TEXAS HOSPITAL ASSOCIATION

Presentation to the Senate Committee on
Transportation & Homeland Security
Regarding Interim Study Charge #3
Disaster Preparedness/Response and Trauma Care

Presented by
Dan Stultz, M.D., FACP, FACHE
President/CEO
Texas Hospital Association

On behalf of the
Texas Hospital Association

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I am Dan Stultz, president/CEO of the Texas Hospital Association. Thank you for the opportunity to share hospitals' statewide perspective on disaster preparedness and response, as well as trauma care. Based in Austin, the Texas Hospital Association represents some 490 hospitals and health systems, or more than 85 percent of the state's hospitals.

More and more, disasters and trauma are tied together – through hospital emergency room and EMS personnel, through state and federal requirements, and through funding streams. Trauma Medical Directors at Level 1 Trauma Centers are required by the American College of Surgeons to participate in the hospital's disaster plan as well as the regional disaster plan; their participation is assessed every three years as part of the re-certification process. Because of their important role, hospitals are and should be included in state and regional planning as well as implementation of disaster response, be the cause natural or man-made. Hospitals along the Gulf Coast and in the surge zone have had several opportunities to learn about disaster response from Hurricanes Katrina, Rita and Ike, and have improved their efficiency and effectiveness with each one. Their "lessons learned" are of value to the state.

The single most important thing Texas can do to be better prepared for a disaster is to have a strong health care system. Unfortunately, the Texas health care system is under duress, strained by the growing volume of patients, inadequate reimbursement for services provided to Medicare and Medicaid patients, and an ever-increasing number of patients with no health insurance coverage or high deductibles that they cannot pay. As you know, Texas has the highest rate of uninsured in the nation, with one in four Texans lacking coverage, and in large cities like Houston and Dallas, one in three individuals is uninsured. While more Texans should have health coverage over the next few years with the implementation of health care reform, Texas is unlikely to have the participation of other states, and illegal immigrants are not covered.

To have a strong health care delivery system, Texas must address these issues:

1. **Reduce the uninsured population.** Hospitals across the state are struggling to maintain adequate emergency room and intensive care unit capacity. The state's population has been growing almost twice as fast as the nation's, and the population is aging, both of which increase the demand for services. The ER provides access to health care for the 25 percent of the state's population that is uninsured. While health care reform will help millions obtain health insurance coverage, it does not guarantee a family doctor or medical home. Many Texans will continue to use ERs for primary care. Unless changes are made to the federal Emergency Medical Treatment and Labor Act (EMTALA) which requires hospitals to assess and stabilize anyone who presents in the ER without regard to ability to pay, the uninsured as well as illegal immigrants will continue to access health care through hospital ERs. Those with non-life threatening illnesses/injuries could be referred and treated more cost efficiently elsewhere.

2. **Address the shortages of health care professionals.** Texas faces serious growth-related challenges; the state's population has been growing almost twice as fast as the nation's, so there are more people who need health care services. And, the population is aging, which is increasing the demand for services. Bed supply must keep pace with population

growth. Texas hospitals face workforce shortages, from nurses and physical therapists to pharmacists and allied health professionals. Texas also has a shortage of physicians. Health care reform will increase the demand for medical professionals, and Texas cannot produce enough doctors quickly to meet the need. Designated trauma hospitals go on diversion status when they lack the capacity to treat more patients, which often is caused by a lack of intensive care unit beds. The nursing shortage contributes to hospitals' struggle to maintain adequate intensive care unit capacity, as does an increased volume of critically ill patients. The state must continue to expand the capacity of nursing, physician and allied health professions education programs, as well as look at new models to deliver safe, effective patient care. With the anticipated growth in the health care field, now is not the time to cut funding for educating more doctors, nurses and allied health professionals. Jobs are waiting to be filled.

3. **Restore Medicaid GME payments.** Medicaid payment for Graduate Medical Education should be restored to support the education and training of more physicians.

4. **Fund government health care programs adequately.** Medicaid caseloads and utilization estimates need to be realistic rather than budget-driven. Hospitals are able to survive due to cost shifting of a portion of shortfalls to paying patients, but more and more businesses and individuals are dropping coverage due to the ever-increasing premiums. Hospitals have little if any "extra" to invest in infrastructure or to build excess capacity needed in emergencies. Medicaid and Medicare provide almost half of all hospital revenue.

Looking specifically at disaster management, the following issues emerged from the experiences with Hurricanes Katrina, Rita and Ike:

1. **Manpower.** RNs are asked to volunteer to go to a disaster location, which reduces manpower in the area that may receive transferred patients. New sources – not a reallocation of RNs who already are in short supply – are needed. The most important thing Texas can do to deal with disaster manpower needs is train enough clinical professionals to meet day-to-day needs. Postponing elective procedures works for short periods of time, but is not an effective strategy longer-term. And volunteers are not a substitute for an adequate number of appropriately trained health care professionals.

   Altered standards of care and associated liability protections must be developed.

   Planning to date has not adequately considered catastrophic events that would make it impossible to care for patients with existing clinical staff. New alternatives for care using family and friends must be developed.

2. **Security.** In widespread disaster events, state and federal governments immediately must allocate security assets to safety net hospitals. In the case of hurricanes, state and federal security assets should be pre-deployed in hardened shelters so that they can be present before, during and after landfall.

3. **Evacuation and Repatriation.** State decisions about evacuation should be made carefully. Hospitals are required to have evacuation plans, but know that evacuation is inherently dangerous for patients. Evacuation disrupts the delivery system; creates financial hardship for government, evacuees and hospitals; and slows the community's recovery efforts. Texas should look to Florida as a model of how to reduce the risks of evacuation. Florida has had extensive experience with weather-related disasters and has developed policy based on "lessons learned."
    - Florida's policy is for hospitals to shelter in place if at all possible.
    - In 2004-05, Florida did not evacuate hospitals in advance of storms. They did evacuate some hospitals after storms because hospitals sustained considerable damage.
    - Each Florida county has hardened shelters that can withstand a category 5 hurricane. Although not all are hardened to withstand a category 5 storm, shelters are available for special needs populations. Florida's approach is to move population inland a short distance within the same county.

    Texas should adopt a policy to make hospital evacuation the last option, increase the number of hardened shelters and harden hospitals in hurricane threat areas. Texas also should increase the number of hardened shelters for special needs populations that are close to home. Texas also must do a better job of informing the general population about who should and should not evacuate. Unnecessary evacuees disrupt evacuation plans, put more people at risk and are immensely expensive.

    When evacuation is necessary, normal standards of care are reduced, which puts patients at increased risk of harm. The Legislature should provide liability protection for hospitals and clinical staff in these situations, except for gross negligence.

    It is important to remember that once patients are evacuated, they need to be returned home. The confusion about who pays for repatriation needs to be addressed, and financial responsibility should be defined. The state must ensure that ambulances are available to repatriate patients after an event has ended.

4. **Information Management and Leadership.** During hurricanes Katrina, Rita and Ike, hospital efficiency was impaired by redundant information requests from state and federal entities. The Incident Command System must be honored, and requests for information outside the ICS must stop. Independent evacuee-, patient- and bed-tracking systems must be coordinated and consolidated when possible. The state should conduct an independent, comprehensive **review** of these systems, plus the disaster/public health-related software and equipment acquired or used by all state agencies and universities, to ensure that gaps do not exist. While testing of these systems is important, a comprehensive analysis is needed to determine if improvements and efficiencies are possible.

Cross-jurisdictional management of health care assets must improve. Use of Trauma Service Areas as regional medical operations centers shows promise, but not all TSAs have the expertise to manage disasters. In addition, TSAs do not have the legal stature or permanent funding to make this alternative effective in all areas of the state.

5. **Finance.** Responsibility for paying for health care provided to disaster-related patients should be pre-determined, and hospitals need to know before a disaster what information to collect to fully benefit from payment options. State and national policies that will make financial responsibility and procedural requirements clear before disaster events must be established. The federal Stafford Act needs to be updated; currently only public and nonprofit hospitals are eligible for FEMA funds. With its large number of investor-owned hospitals, Texas relies on all its hospitals to respond to disasters, and all types of hospitals should be eligible for federal resources and reimbursement.

6. **Effective, timely communication is critical.** The general population must be better informed about how to meet their own needs in disasters. During the hurricanes, many evacuees left without prescriptions or basic survival necessities. Hospitals often acted as drugstores. The general population must understand that they must depend upon their own abilities to meet some basic needs in a disaster. Dr. David Lakey and the Texas Department of State Health Services are to be commended for the Family Preparedness efforts which encourage the general population to prepare. It is important that TDSHS remain vigilant in communicating about preparedness as well as having public service messages related to disaster response ready to go when an event occurs. With 24/7 news and citizen "journalism," the public receives a lot of misinformation and over-reacts. To avoid public hysteria and panic in a disaster – such as a pandemic, government's reaction should be appropriate to the level of threat.

7. **Supplies and Medications.** America must have dependable and redundant sources of domestically produced medications and vaccines, because our dependence on foreign suppliers is a threat to national security and public health. Vaccines must be designed and produced quickly. The recent distribution of H1N1 vaccine caused confusion, and the state should assess the process to determine if improvements are possible. Legal issues related to mandatory vaccination of health care workers also need to be resolved.

Government planners must understand that financial realities require that hospitals use "just in time inventory" systems. Government must assume the responsibility for stockpiling specialized equipment.

Most trauma centers, especially Level 1s, have hundreds of thousands of dollars of equipment needed when a disaster involves hazardous materials, such as chemicals or radioactive substances. The equipment may or may not be used, and must be replaced with newer versions periodically. Despite their infrequent use, hospitals maintain a supply of these expensive items so they can respond appropriately and be adequately prepared at all times. In addition, they stock a broad range of specialized equipment and materials needed to treat major trauma victims. Reimbursement from private and government payers does not cover this readiness and the training that is provided to prepare health professionals. Specialized

funding from state and federal sources is not reliable. In short, trauma centers are being asked to do more to help their communities should a disaster occur, while their day-to-day operation involves more and more uncompensated trauma care every year, as reported to the state.

Summary

While Texas' trauma network has developed and become more effective, it easily could be overwhelmed by a major, long-term disaster. For example, the aftermath of Hurricane Ike produced a bigger strain on the trauma system than the actual disaster itself. The closure of the University of Texas Medical Branch in Galveston in 2008 left two Level 1 trauma centers to serve a population of more than 4 million in the Houston-Galveston area; the American College of Surgeons recommends one Level 1 trauma center for every 1 million residents. This resulted in a drastic increase in diversions and wait times in the emergency centers of Ben Taub and Memorial Hermann Medical Center, and they faced this strained capacity for almost a year.

State and federal agencies called upon THA during the hurricanes, and we responded. THA has the ability to communicate with all hospitals, and THA is best suited to understand the needs of hospitals. Hospitals are better prepared, but resources are inadequate to sustain an extended response. . THA looks forward to continuing to work with all stakeholders to identify hospital needs and realistic state expectations.

Thank you.