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Nursing Home Readiness for a Flu Pandemic

NATION'S PROGRESS IN DISASTER MEDICINE AND PUBLIC HEALTH PREPAREDNESS

A major disaster scenario in the United States would likely overwhelm acute care hospitals. Nursing homes presented one alternative location for providing care. In the case of pandemic influenza outbreak, are these care facilities prepared to handle an overflow of patients. You are listening to ReachMD XM-157, the channel for medical professionals.

Welcome to a special segment focused on disaster medicine.

HOST: Dr. Mark Nolan Hill, Professor of Surgery and practicing General Surgeon.

GUESTS: Dr. Phillip Smith, Professor and chief of Infectious Disease at the University of Nebraska School of Medicine and Dr. Lona Mody, Assistant Professor of Internal Medicine in the Division of Geriatric Medicine at the University of Michigan School of Medicine. Dr. Smith and Dr. Mody are coauthors of a publication in JAMA on preparedness for pandemic influenza in nursing homes.

Dr. MARK NOLAN HILL:

Welcome Dr. Smith and Dr. Mody.

Dr. PHILLIP SMITH:

Thank you.

Dr. LONA MODY:

Thank you for having us.

Dr. MARK NOLAN HILL:

We are discussing nursing home preparedness for pandemic influenza. Doctors, looking at nursing homes across the country is there one person, who is typically in charge of this preparedness and who is that person?

Dr. PHILLIP SMITH:

We have said in our survey and we were very pleased to find out that over three-quarters of the nursing homes had a designated person in charge of pandemic influenza planning, a variety of persons had this role most commonly the infection control practitioner. Other people who occasionally in charge with the directors of nursing or safety coordinators or nursing administrators.

Dr. MARK NOLAN HILL:

Are there specific responsibilities of that leader and even qualifications that are necessary of that leader on this preparedness?

Dr. PHILLIP SMITH:

Well this is a fairly new role, so there are no national standards or certification or qualifications, but in general it seemed to be somebody, who is interested in planning and interested in infectious disease and had a knowledge of hospital policies, so that seemed to be a fairly logic fit with the infection control professional at the facilities.

Dr. MARK NOLAN HILL:

I am sure a lot of our listeners are thinking are the nursing homes obliged to care for the population of larger prioritized with care for their residents in these types of situations?

Dr. LONA MODY:

Yeah, I mean nursing homes are obligated to take care of their own, which is their own nursing home population. However, nursing homes can serve as a backup for other facilities such as acute care hospitals if there is a need for them to step up.

Dr. MARK NOLAN HILL:

Are they required to do so?

Dr. PHILLIP SMITH:

This may actually pose a conflict between moral duties if we avail a long-term care facility. Their primary duty is to the residents that they are taking care of and they have an elderly vulnerable group that would be hard hit by an influenza outbreak. On the other hand, they have at least an indirect obligation to society, so perhaps if they had empty beds they could take some extra patients or extra influenza patients, but that might pose some risk for their own patients. To my knowledge I do not have an obligation to take overflow hospital patients or surge patients during an outbreak, but a number of them have said that they would be potentially interested in doing that.

Dr. MARK NOLAN HILL:

And how would you guide these nursing homes in terms of taking the right posture?

Dr. PHILLIP SMITH:

Oh that is a good question. I do not think that there is a national guide right now. Each nursing home has to look at the risks and benefits and make their own decision. The study that Dr. Mody and I did demonstrated that even if nursing homes wanted to take overflow hospital patients that they had a number of logistic problems. First of all, they were almost 90% full, so there are very few beds available. Secondly, issues like staffing that would pose a significant problem and thirdly they have to deal with a possible risk of introducing influenza into their population. They very strongly expressed a desire not to send out residents, who were living in the nursing home in order to open up beds. In a hospital setting during an outbreak, they are working on protocols, so that if there are people in the hospital that may be or about ready to go home, who are not as sick, the hospital can discharge them a couple of days early and that would not

be a burden for that person. In the nursing home, the patient lives there. It is their home. That is where their possessions are and you cannot send them home because first of all they may have no place to go. I will be interested in Dr. Mody's take on that as well.

Dr. MARK NOLAN HILL:

Please, please.

Dr. LONA MODY:

Yeah, I think that for majority of nursing home residents that is their home. There will be a proportion of what we call as subacute care residents or subacute care beds that a nursing home might have where they can have a flexibility of accepting the patients from a hospital setting or discharging those patients a little bit early if there was a planning. In addition, I do believe that in this end age where the patients are transferred from the community to acute care hospital to skilled nursing care facility, no single entity can operate as a <_____>. I think that collaboration will have to occur and communication lines between these various stake holders will have to be there in order to better prepare our society in general for pandemic preparedness. One likely scenario can be say that a city has seen some activity of pandemic flu and there are couple of patients for example admitted on the seventh floor of an acute care hospital and then nursing home affiliated with that hospital is accepting patients from that hospital gets the patient from sixth floor, but was that patient exposed, not exposed, I think that both nursing homes and hospitals have to work together to identify the suspect cases.

Dr. MARK NOLAN HILL:

Doctors how does the size of the nursing home and the typical occupancy rate affect the planning or ability to contribute in this type of disaster.

Dr. LONA MODY:

There are different types of nursing homes. For example, in an harbor area and local nearby facilities we have certain smaller places such as some 40 to 50 bed nursing homes that have a very, very stable population. They take care of older adults, who are slightly functionally impaired and would not like to stay by themselves at home, but in general are healthy and do not go back and forth to the hospital. To them this facility is their home. Such facilities do not accept subacute care patients, so their population has less indwelling device usage, less antibiotic usage, less acuity of care and on the other hand we have other nursing homes that are 150 to 200 bed nursing homes. There three-quarters of their beds are devoted to subacute care patients, which means that they accept a lot of patients on a daily basis from a hospital, who are for example post hip replacement or require an extended duration of IV antibiotic for say subacute bacterial endocarditis and so on and so forth.

Dr. MARK NOLAN HILL:

Is there a threshold number of days where the facility would need to be self sufficient?

Dr. PHILLIP SMITH:

No that varies a great deal. The joint commission recommends 4 days or 96 hours just as a rough guideline. One of the things that surprised me from our survey was this about half the nursing homes we surveyed were stocked piling something, which I thought was a fairly sophisticated thing to be doing because even some hospitals have not gotten that far yet, but in view of the fact that they are going to be shortages and the suppliers will be short of supplies that they can pass on, I think it is very prudent for nursing homes to stock pile, hand washing supplies, gloves, masks, and so forth. About half of them were stock piling, a variety of different items, even 18% of them were stocked piling food, and Dr. Mody in Michigan asked about antivirals and found that about 18% were stocked piling that. So, I thought there was a sign that they were taking seriously the possibility that they may have shortages during a pandemic.

Dr. MARK NOLAN HILL:

Are they all financially able to do that?

Dr. PHILLIP SMITH:

No, I think it is fair to say that they are stretched. There are much less resources and preparedness for nursing homes and hospitals, there is a so called unfunded mandate and no one is giving them money to buy supplies or giving the money to hire a staff developer, who can develop a pandemic plan, so this is an expense that they are bearing on their own, but I think it is widely recognized that the pandemic will occur and they need to prepare even if it is at their own expense.

Dr. MARK NOLAN HILL:

Let us talk about communication lines with local hospitals, state and public health officials, even families of the patients. How is this sorted out?

Dr. LONA MODY:

We in our survey asked that question. The results were in general mixed. About 45% of them said that they had established some communication with nearby hospitals and about 53% said that they had established some communication with state and local public health officials. In general though, and in Michigan at least, the regional planning has not brought nursing home planners on the table, so certainly more needs to be done in terms of making the communication more open and actually happenings, and I am sure there is case in Nebraska also, although Dr. Smith can add to it.

Dr. MARK NOLAN HILL:

Please sir.

Dr. PHILLIP SMITH:

Yes, that is very much the case. So, I think that overall about half of the facilities had contacted nearby hospitals and public health districts, I think it is essential that they do that.

1. An epidemic affects everyone and there will be patients transferred back and forth and notifying each other there is a potential for helping each other by exchanging supplies, exchanging information, perhaps exchanging staff, and one of the things we found in our survey that was a little disappointing was that so few facilities had exercised their plan, so they might develop a very nice influenza plan and put it on the shelf, and we think that they need to be running in a practice drills so called tabletops, and that the one way to help communication is that you invite the local hospitals and the local public health department to come to your facility when you are doing a tabletop and role play and then you know how to contact each other more readily and what resources are available in the presence of an epidemic.

Dr. MARK NOLAN HILL:

This final question is for both of you please. If you would each look into your respective crystal ball, what you see down the road 5, 10, 15 years from now with respect to this problem?

Dr. PHILLIP SMITH:

I guess, I would see there is a lot of momentum that has been gained in the last several years and I think if you look into your crystal ball even 2 or 3 years from now, I think that the disaster planning or pandemic influenza planning will be something that every nursing home will do, in fact, will be regulatorily required, I am guessing and that since this required hospitals and nursing homes and public health, a premium will be put on collaboration and communication and that you can see much more in the way of information sharing and joint tabletop exercises.

Dr. MARK NOLAN HILL:

And Dr. Mody?

Dr. LONA MODY:

And I would take it further in saying that the planning and the resources that have gone into pandemic preparedness will help these facilities better respond to other major disasters, both natural and man made.

Dr. MARK NOLAN HILL:

I want to thank our guests, Dr. Phillip Smith and Dr. Lona Mody. We have been discussing nursing home preparedness for pandemic influenza.