AHCA Analysis of OIG Report –

Despite media stories that have focused attention on “woefully unprepared” facilities, yesterday’s report from the HHS Office of the Inspector General (OIG), Gaps Continue To Exist in Nursing Home Emergency Preparedness and Response During Disasters: 2007-2010 Report (OEI-06-09-00270), actually focuses more on CMS checklists, survey and ombudsmen’s role in the wake of a disaster.

This report began as a follow up to the August 2006 OIG report, Nursing Home Emergency Preparedness & Response During Recent Hurricanes (OEI-06-06-00020), which found “emergency plans lacked many provisions recommended by experts.” As a result of the 2006 report, CMS developed guidance in the form of checklists that the agency expects facilities, long term care ombudsman programs and State survey agencies to use.

The 2012 OIG report is based on the following:

- Site visits to 24 nursing homes selected by the OIG for the report;
- Interviews with facility administrators and staff, local emergency managers, State ombudsman program and State survey agency representatives; and
- A comparison of each of the 24 facilities’ emergency plans against CMS’ checklist for facilities.

The 24 nursing facilities mentioned, but not specifically identified in the report, were selected by the OIG from among “at least 210 nursing homes in 7 states” substantially affected by specific incidents of flooding, hurricanes and wildfires between 2007 and 2010. A footnote in the report explains how the OIG narrowed its study to include only a handful of disasters: flooding of the Red River in March 2009 and along the Mississippi & Cumberland Rivers in May 2010; Hurricanes Gustav & Ike in September 2008 and Hurricane Earl in September 2010; and California wildfires near San Diego in October 2007 and close to Santa Barbara in May 2009. Including only a handful of disasters helps to explain how the OIG considers such a small sample of nursing facilities as representative of the nation’s nearly 16,000 facilities nationwide. The 24 facilities in California, Louisiana, Minnesota, North Carolina, North Dakota, Tennessee and Texas represent closer to 10% of the 210 facilities affected by the disasters the OIG chose to include in its study as opposed to representing less than 1% of the 3,600 facilities located in those 7 states.

The OIG found that most facilities met the federal requirements for emergency plans (92%) and staff training (72%) – down from 94% and 80% respectively as noted in the 2006 report. Gaps in preparedness such as “unreliable transportation contracts” and “lack of collaboration with local emergency management” remain challenges for facilities. The report also sites ombudsmen who “were often unable to support nursing home residents during disasters,” saying that most ombudsmen had no contact with residents until after a disaster. The OIG also points out that State survey agencies made “some efforts to assist nursing homes during disasters,” primarily around compliance issues.

Key concerns in the OIG report include:

- Staffing – Specifically, facilities need to plan for staffing shortages that can occur during an emergency
- Resident Care – Facility plans reviewed by the OIG lacked detail regarding how to care for residents during an emergency, especially residents who require ventilators or feeding tubes.
• Resident ID & Tracking – Facilities must be able to identify (e.g., using wrist bands) and track residents who transfer to other facilities/locations during an emergency. Such systems must include a plan for transporting individual’s medical records and/or protocols regarding prescription medications.

• Shelter in Place – The OIG faults each of the 24 facilities for not having what it calls a “standard” 7-day supply of water. According to experts on AHCA’s Disaster Planning Committee, a 3-day supply of water is considered “standard.”

• Communication – Facilities in the report had no plans for communicating with local ombudsman.

Other issues raised by the OIG include facilities’ failure to participate in evacuation or emergency drills and operational issues such as problems with cell phone connections or other communication malfunctions.

OIG Recommendations

CMS agreed with the three OIG recommendations that federal regulations be revised “to include specific requirements for emergency plans and training, update the State Operations Manual to provide detailed guidance for State Survey agencies on nursing home compliance with emergency plans and training, and promote use of the checklists.”

The OIG also recommended that the Administration on Aging (AOA) develop model policies and procedures that long term care ombudsmen could use to protect residents both during and after disasters.

With OIG recommendations centered on making facility plans and training a federal requirement and survey guidance more specific and detailed, facilities should reconsider whether or not emergency plans and training documentation is sufficient.

Learn more by reading the OIG memorandum report (OEI-06-09-00271), which outlines how CMS can revise its checklist for health care facilities.

AHCA’s take away from this report?

• Facilities should review CMS’ Emergency Preparedness checklist and use it to cross-check facility disaster preparedness plans and training.

• AHCA is working closely with HHS on emergency planning and preparedness issues. In fact, our Disaster Planning Committee has met with HHS and ASPR, and several of the Committee members are now involved in state and regional health coalitions operating with direction from ASPR. AHCA State Affiliates are encouraged to get involved with regional health coalitions.

Questions about the OIG report may be directed to staff liaison to AHCA’s Disaster Planning Committee, Peggy Connorton (202.898.2833, pconnorton@ahca.org).