

**Testimony
of the
American Hospital Association
before the
Committee on Health, Education, Labor, and Pensions
of the
U.S. Senate**

"Enhancing Public Health and Medical Preparedness: Reauthorization of Public Health Security and Bioterrorism Preparedness and Response Act"

March 16, 2006

Good morning, Mr. Chairman. I am Dan Hanfling, M.D., a board certified emergency physician practicing in the Department of Emergency Medicine at Inova Health System (Inova) in Falls Church, Va. On behalf of the American Hospital Association's 4,800 hospitals, health systems and other health care organization members, and our 33,000 individual members, we appreciate this opportunity to present our views on medical preparedness as you consider reauthorization of the *Public Health Security and Bioterrorism Preparedness and Response Act of 2002*.

I am Director of Emergency Management and Disaster Medicine at Inova, a six-hospital health system with over 1,500 licensed beds in suburban Northern Virginia. In addition, I currently serve as State Medical Director for PHI AIR Medical Group – Virginia, the largest private rotor-wing air medevac service in the states, and as a Medical Team Manager for Virginia Task Force One, a FEMA- and USAID-sanctioned international urban search and rescue team. I have extensive experience in the delivery of out-of-hospital emergency medical care, including disaster scene response, most notably at the Pentagon on September 11, 2001 and the recent responses to Hurricanes Katrina and Rita. I was also intricately involved in the response to the anthrax bioterror mailings in the fall of 2001, when two cases of inhalational anthrax were successfully diagnosed at Inova Fairfax Hospital.

Hospitals have long had emergency management plans in place that have been carefully developed and tested. These plans are multi-purpose and flexible in nature because, as we have recently witnessed, the number of potential disaster scenarios is large. As a result, hospitals maintain "all-hazards" plans that provide the framework for managing the consequences of a range of events, including natural and man-made disasters. The



funding provided to hospitals through the National Bioterrorism Hospital Preparedness Program (NBHPP), a program authorized by *the Public Health Security and Bioterrorism Preparedness and Response Act of 2002*, has been a good first step toward increasing the readiness of the nation's hospitals and their communities and developing improved strategies for dealing with all kinds of threats facing our communities. At the time preliminary estimates suggested that hospitals would require approximately \$11 billion to obtain a basic level of "all hazard preparedness." To date, Congress has appropriated approximately \$2.1 billion over five years for the program. The amount that hospitals have actually received is significantly less due to dollars taken off the top for the federal government's administration of the program and overhead allotments that the state grantees have retained. As you will hear, we have become smarter with time and experience, but we still have a long way to go before we can say we are fully prepared to handle disasters that will surely occur in the future.

Defining Surge Capacity

The public looks to hospitals to play a critical role in the event of a disaster. As such, hospitals must be able to accommodate the surge in demand for care in order to screen, stabilize and provide definitive care for affected persons. Traditional disaster planning has largely concentrated on "fixed occurrence" events, such as those created by transportation accidents or the terrorist attacks of September 11, 2001, in which there are a finite, and usually relatively small, number of victims requiring hospitalization. However, the swiftly changing and sophisticated nature of terrorism, the growing threat of natural disasters such as Hurricanes Katrina and Rita, and emerging infectious diseases such as "avian flu," require that hospitals update their emergency management plans. Hospitals must be able to effectively extend their ability to deliver uninterrupted medical care in the face of a prolonged event involving large numbers of victims, such as an attack utilizing chemical, biological or radiological (CBR) weapons or a pandemic disease.

Because of the dual nature of disasters – fixed versus prolonged events – hospitals and their communities must plan to create surge capacity for each of these two distinct types of events. Hospitals can increase their patient care capacity in relatively short periods of time by "surging in place." This involves rapidly discharging existing patients, cancelling scheduled procedures, and taking steps to increase the number of patient care staff in the facility in order to make additional staffed hospital beds available for incoming disaster event patients. In addition, "surge in place" includes the creative reconfiguration of available space by a health care facility for use in the initial management of disaster victims. Many hospitals, in addition to creating inpatient availability, have plans to extend emergency department capability by using lobby and waiting room areas, as well as other patient care areas typically reserved for specialty patients undergoing gastroenterology, pulmonary and cardiac procedures, to accommodate additional patients.

Examples of the creation of internal surge capacity abound from the experiences of the health care systems most impacted by the attacks in New York City and Northern

Virginia on September 11, 2001. Upon learning of the events that transpired at the Pentagon that day, Inova, which has facilities within mere miles of the Pentagon, implemented its facility emergency management plan. Patients already designated to go home sometime that day and those deemed stable enough for continued management of their medical conditions at home were discharged as quickly as safely possible. Elective surgeries were cancelled, and all ongoing surgical cases were completed. As a result, an additional 343 hospital beds (out of approximately 1500 beds across the health system) and 43 operating rooms were made available within three hours of the attack on the Pentagon.

While this type of strategy can provide for a temporary ability to increase patient care capacity, most hospitals cannot sustain such a surge for extended periods of time. Individual facilities would quickly become overwhelmed if the disaster involved large numbers of victims presenting over a prolonged period of time.

Prolonged disasters involving large numbers of victims that overwhelm the health care system in a community, such as would be seen in pandemic influenza, would require the development of “community surge capacity,” involving the development of alternative care facilities. This type of community surge capacity is complicated and costly to achieve and involves advance planning for logistical support, the development of protocols, and the determination of specific mission goals. Communities must plan for this contingency using the advanced designation of facilities that can be used to accommodate patients, perhaps under more austere circumstances than would be faced in everyday medical care.

A Demonstrated Need

Like the attacks of September 11, 2001, a number of recent man-made and natural disasters have also demonstrated the necessity of hospital surge capacity. The evacuation of hospitals and nursing homes in Louisiana and Mississippi due to Hurricanes Katrina and Rita, and the illnesses and injuries resulting from the hurricanes, required that thousands of acutely ill and fragile patients be admitted to hospitals in surrounding communities and states. Here in the Washington area, the delivery of anthrax spores to the Hart Senate Office Building in 2001 caused a surge in demand for care at Inova. The emergency department of Inova Fairfax Hospital diagnosed two confirmed inhalational anthrax cases and screened over 1,127 patients with influenza-like symptoms or concerns of “anthrax exposure” over a two-week period of time.

Key Assumptions Validated

Review of these, and other recent disaster events that generated definable surges in demand for care, validates a number of important assumptions regarding the development of acute care surge capacity. First and foremost, the rate limiting step in mounting any coordinated response to a surge in demand for care will be the sustained availability of medical and nursing staff. Whether the disaster results from the use of weapons of mass exposure (WME) – including biological, chemical or radiological attacks – a contagious,

infectious disease, or the widespread disruption in civil order, it must be assumed that staffing will be a problem. With the use of WME in particular, workforce attitudinal survey suggest that one-quarter to one-third of workforce may be deliberately absent for some period of time. The experience of several hospitals, including the Ochsner Clinic in New Orleans, during and after Katrina give further credence to the importance of adequate planning for workforce reductions in a prolonged event. Infectious disease outbreaks would also reduce the workforce if caregivers or their family members succumb to the very illnesses they treat.

It is also important to note that in planning for surge demand for care due to a disaster, decision-makers must also consider the ongoing need to continue to deliver basic health care services. Hospital services will be required to maintain routine delivery of emergency care, such as delivering babies, dealing with traumatic injuries and sudden acute illness. In fact, some researchers have noted that certain conditions, particularly those related to cardiovascular events, may even increase in times of great stress related to disaster.

In addition, last year's response to Hurricanes Katrina and Rita emphasize the key assumption that the initial forward movement of patients is not likely to occur, and that federal resources could be unavailable for up to three days following the onset of any disaster event. A surge in demand for care is going to have to be handled locally, with locally available resources.

Lack of Funding Hinder Readiness

Emergency readiness requires a significant investment in staff and resources. But the ability to meet these investment challenges is compromised by the significant financial pressures facing hospitals. Today, a third of hospitals lose money on operations – with Medicare and Medicaid under-funding being a key driver. On top of under-funding by government payors, hospitals face other financial pressures: labor costs continue to rise as hospitals increase wages to attract scarce workers; the number of uninsured patients also continues to grow, contributing to greater levels of uncompensated care; and hospitals face skyrocketing costs for medical liability insurance, pharmaceuticals and medical supplies.

A hospital's ability to deliver optimal medical care in the setting of any disaster event, regardless of its cause, is in large part contingent upon an immediately available supply of key medical equipment, supplies and pharmaceuticals, as well as adequate staffing. However, due to financial pressures, hospitals have adopted just-in-time supply chains for their equipment and supplies. As a result, in a disaster hospitals would face an almost immediate shortage of critical supplies such as ventilators, personal protective equipment for staff, drugs and other supplies. In addition, most hospitals routinely operate at or near full capacity and have only limited ability to rapidly increase their workforce.

The NBHPP, administered through HRSA, and the Department of Homeland Security's (DHS) Urban Area Security Initiative (UASI) grant program have helped to fund initial

purchases of some basic medical supplies and equipment, as well as some health care worker training. However, these programs have not provided the level of funding required to establish adequate “all-hazards” acute care surge capacity. As a result of the relative paucity of funding, only piecemeal solutions have been developed to address the problem of developing surge capacity. The amount of available funding for supplies and equipment has not been adequate to support the purchase and use of items of significant cost, such as ventilators, intravenous pumps, or cardiac monitoring equipment. For example, *The New York Times* recently reported that the national supply of ventilators, which would be critical for caring for patients in a pandemic influenza outbreak, falls far short of their estimated need, even considering the numbers that are being stockpiled by the federal government. In addition, the rate limiting step in surge capacity planning, namely the ability to recruit, retain and deploy staff to the bedside during any given crisis, has not been fully and comprehensively addressed, despite some progress in the development of systems to identify and register in advance health professionals willing to volunteer for service in a disaster.

As a result, the ability to provide acute and extended health care delivery in the setting of a surge in demand remains significantly limited. Furthermore, planning and funding for medical surge capacity remain far behind the other elements of the nation’s tactical response to creating a secure homeland. And given the very real concerns regarding an impending influenza pandemic, communities must focus on priorities for building such capacity that goes beyond the purchasing of beds, a metric which is too simplistic, and of little use, in creating the sort of capacity that is truly needed.

The federal government must help protect the nation by providing greater resources to hospitals to meet the challenges of emergency readiness and ensuring that those resources are made available in a timely manner. In addition, given what Americans need from our nation’s hospitals, today is a time for investment, not cutbacks.

Key Principles to Consider Moving Forward

As Congress prepares to reauthorize the NBHPP, I would like to share with you eight key principles the AHA has developed after carefully analyzing the program’s successes and shortcomings since its inception in 2002. We hope that you will take these principles, along with the information I have just shared with you on the challenges of creating adequate surge capacity, to heart during the reauthorization process.

Ensuring Program Sustainability

First, the AHA supports reauthorizing the program for a full five, or more, years. We urge Congress to continue to include “such sums as may be necessary” for ensuring consideration of needs during the appropriations process. Disaster readiness is an investment that is well worth its cost. However, hospitals simply do not have the extra funds to pay for what is needed to ensure their readiness to respond. As noted previously, hospitals’ ability to adequately respond in a disaster will depend in large part on the availability of key medical equipment, supplies and pharmaceuticals, as well as optimum

staffing levels. Simply put, to adequately meet the most basic needs of our communities in the event of a disaster, more money is needed.

Funding Acute Care Hospitals

Many in the field believe that too large a proportion of the hospital readiness funds have been funneled to non-hospital providers. Given the challenges hospitals face in responding to the threats such as pandemic influenza and catastrophic natural disasters and the significant gaps remaining in hospital preparedness for these threats, program funding should be primarily directed to acute care hospitals.

Improving Coordination between all Federal Preparedness Programs

Over the last several years, various federal departments and agencies, including HRSA, the Centers for Diseases Control and Prevention (CDC) and DHS, have administered funding to enhance health care, public health and first responder preparedness. These streams of funding have often worked at cross-purposes, including inconsistent requirements and redundant purchases. The law must ensure that federal agencies plan in a coordinated way to enhance national preparedness and avoid confusion and waste.

Broadening State and Metropolitan Hospital Associations' Roles

State health department should continue to be the “grantees of record” for preparedness funds. However, the AHA strongly recommends that state and metropolitan hospital associations be given a more substantial role in disbursing funds to the proper recipients. While many of these hospital associations have had some level of involvement with their state departments of health with regards to this program, we are concerned that states have not often permitted their hospital associations to have real input into decision-making. Therefore, we recommend that each state’s grantee agencies be required to work with the state hospital association (or metropolitan hospital associations for city-specific funding) to develop the state’s preparedness plan and to determine how funds will be disbursed.

Greater Flexibility in Approved Use of Funds

Under the current legislation, hospitals have been subject to myriad federal and state requirements in order to receive preparedness funding. The AHA recommends minimizing the number of federal/state requirements imposed on hospitals as a condition of funding to reduce the potential for unfunded mandates. As stated previously, ensuring adequate supplies, equipment and staff in the event of a disaster is very costly. Placing additional unfunded mandates on hospitals in the form of numerous federal and state requirements further stretches hospitals’ already scarce resources, limiting their capacity to not only respond in the event of an emergency, but to deliver the care their communities need every day.

We also recommend expanding the “allowed uses” of NBHPP preparedness funds in appropriate areas. For instance, funds should be allowed to be used for making facility/security enhancements (i.e., allow construction for enhancing ventilation systems, window enhancements, etc.). These upgrades are a vital part of ensuring hospitals’ response capabilities and should be eligible to receive funding. The AHA also

recommends more comprehensive funding for education for hospital preparedness. For instance, permit funds to be used to pay for staff to attend education sessions and as “backfill” for staff who are attending educational sessions.

Reduce Ability to Use Funds to Build State Health Department Infrastructure

The AHA recommends Congress take steps to minimize the use of hospital preparedness grant funds by health departments for internal operations and hiring. While we understand the need for the state to have adequate staff and resources to administer their hospital preparedness program, we are concerned about reports that some states are inappropriately using hospital preparedness money for purposes that are more appropriately funded under the CDC’s public health infrastructure stream of funds. Congress should also make states accountable for how they expend funds. Specifically, we recommend the creation of ongoing state progress reports.

Maintain HRSA Program Administration

While we recommend greater coordination between federal preparedness programs, we believe the National Bioterrorism Hospital Preparedness Program should continue to be administered by HRSA.

Conclusion

Hospitals face new and emerging threats – both man-made and natural – every day. We have always been ready for the foreseeable. Now we must plan for the previously inconceivable.

Hospitals are upgrading existing disaster plans, and continue to tailor their disaster plans to suit the individual needs of their communities in the face of new threats. America's caregivers perform heroic, lifesaving acts every day. And, in the face of the unexpected, they can be depended on to rise to the needs of their communities.

We look forward to working with this committee and staff to forge ahead toward to a shared goal of improving the overall preparedness of America’s hospitals and communities.