



Dedicated To Long Term Care Medicine

AN OFFICIAL
PUBLICATION OF THE
AMERICAN MEDICAL
DIRECTORS ASSOCIATION

Caring *for the Ages*

A Monthly Newspaper for Long-Term Care Practitioners

In This Issue

Dear Dr. B

A primer on why doctors act the way they do.3

Patient Give and Take

Studies show it's frustrating for caregivers, too—but here are some communication tips. . . .4



Focus on the Elderly

A photo show features one doctor's views on aging.18

Seeing Stars

Medicare will rate nursing homes on a five-star scale.20

In Case of Emergency, Break Out Exit Plan

Stay if possible, but be ready to transport residents.

BY JOANNE KALDY

The first goal of a long-term care evacuation plan is “whenever possible, you want to avoid evacuating,” said Scott Aronson. “There have been some unnecessary evacuations. It’s not always best to go, but sometimes there’s a fear factor.”

However, long-term care facilities must have evacuation plans in place and be prepared to make intelligent, informed evacuation decisions, said Mr. Aronson of the fire and emergency management company Russell Phillips & Associates of Plainville, Conn.

Facility leaders should be prepared to answer several questions when facing an evacuation, including the following:

- ▶ Does the situation call for a full building evacuation or merely a relocation of residents within the facility?
- ▶ Should staff callbacks go into effect? If so, when?
- ▶ Will we transport patients directly to EMS transports or can internal holding areas be utilized to stabilize and track them?
- ▶ Is this a regional incident or will we have local and state assets supporting us?
- ▶ Is the building infrastructure affected?

How does this affect means of travel?

▶ Are area health care facilities prepared for a surge?

Answers to these questions can serve as the basis of an evacuation plan.

Include Every Detail

Key components of the evacuation plan should include activation of a labor pool (a chain of command), establishment of internal holding areas, coordination of internal and external transportation, patient preparation on units, evacuation path of travel, determination of receiving sites, and internal and external patient tracking.

“The evacuation plan needs to involve a straightforward process. Everyone has to understand what’s going on,” said Mr. Aronson.

The plan should include every detail that will affect or be affected by the evacuation. For example, it is important to designate evacuation stairs and elevators. It’s also

necessary to predetermine holding areas. Mr. Aronson suggested color-coding these areas and designating a patient pick-up location for each area.

Everyone who will be involved in the evacuation should have a map with emergency stairwells and elevators, holding

See **LTC Emergencies** • page 5



Some facilities keep emergency “sleds” on hand to move residents down stairs and over other obstacles without the need for lifting. Training is critical.

ARC PRODUCTS LLC

CMS Announces New Hospice Regulations

BY KATHLEEN WILSON

The Centers for Medicare and Medicaid Services has published its final rule governing hospice services under Medicare, a massive overhaul of standards for patient rights, comprehensive assessment of patients, care planning, and relationships between hospice programs and nursing homes. The rule, Medicare and Medicaid Programs: Hospice Conditions of Participation, will take effect Dec. 2.

The regulations echo those of the OBRA '87, which governs nursing homes, said Daniel Swagerty, MD, CMD, a past president of AMDA, of the University of Kansas center on aging in Kansas City. “The performance-improvement projects and quality-assurance provisions of the new Conditions of Participation [mirror] the progress of the quality of care that has been required

in nursing facilities,” said Dr. Swagerty, who cochaired the AMDA working group that wrote the 2007 “White Paper on Palliative Care and Hospice in Long-Term Care.”

The new regulation is the first to set out a detailed list of rights for hospice patients. Specifically, patients deserve participation in their treatment plans, effective pain management and symptom control, and the right to choose their own attending physicians and to refuse treatment.

The final rule also prescribes the stages of each patient’s care as follows:

- ▶ **Initial assessment.** A registered nurse will, within 48 hours after the patient elects hospice care, assess physical, psychosocial, and emotional status related to the patient’s terminal illness and related conditions in order to provide immediate care.
- ▶ **Comprehensive assessment.**

The hospice must complete the comprehensive assessment within 5 days of the patient formally electing hospice. This process is to be based on the hospice’s policies and procedures as well as on the information gathered in the initial assessment.

▶ **Plan of Care.** A hospice interdisciplinary team, in collaboration with the patient’s attending physician, must develop an individualized plan of care in accord with the information gathered in the comprehensive assessment.

▶ **Update of the Comprehensive Assessment.** The hospice should update each patient’s comprehensive assessment no less frequently than every 15 days.

The rule also addresses the relationship between hospices and nursing facilities, requiring that they develop written agreements that specify how hospice services

will be provided in a facility and that ensure communication between providers.

Elements of the agreement include written documentation of the patient’s or a representative’s desire for hospice services, identification of the services that the hospice and the facility would provide, the manner in which the facility and the hospice would communicate to meet the needs of the patient, a statement that the hospice assumes responsibility for determining and changing the appropriate course and level

of care, and a provision that the hospice could use the facility’s nursing personnel, as permitted by law.

When the hospice rule was first proposed in 2005, AMDA asked CMS to strengthen the role of the nursing facility and its medical director in the relationship with a hospice and hospice medical director. “The nursing facility medical director or attending physician has the responsibility of oversight of the

See **Hospice Regulations** • page 5

Have a Thorough Plan

LTC Emergencies • from page 1

areas, and pickup locations marked. This map also should be posted throughout the facility prior to the evacuation.

Making assumptions about what people will know or do in the event of an evacuation can spell disaster, Mr. Aronson noted. "In every disaster, we see communication fail. Simple things like just-in-time training on radio use can make a difference," he said.

The evacuation plan should include a list of equipment requirements for each unit, department, or floor—such as portable oxygen, wheelchairs, and stretchers. Additionally, the facility should determine what standard equipment, tools, and other items should be accessible at each holding area and on buses or other evacuation vehicles. These include first-aid kits, various medications, flashlights, nonperishable food, and drinking water. "You need to have the ability to treat patients or staff if they get hurt during the evacuation," said Mr. Aronson.

Outlining evacuation priorities is a key part of the plan. Mr. Aronson suggested prioritizing according to issues such as ambulatory, nonambulatory with low to mid acuity, nonambulatory with high acuity, and nonambulatory with unstable high acuity. He also recommended considering behavioral health in prioritizing patients for evacuation.

It's Time ...

In preparing for an actual evacuation, Mr. Aronson said, "Decisions can be made easily if you have an incident command system/plan in place." He suggested having a very detailed incident-command tree. This should include all roles relevant to the evacuation, such as patient-bed checker.

Preparing patients for evacuation is as important and can be as challenging as actually evacuating them. Mr. Aronson suggested using a tracking form that includes detailed information about each patient, such as his or her name, significant diagnosis, holding area the patient is to go to, allergies, last temperature, breath sounds, code status, mental status, fall-risk status, and behavioral problems. This form should be completed in triplicate, with one copy staying with the patient, one kept by the evacuation team, and one sent to the new location.

Involved personnel should be designated into teams or groups. For example, a stairwell evacuation group would be responsible for receiving patients from the floor evacuation group and moving these patients via the stairs to the appropriate holding area.

Each group should have a designated leader. This individual needs to accept and understand this role and be

comfortable that he or she has the skills and knowledge to do this job. "Each group must have a trained leader to protect patient and staff safety," said Mr. Aronson.

Governments Focus on Evacuations

Since the devastation of Hurricane Katrina, federal and state governments are beginning to acknowledge health care facilities' need for guidance regarding evacuation. For example, in 2006, Sen. Herb Kohl (D-Wis.) held a hearing to address the needs of seniors in the case of a national emergency. At that time, he called on the Department of Homeland Security to implement specific plans and programs for all seniors facing emergency situations.

In April of this year, Sen. Kohl and Rep. John Dingell (D-Mich.) released a Government Accountability Office report on the status of the federal government's level of preparedness to evacuate vulnerable populations in the event of an emergency.

The report noted that the Department of Health and Human Services has only partially implemented earlier recommendations to determine a concrete plan to meet the needs of nursing home residents during a crisis. Specifically, the department has not addressed the federal government's role in the evacuation of nursing homes in its hurricane "playbook."

On the state level, the Louisiana Health Care Review established a work group after Katrina to develop recommendations for nursing home evacuations. Among the group's recommendations are the following:

- ▶ It is not necessary to wait for a mandatory evacuation. Leave as early as possible.
- ▶ Notify staff, medical director, and pharmacy once the decision has been made to evacuate.
- ▶ Alert your transportation early. Have buses and ambulances on standby.
- ▶ Make up emergency kits for each bus.
- ▶ Appoint a staff person to be the first on arrival to direct activities at the evacuation site.
- ▶ Designate some staff to stay to close the facility and be there to reopen it before the residents return.
- ▶ Notify families regarding the evacuation.
- ▶ Triage residents for the buses.
- ▶ Staff your buses by acuity of residents, with at least two staff per bus.
- ▶ If possible, place roommates, spouses, or siblings together.
- ▶ Complete a walk-through check, including all bathrooms, to ensure that no resident is left behind.

Evacuation Experience

AMDA member and Louisiana medical director Charles Cefalu, MD, MS, has experience with evacuations. "Thinking about the 'what ifs' in advance can help you

plan for a variety of situations and avoid surprises," he noted. For example, "you need to realize that the evacuation could take several hours. Your residents will get hungry or thirsty. They will have to go to the bathroom. And some will get agitated and upset. You need to be prepared for these eventualities and be able to make everyone as comfortable as possible."

Ideally, Dr. Cefalu observed, facilities should have a protocol recommending—whenever possible—that the evacuation decision be made 60 hours out. "Have a timing sequence that includes when buses will arrive, when support personnel will arrive, and when you will load supplies and residents," he said. Of course, he added, "you don't always have this luxury, so you also need to prepare for unplanned evacuations as well."

Facilities can't plan for every possible situation. However, Dr. Cefalu suggested that each one have a general plan that can quickly be customized to any situation at any time.

"Work with a safety or disaster planning committee that includes outside players such as emergency management, fire and rescue, and other professionals who have experiences and expert insights on evacuations," he offered. This group also can help facilities train staff and implement evacuation drills.

Medical Directors' Role

Dr. Cefalu stressed that the medical director should review the facility's evacuation plan and be well versed in evacuation procedures. He or she should also make sure that staff and families are educated about evacuation plans and procedures. "You have to give families the option to come transport their loved ones personally. In Louisiana, we discuss this on admission," he said.

The medical director also should make sure that evacuation planning is part of new-employee orientation and that staff with specific evacuation roles understand and are trained to handle their responsibilities. "Everyone should have a copy of the facility's evacuation plan," Dr. Cefalu said.

The work isn't finished just because the evacuation is completed, said Mr. Aronson. "Once each unit or floor is evacuated, you need to make sure everyone has been evacuated, account for all staff, direct staff to report to the labor pool, report evacuation status to the command center and holding area, and deliver patient destination forms to the command center," he said. "You have to tag each unit or floor in some way so you don't have to go back and recheck each room."

Senior contributing writer Joanne Kaldy is a freelance writer in Hagerstown, Md., and a communications consultant for AMDA and other organizations.

New Rule Is Hospice's OBRA '87

Hospice Regulations • from page 1

patient's plan of care contingent on the advice, counsel, and agreement of the hospice medical director," wrote AMDA.

While the CMS agreed that designated long-term care facility staff should actively participate in a patient's hospice interdisciplinary group, the new rule states that it's the hospice's responsibility to decide what care is provided, based on the information gathered during the patient assessments. But hospices are not permitted to delegate their responsibilities to the long-term care facility medical director and staff.

AMDA President Charles Crececius, MD, PhD, CMD, said the new regulations give hospices specific guidance on working in the long-term care environment. "While the nursing facility medical director cannot unilaterally mandate services," said Dr. Crececius, he or she should "en-

sure services rendered are appropriate and thorough, and discuss concerns with the hospice medical director."

William Smucker, MD, CMD, a hospice medical director in Westfield Center, Ohio, commented that, "LTC caregivers have the professional responsibility to contribute their unique knowledge and insights about patients and families to the creation of the hospice care plan."

He added that the new rule's requirements for quality improvement activities "provide an excellent opportunity for both hospices and LTC facilities to work together on initiatives that recognize the unique challenges of shared care for frail elders living in long-term care."

Other provisions of the new hospice rule include:

- ▶ A requirement that each patient receive a full drug assessment that examines issues

ranging from the effectiveness of current therapies to potential drug interactions and side effects. A treatment team must consult with a qualified individual, such as a pharmacist, to ensure that drugs meet the needs of every hospice patient.

▶ Permission for Medicare-certified hospices to contract with each other for nursing, medical social services, and counseling services under extraordinary or other nonroutine circumstances, including travel of a patient outside of a hospice's service area.

▶ Removal of the requirement that an inpatient facility providing only respite care have a registered nurse on duty 24 hours a day. The patient's needs, acuity, and plan of care will drive the nursing and staffing requirements.

▶ A requirement that hospices have an infection control policy and procedure.

▶ Implementation of a mandatory quality assessment—performance improvement program in each hospice to continually boost responsiveness to the needs, desires,

and satisfaction levels of patients and their families. Physicians are expected to be involved in the assessment and improvement process but are not required to direct it.

Judi Lund Person, MPH, a regulatory affairs specialist with the National Hospice and Palliative Care Organization, said her organization is pleased with the rule's clarification of the hospice-nursing home relationship.

She added that even more specifics should come in another rule now in the works. "It is CMS' intention to issue a companion rule for nursing homes, so that both hospices and nursing homes would have complementary rules for the relationship," said Ms. Lund Person.

The final regulations issued so far can be viewed in the Federal Register on CMS' Web site (www.cms.hhs.gov/CFCsandcops/05_hospice.asp).

Kathleen Wilson, PhD, is director of government affairs for AMDA.