Volunteer Disaster Medical Assistance Teams Need You

BY MARY ELLEN SCHNEIDER
New York Bureau

DALLAS — Last year's Gulf Coast hurricanes and their devastating aftermath left many physicians wondering how they could help in future disasters, Dr. Joseph A. Scott, director of the division of prehospital and emergency health care at the University of Miami, said at the annual meeting of the National Medical Association.

There are a number of federal disaster response teams for which physicians can volunteer, Dr. Scott said.

The National Disaster Medical System (NDMS) is a public-private partnership, based primarily in the Department of Homeland Security, which coordinates teams of medical providers to respond to storms, floods, airplane crashes, and even large-scale events like the Olympics or presidential inaugurations. The NDMS was set up to supplement state and local medical resources.

The disaster medical assistance teams (DMATs) make up one component of the NDMS. DMATs are 35-person teams that can be on the ground at a disaster anywhere around the country within 24 hours. A DMAT typically comprises physicians, nurses, paramedics, emergency medical technicians, pharmacists, respiratory therapists, psychologists, and social workers.

All team members are cross-trained in medical, logistical, communications, and administrative aspects of the response, said Dr. Scott, who serves as medical officer for a DMAT based in south Florida.

These teams handle a variety of medical situations—from triage to primary medical care to trauma—once they are on the ground, he said.

The DMAT usually rolls out the door with a cache of medications provided by the federal government. The medications include drugs for treatment as well as for dispensing purposes, because most pharmacies will be shut down in a disaster, Dr. Scott said. The NDMS also supplies the equipment, but Dr. Scott said his group also accepts donated equipment to supplement that stock.

Emergency medicine training is ideal for these types of teams, he said. Experience with urgent care, trauma, and pediatrics is especially important for disaster deployments.

The usual deployment period for members of a DMAT is about 1-2 weeks, which includes predisaster staging. Physicians in the past were required to commit to a 2-week deployment, but that has been changing to 1 week for physicians only, he said.

Volunteering to be part of an organized response team can forestall many of the problems that can occur at a disaster site when individual, well-meaning volunteers flood the scene. An overabundance of volunteers can divert resources, Dr. Scott said. And unsolicited volunteers often lack appropriate training, equipment, and supplies. They may also be outside the formal accountability system and may lack proper credentials, he said.

A big fear when volunteers—especially physicians—show up without formal coordination is that no one will be at home to take care of the regular emergencies, he said.

Physicians who can't volunteer for a DMAT can still help in a disaster by staying home, Dr. Scott said. Not everyone has the flexibility—either at home or at work—to volunteer for a 1- to 2-week deployment. But physicians can make a difference by volunteering to cover shifts for a colleague who is a member of a response team.

There are also increasing opportunities for physicians to volunteer for similar teams at the state level. Physicians can check with their state emergency management offices to find out if their state has a team, he said.

Other federal teams that need physician volunteers include:

► **National medical response teams.** These are 50-member teams that deploy less often than DMATs. They are generally tasked to respond to nuclear, biologic, and chemical incidents.

► **Disaster mortuary operational response teams.** These teams include pathologists, forensic pathologists, fingerprint experts, and dental assistants who help to identify victims' remains in a disaster. There are about 9-10 such teams in the country.

► **International medical/surgical response teams.** These teams generally take care of American civilians overseas, Dr. Scott said. They are similar to DMATs, but generally deploy with a trauma surgeon and anesthesiologist; they can perform surgery in the field.

► **Urban search and rescue teams.** These teams specialize in on-site medical treatment for victims trapped in confined spaces, such as those resulting from structural collapses. The physicians on these teams frequently care for both victims and responders, he said.

Physicians who are deployed as part of a federal team become federal employees during deployment and do collect a small paycheck, Dr. Scott said. In addition, physicians get other protections during their deployment, including federal liability protection.

But there are some disadvantages, Dr. Scott said. The initial credentialing process can take 6 months or more.

Overall, the experience can be very rewarding, Dr. Scott said. It's an opportunity to provide good care to appreciative patients with minimal paperwork. "You're actually really practicing emergency medicine the way most us went to medical school to do it," he said. ■

To learn more about volunteering for a federal medical response team, visit www.ndms.fema.gov or contact Jack Beall at the Federal Emergency Management Agency at jack.beall@dhs.gov.

POLICY & PRACTICE

Role of International Medical Grads

Family physicians who are international medical graduates provide an important access point for Medicare and Medicaid patients, according to a study published in the online journal Human Resources for Health. The study compared practice patterns between family physicians who are international medical graduates (IMGs) and those graduated from U.S. medical schools. More IMGs accepted all new Medicare and Medicaid patients, compared with their U.S.-trained counterparts, according to the study. About 67% of IMGs reported accepting all new Medicare patients, compared with 60% of U.S. medical graduates. Forty-nine percent of IMGs said they accepted all new Medicaid patients, compared with 40% among U.S. medical graduates. The researchers also found that IMGs earned a greater percentage of their revenue from these federal health programs than did U.S. medical graduates working in family medicine. The analysis is based on 1996-1997 data from a nationally representative survey of physicians. The survey included 2,726 family physicians, of whom 2,360 graduated from U.S. medical schools and 366 graduated from international medical schools.

DEA Reverses Pain Rx Restrictions

A new proposal from the U.S. Drug Enforcement Administration would allow physicians to issue up to a 90-day supply of schedule II controlled substances in a single visit. The notice of proposed rule making, which was issued in September, is open for public comment until Nov. 6. If finalized, the proposal would reverse the agency's previous position that physicians must write new prescriptions each month. Instead, physicians would be able to issue three monthly prescriptions at once, specifying the fill date for each prescription. The agency also issued a policy statement aimed at answering physician questions about dispensing pain medications. "Today's policy statement reaffirms that DEA wants doctors to treat pain as is appropriate under accepted medical community standards," DEA Administrator Karen P. Tandy said in a statement. "Physicians acting in accordance with accepted medical practice should be confident that they will not be criminally charged for prescribing all appropriate pain medications." The American Academy of Pain Medicine (AAPM) praised the proposal, noting in a statement that it could help eliminate the burden on cancer patients and others with chronic pain who have been forced to visit their physician every month for a new prescription.

Medicare Risk Reduction Demo

Officials at the Centers for Medicare and Medicaid Services are seeking proposals for a new demonstration project that will test the effectiveness of health promotion programs in the Medicare population. The Medicare Senior Risk Reduction Demonstration will target multiple risk factors for chronic diseases including physical inactivity, obesity, smoking, depression, high blood pressure, high cholesterol, and high blood sugar. Officials will also look at underuse of Medicare preventive benefits. CMS officials plan to select up to five organizations to participate in a 3-year demonstration project; participants will be announced next spring. Officials plan to invite about 85,000 Medicare fee-for-service beneficiaries to take part. Beneficiaries will complete a risk assessment, receive information on their specific health risk factors, and receive referrals to community resources that can help them to make lifestyle changes. "This demonstration can support doctors and other health professionals by providing support in their efforts to help seniors make important changes, such as starting an exercise program and using recommended preventive care," the agency said in a statement.

Fueling the Rise in Medicare Costs

The rapid growth in spending for Medicare beneficiaries is largely because of the increasing portion of those beneficiaries receiving treatment for five or more conditions in a year, according to a study published in an online edition of Health Affairs. Between 1987 and 2002, the number of beneficiaries who sought care for five or more conditions rose from about 9 million to 19.8 million. In 2002, beneficiaries with five or more conditions accounted for more than 75% of health spending, according to the study. And Medicare beneficiaries with three or more conditions accounted for 92.9% of health care spending in 2002. "One of the biggest challenges we face is that the Medicare system makes it very difficult for physicians to effectively treat people with multiple chronic illnesses," Kenneth E. Thorpe, the study's lead author and chair of the department of health policy management at Emory University, Atlanta, said in a statement. "Medicare's fee-for-service structure does not reimburse for services critical to medically managing chronic illness—preventative measures, monitoring medication intake and blood sugar." The researchers received support from the Pharmaceutical Research and Manufacturers of America.

Access to Mammography

The national capacity to provide mammography services is adequate, despite a 6% drop in the number of mammography facilities from 2001 to 2004, according to a recent report from the U.S. Government Accountability Office. In addition to the decrease in the number of facilities, the GAO reported a 4% drop in the number of machines, a 3% drop in the number of radiologic technologists, and a 5% drop in the number of physicians who interpret mammograms. Experts interviewed by the GAO said that the capacity nationwide is likely adequate to meet the current demand for screening and diagnostic mammograms but cautioned that there could be access problems in the future. The report was requested by Sen. Arlen Specter (R-Pa.) and Sen. Barbara Mikulski (D-Md.).

—From staff reports