list?" David or Sarah, do you have any understanding of that?

David Howard:

So when you say the task list is this the - I mean, CMS has put out guidance and recommendations about emergency preparedness planning and I believe we've included that as a link. I'm not familiar that there are any specific regulatory requirements mandating compliance with the list. A lot of the guidance that CMS has put out vis-à-vis disaster and preparedness planning has been around the issue of billing and reimbursement and when is it okay to waive certain requirements to facilitate access to care among disaster victims. So, you know, most - I think most of the - again most of the CMS activity around disaster planning has been around those types of issues not necessarily about how do you prepare although I think CMS with dialysis centers and perhaps in the future with nursing homes and skilled nursing facilities will be taking a more active role.

Mary Leinhos:

Thank you, David. I'm not showing any additional questions. Operator, do we have any other callers on the line?

Coordinator:

Somebody just popped in. Give me one second to get their name.

Mary Leinhos:

Great, thank you.

Loretta Jackson-Brown:

And we will go ahead and make this our last question for today.

Coordinator:

If you had a question your line is open. I didn't - you didn't like record your name. If you just went into the queue. You might be muted. Participants, if you had a question your line is open.

Woman:

Have any other states, begun working with the coalition model that's designed to bring together healthcare organizations, emergency management, dialysis centers, just to the table to start on that emergency preparedness on more of a local regional level so that everyone in that community is prepared?

Sarah Blake:

This is Sarah. We have not seen anything specific to nursing homes or home health agencies

outside of San Diego. But as I mentioned and that, you know, is a model that really does engage not only the nursing homes and the nursing home association in the San Diego region but also preparedness officials as well as public health officials. I think that it's - as we've noted from discussing the model it's been used in other type of care environments. But it has not necessarily been replicated as envisioned outside of the San Diego model. But it could potentially certainly be used. I know the person who is the main creator of the Area Coordinator's Model is constantly being flown to different parts of the country being asked to talk about the model, about how it works and how it's - they execute the model. So that has certainly been discussed and certainly has the opportunity to be replicated elsewhere.
David, do you have anything else to add?

David Howard:
Nope.

Woman:
Thank you.

Coordinator:
And I'm showing no further questions.

Loretta Jackson-Brown:
On behalf of COCA I would like to thank everyone for joining us today with a special thank you to our presenters, Dr. David Howard and Miss Sarah Blake and today's moderator, Dr. Leinhos. If you have additional questions for today's presenters please email us at coca@cdc.gov. Put May 8 COCA call in the subject line of your email and we will ensure that your question is forwarded to the presenters for a response. Again the email address is coca@cdc.gov .

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Thank you again for being a part of today's COCA Webinar. Have a great day.

Coordinator:
That concludes today's conference. Thank you for participating. Please disconnect your lines at this time.

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