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A REVIEW OF DISASTER MEDICAL PREPAREDNESS: IMPROVING COORDINATION AND COLLABORATION IN THE DELIVERY OF MEDICAL ASSISTANCE DURING DISASTERS

HEARING

BEFORE THE

AD HOC SUBCOMMITTEE ON STATE, LOCAL, AND PRIVATE SECTOR PREPAREDNESS AND INTEGRATION

OF THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

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THURSDAY, JULY 22, 2010

U.S. SENATE,
AD HOC SUBCOMMITTEE ON STATE, LOCAL, AND
PRIVATE SECTOR PREPAREDNESS AND INTEGRATION,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:05 a.m., in room 342, Dirksen Senate Office Building, Hon. Mark L. Pryor, Chairman of the Subcommittee, presiding.

Present: Senator Pryor.

OPENING STATEMENT OF SENATOR PRYOR

Senator PRYOR. I will go ahead and call the meeting to order. I want to welcome everyone and thank you for being here today, especially our panelists.

I know that we have some Senators who could not attend today, but we are going to keep the record open for questions for a few days after the hearing. I will do a quick opening statement and then we will let you guys do your opening statements. I think we are limiting those to 5 minutes, so if you could keep those at 5 minutes each, that would be great. And then I will have some questions and I may get some questions from various Senate offices but otherwise, we will leave the record open and get you guys to follow up.

We have two panels and I just want to welcome everyone here and thank you all for coming. Today, we are talking about the National Disaster Medical System, (NDMS), and I appreciate you all's expertise and you all's work in this program and to help this Subcommittee to provide some oversight here.

Weakness in our public health and medical response capabilities have been highlighted in catastrophic events over the last decades, such as the September 11 terrorist attacks, Hurricane Katrina, and the H1N1 outbreak. To that end, Congress has enacted legislation to improve Federal medical preparedness and response efforts, such as the Pandemic and All Hazards Preparedness Act.

I really believe that strong planning is the foundation for effective action, and I think last year we saw how our investments had mitigated the effects of the H1N1 outbreak. However, State and

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local entities continue to worry about the next severe health threat or event that could overwhelm the medical system, and they have a series of concerns. We will talk about some of those today.

To begin addressing these uncertainties, today we will examine the National Disaster Medical System as a case study of Federal medical response efforts. NDMS, operated by the Department of Health and Human Services (HHS), partners with other Federal agencies and the private sector to provide medical services in response to emergencies and disasters. More frequently, NDMS sends teams of volunteer medical providers to areas affected by a disaster, and that is great. I think we need to be doing that.

And on three occasions, NDMS has activated volunteer hospitals to ensure patients affected by a disaster are able to receive medical care services in an unaffected area. As hospitals were activated for the first time, we discovered gaps in our planning and faced newly identified challenges with the NDMS. I think this Subcommittee is very interested in closing those gaps and making sure that as we go forward, we don't see these problems on a continuing basis.

Today, we will hear from Federal officials regarding medical preparedness and response efforts as it pertains to NDMS. That is our first panel. On our second panel, we will hear from the Arkansas Hospital Association and they will share the experiences of volunteer Arkansas hospitals that were activated in response to Hurricane Katrina and Hurricane Gustav and their suggestions on ways to improve NDMS.

It is my hope that this hearing will provide a better understanding of our utilization of the NDMS and how we can learn from these experiences to improve medical response needs of those affected by disasters. I believe what we will learn today will not only strengthen the current program, but will serve as a model of disaster medical response efforts for other Federal, State, and local stakeholders.

With all that said, let me go ahead and introduce our first panel, and our first witness is Robert Fenton. He is the Deputy Assistant Administrator for Response for the Federal Emergency Management Agency (FEMA). Mr. Fenton is responsible for coordinating and integrating Federal interagency all-hazards disaster planning and response operations. He also manages Emergency Response Teams and oversees Disaster Emergency Communications (DEC) programs.

Our next witness is Dr. Kevin Yeskey. He is Deputy Assistant Secretary and Director of Preparedness and Emergency Operations of the Office of the Assistant Secretary for Preparedness and Response (ASPR), at the Department of Health and Human Services. Dr. Yeskey is responsible for managing the National Disaster Medical System and addressing medical response efforts to disasters and emergencies. Dr. Yeskey has a long history in working on a variety of disaster response positions within the government.

So, like I said, if you can do your opening statements in 5 minutes, that would be great, and then I will have some questions.

Mr. Fenton, would you like to go first?

TESTIMONY OF ROBERT J. FENTON, JR.,[1] DEPUTY ASSISTANT ADMINISTRATOR FOR RESPONSE, FEDERAL EMERGENCY MANAGEMENT AGENCY, U.S. DEPARTMENT OF HOMELAND SECURITY

Mr. FENTON. Good morning, Chairman Pryor. I am Robert Fenton, Jr., the Federal Emergency Management Agency's Deputy Assistant Administrator for Response. I am responsible for ensuring the delivery of coordinated disaster response operations, integrated Federal interagency all-hazards disaster planning and response operations, and managing the Disaster Emergency Communications programs.

As you know, States, not the Federal Government, have the fundamental authority for evacuations. The State or local governments may order mandatory evacuation or recommend a voluntary evacuation when a State or local government determines that evacuation is necessary. It may also request assistance from the Federal Government. Emergency mass evacuation is the movement of general population from a dangerous area due to the threat of occurrence of a natural or terrorist attack, including the movement of patients in health care facilities and individuals in the community who have medical needs. HHS is a key partner to FEMA in carrying out disaster medical evacuation activities.

FEMA's support to and involvement in medical evacuation activities falls into four key areas, the first being preparedness. FEMA is helping prepare State and local governments to provide updated guidance for incorporating the evacuation planning into emergency operations plans, as well as providing technical assistance to facilitate evacuation planning. Many of FEMA's grant programs are used to support evacuation-related activities. For example, the Regional Catastrophic Preparedness Grant (RCPG) program promotes planning for both evacuation and reception of evacuees and emphasizes the need to work with potential host-State communities to develop agreements prior to the occurrence of incidents.

The second area is planning. In partnerships with State and local governments, FEMA is developing Federal-level Catastrophic Disaster Response Plans that include evacuation and medical evacuation elements. This planning takes into account the need for a significantly higher level of response assets, the possibility of little or no advance notice or warning, and the need to rapidly respond with massive support.

The third area is coordination of Federal support. During response and recovery operations, the interagency community through the National Response Framework's Emergency Support Functions convene at the national level to support regions and States by leveraging authorities, supporting resource allocations and decisions, addressing policy issues, and supporting operational planning efforts. Many Federal departments and agencies provide their own resources and expertise that are critical to life-saving operations.

Supporting the local response and recovery process. The Stafford Act authorizes FEMA to direct other Federal departments and agencies to utilize their own resources in support of State and local

[1] The prepared statement of Mr. Fenton appears in the appendix on page 21.

assistance efforts. State and local governments may request resources from FEMA to address unmet needs. Through mission assignments, FEMA can task appropriate departments or agencies to provide support to the requesting governmental entity. In anticipation of or in response to a Presidential declaration or a major disaster or emergency, FEMA can issue mission assignments to support medical response and evacuation activities.

Under Emergency Support Function (ESF) #8, NDMS can be mission-assigned to deploy to support the medical response activities of the State and local governments overwhelmed in disaster situations. FEMA, Health and Human Services (HHS), the Department of Defense (DOD), and the U.S. Coast Guard together have developed prescripted mission assignments that are specifically available to request medical support and other associated capabilities. ESF #8 alone has more than 20 prescripted mission assignments available to cover a variety of health and medical issues. FEMA also administers a contract that can provide ambulance and paratransit services that can support patient and medical evacuations.

The fourth area is our recovery programs. FEMA also provides assistance to State and local governments as well as the individuals and families through two recovery programs. Under the Public Assistance Program, when the Emergency Medical Service Delivery System within a designated disaster area is severely compromised or destroyed by a disaster event, FEMA may reimburse State and local governments and certain private nonprofits for the cost of extraordinary medical care and medical evacuation expenses. Assistance for emergency medical care and medical evacuations for disaster survivors from eligible public and private nonprofit hospitals and custodial care facilities may also be made available.

Under Individual Assistance, FEMA may provide eligible disaster survivors with a full range of programs designed to help meet individual needs, including but not limited to individual and household grants for housing and other needs assistance, crisis counseling, disaster unemployment assistance, and SBA low-interest loans.

Certainly in the future, major disasters or emergencies will seriously threaten and damage local medical facilities which will necessitate patient evacuation and transport to either a temporary facility or an existing facility with spare capacity. With the appropriate coordination of Federal agencies working together with States, local Tribes, and voluntary agencies, we can meet the great challenges presented to the public when medical mass evacuations are required.

Thank you for the invitation to appear before you today to explain FEMA's roles and responsibilities in medical evacuation during disasters and I look forward to any questions that you may have today. Thank you.

Senator PRYOR. Thank you. Dr. Yeskey.

TESTIMONY OF KEVIN YESKEY,[1] M.D., DEPUTY ASSISTANT SECRETARY AND DIRECTOR OF PREPAREDNESS AND EMERGENCY OPERATIONS, OFFICE OF THE ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. YESKEY. Good morning, Chairman Pryor. Thank you for the opportunity to discuss the National Disaster Medical System and the key role it plays in our Nation's response to disasters.

NDMS remains one of the Nation's most significant Federal medical response resources. Conceived in 1981 as an evolution of the Civilian-Military Contingency Hospital System, NDMS is an interagency cooperative effort among HHS, the Department of Defense, Veterans Administration (VA), and the Department of Homeland Security (DHS) that has over 7,800 employees, 95 response teams, and approximately 1,700 participating hospitals.

HHS can activate the NDMS to provide aid to victims of a public health emergency or to be present at locations at risk of a public health emergency. In recent years, NDMS has been called upon to respond to hurricanes, earthquakes, floods, ice storms, and a variety of national special security events, including the 2009 Presidential inauguration. In 2010 alone, NDMS has deployed over 1,700 personnel.

NDMS has three components that I will briefly discuss: Field medical care, patient movement, and definitive care.

Field medical care is provided by Disaster Medical Assistance Teams (DMATs). In response to the Haiti earthquake, NDMS deployed over 1,200 personnel that began deploying within 24 hours of the request for assistance.

The second component of NDMS, patient movement, requires extensive collaboration with our partners. DOD has the lead for providing air assets for movement out of the affected area. FEMA provides ambulance transport for short-distance patient evacuation.

The final component of NDMS is definitive care, the provision of inpatient hospital services in participating hospitals. Hospitals participate on a voluntary basis and agree to provide available beds when requested by NDMS. Patient distribution is coordinated with the States and localities.

NDMS as an organization continues to evolve and improve as it learns from previous responses. Some of those lessons learned include the need to enable more rapid deployments, improve the provision of definitive care, reduce costs, and more effectively coordinate activities regarding the evacuation of victims, their tracking, and their return. We employed these and other lessons learned in our recent Haiti response, including the deployment of HHS Service Access Teams to serve as case managers for patients evacuated to NDMS hospitals.

HHS greatly appreciates the contributions made by Little Rock, Arkansas, hospitals to the victims of Hurricane Gustav. The Arkansas Hospital Association has challenged us to do better. This collaboration is helping us achieve a higher standard of response. ASPR leadership met with the Arkansas Hospital Association three times, most recently in May 2010. ASPR staff have ongoing com-

[1] The prepared statement of Dr. Yeskey appears in the appendix on page 27.

munications with the Arkansas Hospital Association and the Arkansas Department of Health.

In our corrective action process, several issues were identified and changes have been implemented that should all but eliminate those problems from recurring. We are working with the Department of Veterans Affairs to determine if it would be suitable to place an HHS-staffed Federal Medical Station at the Little Rock VA Hospital, which would serve as a temporary medical facility for those patients who are ready for discharge but unable to return to home.

HHS has also worked with Louisiana to establish a 250-bed Federal Medical Station in Northern Louisiana to serve as a temporary receiving facility for patients discharged from Arkansas hospitals if patients are unable to return to their home of record or starting location.

We will deploy our Service Access Teams early to assist in the case management of NDMS-evacuated patients. As mentioned previously, we are awarding a standing contract that will make nonemergent medical transport available to return evacuated patients to their homes or other receiving facilities.

Our improvements made to NDMS and the newly implemented efforts dedicated to improving patient return are based on a thorough process of evaluations and system modifications. We are confident that these changes will prevent recurrence of delays experienced by Arkansas hospitals in 2008. NDMS has been a national resource for over 25 years and we are committed to the continuous improvement that will enable NDMS to remain flexible and responsive to current and new public health threats.

Thank you for the opportunity to testify this morning, and I am happy to answer any questions you may have.

Senator PRYOR. Thank you both, and Mr. Fenton, let me start with you. Really, this is for both of you, but I will start with you, Mr. Fenton.

I know that in this circumstance, you get two Federal agencies. You have FEMA and HHS, and HHS is the lead agency for medical care, but FEMA is the overall coordinating agency for all emergency response. And so I guess my first question is a general one, and that is when it comes to the kind of roles and missions here, is FEMA clear on its appropriate role and how it interfaces with HHS and vice-versa? Do you guys have a good working relationship, or have you noticed that there are some overlaps or gaps that needs to change and that needs to be honed a little bit? Mr. Fenton.

Mr. FENTON. Yes, sir. I do believe we have a very cohesive and a very good working relationship and team up on a number of issues as it relates to medical areas. I think, first, starting from a doctrine perspective, the National Response Framework outlines roles and responsibilities. The National Incident Management System is the architecture for how we come together and how it organizes us into a management system. When we respond, we not only both understand this system and its roles and responsibilities as outlined in there, but we also partner together in many planning activities throughout the year, from the national level down to the regional level. So in each one of FEMA's regional offices, there are

Health and Human Services personnel that are down there working collaboratively at that level.

And then in addition, FEMA also brings together the interagency body which Health and Human Services is a part of through the Emergency Support Function Leadership Group that meets monthly to discuss specific issues or planning issues, like a lessons learned refined processes and procedures or those kinds of things at the national level. Also, at each region, they have a Regional Interagency Steering Committee (RISC) that is doing the same thing to align State and local and Federal Government at that level.

And then, in addition, there are a number of exercises that we do together throughout the year to look at the plans for developing, continue to assess them, evaluate them, and make sure that we are able to adequately respond. And I think that just the number of mission assignments that I have talked to you about, we have outlined—as we continue to work through and see lessons learned, we either amend them or develop mission assignments that give HHS clear guidance on what we expect from them during disasters and how those relationships work. So I think it is a good relationship and we continue to work at it and resolve issues.

Senator PRYOR. Good. I may have some follow-ups there in a minute——

Mr. FENTON. Yes, sir.

Senator PRYOR [continuing]. But that is good. I would like to hear from Dr. Yeskey.

Dr. YESKEY. Yes. I would reiterate what Mr. Fenton said about our very good collaborative and cooperative interactions that we have. We support the DHS and FEMA in the National Response Framework as the lead for Emergency Support Function #8 Public Health and Medical Services.

We have Regional Emergency Coordinators in each of the 10 HHS regions, which overlap with FEMA regions, and they are interactive with the FEMA regional offices and participate in planning exercises. As HHS develops its response playbooks, we bring in partners from the interagency to include FEMA and DHS to participate in the development of those playbooks.

In responses, we have HHS liaison officers and the Joint Field Office that FEMA runs. We put liaison officers in the Operations Centers, the National Incident Command Center and the Regional Coordination Centers that FEMA manages. And then FEMA participates on all our ESF #8 calls that we have as we respond. So we think there are very good communications and it is not unusual for us to pick up the phone and call one another if there are glitches, and so we have that relationship, as well.

Senator PRYOR. Good. Well, that is encouraging.

Let me ask about a little more about roles or missions, and I am not sure where the line is, but one of the challenges I think we will hear about from the second panel today, from our Arkansas witness, is that some things seem to go very well, good planning and preparation but maybe there were a few areas that didn't go so well and one of those would be discharging the patient or returning the patient back to their home area. Whose responsibility is that? Is that HHS's responsibility?

Dr. YESKEY. HHS maintains the responsibility to return patients back to their home of record, and that is usually accomplished through a mission assignment from FEMA.

Senator PRYOR. OK. So there again, that is collaborative, as well, in terms of how that works. And also, when it comes to the hospitals and other medical professionals getting compensated for their services, is that more under HHS or under FEMA?

Dr. YESKEY. That is more under HHS.

Senator PRYOR. Let me go ahead and ask about that, then. You probably are familiar and probably know a lot more about it than even I do, but there was maybe an outstanding balance, I guess you might say, a few hundred thousand dollars in our State. I understand you guys are working through this right now with Arkansas, and we appreciate that. But again, is that more on the HHS side or the FEMA side?

Mr. FENTON. We mutually work together on these issues and we are taking from this, I think, in lessons learned, we are taking issues to mitigate this in the future. But FEMA has a Host State Evacuation Sheltering Policy (HSESP) to reimburse local and State governments that host evacuees and FEMA reimbursed through the State of Louisiana to the State of Arkansas funding for certain costs that would be eligible, some of those for providing non-congregate care sheltering for individuals released from hospitals.

It appears that the mechanism to capture that would be from the hospitals to Arkansas to Louisiana and then we would reimburse it. It appears that a number of hospitals, we didn't have their information through that system, so now that we have been made aware of it, we have gone back and we are going to recapture any costs that are eligible underneath that system.

In addition to that, and I think because there are two different streamlines of patients going to the hospitals, there is one set of patients coming through NDMS's system, through the mission assignment that we tasked HHS underneath their authority to evacuate patients from Louisiana, and then there are other patients that are moving through normal means, maybe from hospitals to hospitals. So we have one system that allows us to reimburse local and State governments for those costs, for those out-of-pocket costs for that. Underneath HHS, what we have done now is we are expanding their mission assignment to allow them to capture and support those costs so it doesn't need the extra coordination of the receiving State to be able to do that.

I don't know if you want to add anything to that or not.

Dr. YESKEY. Yes, just a couple of things, and again, we are working with FEMA on all those issues. Just understand, the NDMS reimbursement is that NDMS reimburses after private third-party insurers and Medicare but before Medicaid. So if a person has other insurance, then hospitals in the MOU that they sign, they go to bill those insurers first before they come to NDMS. Now, if a person doesn't have insurance or is Medicaid-eligible, or a Medicaid recipient, then NDMS covers the reimbursement ahead of those self-pays or Medicaid.

Senator PRYOR. And if I understand, part of what you are both saying is that this is an area that you are trying to address, the Arkansas specific situation——

Dr. YESKEY. Yes, sir.

Senator PRYOR [continuing]. But also, it is a lesson learned area that you guys are working on to try to make sure it doesn't happen like this in the future, or at least that it is handled appropriately in the future, is that the understanding?

Dr. YESKEY. Yes, sir, and I think what we are trying to do is prevent the delays in returning patients, and some of the things I outlined as far as having our case managers actively engaged so we know when patients are ready for discharge and we can get them discharged, looking at alternate facilities, so if there is a mitigating circumstance where they cannot be returned to their home of record—in 2008, it was Hurricane Ike that was coming through Louisiana and Texas—we want to have the ability to have other outlets so the hospitals don't have to hold onto those patients, making sure that we have a liaison officer in the State Emergency Operations Center (SEOC), if requested, so they can work through those details about how those patients are going out, making sure that those are implemented as well as having that contract in place with a medical transport organization to take patients back when they are ready to go back home.

Senator PRYOR. So it sounds like this is a lot more involved than just the two of you sitting down, because you have already referred to—like in that case, to the Louisiana Emergency Management People, the Arkansas Department of Emergency Management, and then the transportation company. There are probably a lot of—well, of course, the hospital, and there are a lot of other interested parties that are involved in this process.

Do you feel like, for any of those hurricanes, Gustav, Ike, Katrina, do you feel like there was adequate planning and preparedness on this specific area, or is that part of the lessons learned is that you found some gaps, and obviously one of those might be the payment issue, but you found other gaps that you guys are addressing to make sure it won't happen in the future?

Dr. YESKEY. Yes. I think we try and learn from every response that we do, whether it is an exercise or whether it is an actual response, and we have a corrective action process that we have implemented so we can try and learn from these lessons and prevent them from recurring. Some of these are very complex interactions, as you stated. But we think we are making a great deal of progress and learning from this and hope to be able to generalize what we learn from Arkansas to the rest of the system so it doesn't happen there or elsewhere.

Mr. FENTON. I was just going to add that, I think as you outlined, there are a number of moving parts when you start to execute medical evacuations or evacuations of the general public, and FEMA has a number of things to prepare for Hurricane Gustav, as lessons learned from Hurricane Katrina, from issuing contracts to—we have a contract for ambulances, for paratransit, to developing plans, to funding a lot of planning at the local and State level, to issuing policies that we never had before that allow us to reimburse host States, to bring States together to sign agreements on how many personnel they can accept and exactly where you go and work on transportation resources and bringing in the Depart-

ment of Defense to this and the U.S. Coast Guard and everyone else that has a capability that may benefit that.

And so we took on a number of activities to prepare us for Hurricane Gustav and make sure that we could respond, but I think that the best laid plans never survive the first disaster and there are a number of lessons that we learned from there and we will continue to make progress to improve those or address any shortfalls within those.

Senator PRYOR. OK. Let me see. I was going to ask about, I believe it was you, Dr. Yeskey, mentioned that maybe one of lessons learned or part of the plan that you are working on now are these Federal Medical Stations, and you are talking about one in Northern Louisiana and maybe one in Little Rock. What does that mean exactly? I don't know who to direct the question to. OK, Dr. Yeskey.

Dr. YESKEY. No, that is for me.

Senator PRYOR. And so how will those work, and logistically, what is that?

Dr. YESKEY. Yes, sir. A Federal Medical Station is a 250-bed capacity that can be modularized in 50-bed capacities, but the maximum capacity is 250 beds. We staff those with medical personnel and they can perform a number of different functions, anywhere from just providing basic primary care to patients, or in previous experiences, we have had our Federal Medical Stations providing care to critical care patients as we were looking for other facilities. So we usually have a staff of about anywhere from 60 to 100 medical providers in those facilities. We look for buildings of opportunity, so they don't come with—it is not really a field hospital, but we look for large spaces where we can set up our cots, put our equipment in, and then we can house those patients and take care of them in those facilities.

Senator PRYOR. So you just need a building with adequate space for you to modularize this and kind of build it as you need it?

Dr. YESKEY. Yes, sir. It is space and sanitation, water, things like that, and then wrap-around services, as we call them.

Senator PRYOR. And where do you get the personnel to do that?

Dr. YESKEY. We draw our personnel from the National Disaster Medical System for a large part of this. We also used the Commissioned Corps of the Public Health Service, one of their Rapid Deployment Force teams. They provide help. We also use our Federal interagency partners, such as Veterans Administration. We can task them to provide clinical personnel for those and have in the past.

Senator PRYOR. I have heard, and I don't know how accurate it is, that it may be difficult for a lot of Federal employees to actually serve on those response teams. Is that accurate, that because of the Federal regulations or Federal rules? Do you know?

Dr. YESKEY. I don't know. It requires some administrative activity so that person doesn't—since if they are an NDMS employee, they get paid by NDMS for their salary. If a Federal employee who is already receiving a Federal paycheck wants to join a team and participate on a team, they have to get approval from their parent organization, and then if they want to get paid from NDMS, then they would have to take an administrative break in pay so they

could do that. Otherwise, we would expect them to participate in that Federal organization as part of that Federal organization and our tasking to that organization to participate in our response.

Senator PRYOR. OK. I will have to think about that a little bit to think through if that is the right way to handle that, because it seems if the Federal Government has a lot of expertise, has a lot of people that have expertise that might be part of that team, I just wonder if there are maybe too many barriers for them to serve. But let me think through that. We may have some follow-up questions.

And you mentioned the Federal Medical Station in Northern Louisiana, and did you say you are going to do one in Little Rock, as well?

Dr. YESKEY. We are working with the VA on the suitability of putting one at the VA facility there. And again, if this is to take care of patients who are ready for discharge, it would be a small facility and require a minimal level of care that we would be able to staff that.

Senator PRYOR. Would you do that in other locations around the country?

Dr. YESKEY. Sure.

Senator PRYOR. And I assume you just have to look at their list of disasters and potential disasters to know strategically where to plan on putting those, is that right?

Dr. YESKEY. Yes, sir. As part of NDMS and the Patient Evacuation System, we have Federal Coordination Centers. There are 72 of them nationwide, and that is where we, in our plans, where we choose from to evacuate patients to. And then we have VA or DOD Federal Coordinating Center staff there who work with the local hospitals and public health and emergency management to arrange the transport from the receiving point of debarkation to the hospitals. So those are the cities that we choose from to use for evacuation.

Senator PRYOR. OK. Dr. Yeskey, I don't know if this should go to you, but I will direct it to you unless Mr. Fenton wants to jump in here. In his written testimony, I don't know exactly what Paul Cunningham is going to say here in a few minutes, but in his written testimony, he mentions that the instructions provided by FEMA usually, or maybe through HHS, as well, but the instructions provided from the government seem to be constantly changing and oftentimes confusing. I understand how the aftermath of a major catastrophe can be very confusing. I get that. But to me, that seems that planning would take care of a lot of that.

Can you all evaluate how you did in terms of communicating to the hospitals and other medical providers during this very challenging time? And again, I don't know if that is for you, Dr. Yeskey, or for you, Mr. Fenton, but——

Dr. YESKEY. I can take a first crack at that. I think it is clear that we try and communicate as much as we can and we try and make sure that the information is clear and gets to the end users, the people who have to implement the guidance or the communications that go out. We try, when appropriate, to have telephone calls with appropriate personnel, whether that is the hospitals or a State Health Department or emergency management. We have an

ongoing presence in the region through our Regional Emergency Coordinators (RECs) that, hopefully in the planning process and the exercises have a presence there and can answer questions and can provide a unified HHS response to questions that are asked. We also have other organizations, like Centers for Medicare and Medicaid Services (CMS) and Food and Drug Administration (FDA) in the regions who have a presence there who can answer some of the technical aspects about those programs.

It is clear that we didn't do as good of a job as we would have liked to have done and continue to try and work with the localities to improve our communications.

Senator PRYOR. Dr. Yeskey, before Mr. Fenton jumps in on that answer, and it looks like he wants to, but let me ask a quick follow-up to that specific thing, and that is when you set up your relationship with these hospitals and you want them to participate in this, I am assuming that there is some sort of Memorandum of Understanding (MOU), or, Memorandum of Agreement (MOA) or whatever you may call it, but I am assuming there is some written understanding between HHS and the hospitals, and I am assuming that comes from HHS, not from FEMA.

Dr. YESKEY. Yes, sir.

Senator PRYOR. Is that in the form of a blanket agreement, where you have a standard form that they sign onto, in other words, maybe—I hate to say this phrase, but a one-size-fits-all, or do you tailor that based on the specific needs or requirements or circumstances of that particular institution?

Dr. YESKEY. The MOA is a standard form that all participating hospitals sign.

Senator PRYOR. Does every one fit every circumstance, though?

Dr. YESKEY. I don't know the answer to that question, per se. I think that the form is general. It talks about obligations of—responsibilities of HHS, responsibilities of hospitals, etc.

Senator PRYOR. OK. Mr. Fenton, did you want to jump in on this idea of the communication, either between FEMA—actually, I heard it was between FEMA and the hospitals was changing and there was maybe contradictory information given at different times to different people, different meetings. Do you have any comments on the communication and kind of evaluate how you guys did on that?

Mr. FENTON. I would just, I guess, offer that I think that anytime during a major disaster, communications, whether physical communications or just the ability of communications, seems to be the root of most issues. It is not that there aren't plans in place or people in place trying to take the right actions. And in the case of Hurricane Gustav, I think you look back and you look at Hurricane Katrina and a number of new policies, laws that were pushed into effect following Hurricane Katrina as part of the Post-Katrina Reform Act, and then those new laws causing new policies was a substantial amount of new information to get out, educate, and communicate and rebuild plans to allow us to do some of those things now that we have been given authority to do underneath that legislation.

So, that could be some of the changes. Some of the other changes could be as we continue to look at areas that we never looked at

before, like the policy I referred to that allows us to provide—host States to accept evacuation and us to reimburse them at 100 percent of the costs. In there, there is an agreement that the host State has to accept. They have to agree to give 10 percent of their shelter capacity to a State that is evacuating.

And so there are a number of things that we continue, as we go to whether it is September 11, 2001, Hurricane Katrina, other events, and we see areas that we either in our planning or historically never had to deal with before, we are continuing to build the capacity to work through and provide assistance to those issues. And after Hurricane Katrina, it was build a better ability to evacuate and receive people. So I can only guess that some of that, maybe the new policies coming out and the ability to communicate those, educate those, train the whole Nation on what those are. I think we have done an effective job on doing that, but obviously we need to continue to do that and to be able to improve on that.

Senator PRYOR. Dr. Yeskey, let me ask you another follow-up question here about the NDMS and the overall response from hospitals that you are reaching out to. Are hospitals generally willing to do this? Are they generally agreeable to participate in the program?

Dr. YESKEY. I think they are generally willing to participate in the program. Hospitals have certain requirements for accreditation that participation in NDMS helps satisfy. They get to do exercises. They get to perform mass casualty drills and things like that. So I think there are some intangible benefits for the hospitals participating in that.

Senator PRYOR. What are the biggest barriers, the biggest reasons why hospitals wouldn't want to participate?

Dr. YESKEY. I think one may be unfamiliarity with all the details that goes into participation as an NDMS hospital. Some may have fears that it may become an involuntary agreement to participate as an NDMS hospital, or they may be tasked to do that. This is a voluntary system and certainly we would not force any hospital to take patients that they wouldn't. But those might be some of the reasons they would not want to——

Senator PRYOR. Do you have any areas of the country where you have a deficiency in hospitals, that you need more volunteers, more hospitals?

Dr. YESKEY. I would have to go back and look at that, but I can get that answer for the record.

Senator PRYOR. Well, speaking of answers for the record, I have some more questions for our two panelists, but what I will probably do is just submit those for the record and I will bring up our second panel here in a moment.

But do either of you two have something you want to say in closing, or is there any point that I——

Mr. FENTON. I would just say, when you look at this very complex issue, whether it is FEMA or HHS, we are just part of a team, a team that includes State, local government, the hospital providers, and private entities and all those, and to make it work, it takes all those entities coming together and the communication involved in all those. It is FEMA's responsibility to coordinate against a broad spectrum, not just medical evacuations, but every-

thing from evacuations of the general population to debris removal to life-saving to, you go on and on of all the things that happen when a disaster comes together.

I think we continue to work at that. We continue to develop capabilities to local and State governments to improve the planning, to improve the education, training, and exercising, to continue to try to validate those and improve our capability, and we will continue to work toward those. So thank you for the opportunity to be here today.

Senator PRYOR. Thank you. Dr. Yeskey.

Dr. YESKEY. Thanks for the opportunity to discuss NDMS.

Senator PRYOR. Well, thank you all for being here. I think we see this on this Subcommittee as just part of our general oversight. I think that everybody's heart is in the right place, trying to do the right thing. We just want to make sure our system works well, and the preparedness and the planning just works the way it should, because in a crisis, you don't have time to think through that. I am sure in any given crisis, no matter when or where, nothing works 100 percent of the time exactly the way you wanted it to go, but I think—it sounds like you guys have identified some areas that we need to focus on and it sounds like you guys are focusing on those.

So again, we may have some follow-up questions for you, but I do want to thank both of you for being here today and I will go ahead and dismiss you all and we will bring up our second panel. So thank you for being here.

As the staff here is switching out the table, I will go ahead and introduce our second panelist today. I want to welcome Paul Cunningham, who is from Arkansas and is a Senior Vice President at the Arkansas Hospital Association. He is responsible for policy analysis, Federal relations, and reimbursement issues for the Arkansas Hospital Association. Mr. Cunningham will speak to the experience of Arkansas volunteer hospitals that were activated under NDMS. He brings a lifetime of experience to this equation and this conversation and we appreciate you being here today and appreciate the work that your association does.

I want you to give your opening statement, but if you can remind me how many members you have in your association. How many member hospitals are there?

Mr. CUNNINGHAM. We have 104 member hospitals in the association.

Senator PRYOR. Go ahead with your opening statement, please.

TESTIMONY OF PAUL CUNNINGHAM,[1] SENIOR VICE PRESIDENT, ARKANSAS HOSPITAL ASSOCIATION

Mr. CUNNINGHAM. Thank you, Mr. Chairman. I am Paul Cunningham, Senior Vice President of the Arkansas Hospital Association in Little Rock, Arkansas.

I am here today speaking on behalf of a dozen hospitals located in and around the metropolitan Little Rock area which were, until June 1 of this year, participants with the National Disaster Medical System. They were also part of the only activations of civilian hospitals in NDMS's 25-year history for the combination of patient

[1] The prepared statement of Mr. Cunningham appears in the appendix on page 39.

evacuation and definitive medical care purposes following disasters that occurred on U.S. soil. During their activation in late August of 2008, prior to the landfall of Hurricane Gustav, our hospitals identified several problems with the system. We have been working since then to resolve those issues, but with limited progress.

During the activation 2 years ago, Little Rock hospitals received and cared for 225 patients who were included in the evacuation from Hurricane Gustav in Southern Louisiana. They continued caring for many of the patients for nearly a month, and in some cases more, waiting for Hurricane Gustav and then Hurricane Ike to clear the area, allowing the returning of patients to their home State. During the activation, it became clear that the NDMS Memorandum of Agreement with hospitals needs to be revised to make the program more viable for similar events in the future, wherever they might occur in the country.

Efforts to get our concerns addressed date back to late September 2008, and more than a year has gone by since we first notified HHS about the need for changes in the agreement. Delays in getting that needed attention prompted Little Rock hospitals to withdraw their participation effective June 1 of this year. We want to point out that there has been progress made in the past few months working with the ASPR, Dr. Nicole Lurie, and Dr. Kevin Yeskey, and yet we are disappointed that there has been no specific action to address our proposed revisions to the agreement that were submitted in June 2009.

Our hopes were that at least some of the changes could be incorporated before the 2010 hurricane season began last month. They were not. We believe the same concerns could later prove to be a barrier that will hold back hospitals in other States from participating, as well, limiting NDMS's capabilities in the future.

A key change involves getting patients back to their home States following an evacuation. At this time, the agreement doesn't speak to the return of patients. Although the Air Force is directly involved with evacuation of patients from a disaster area to a host State, it is not an available NDMS resource for getting those same patients back to their home States or to the original transferring hospital. Private contractors must be used.

Delays in getting the contractor ready to transport patients and the inability to return them in a timely manner created a number of problems. Those included extended hospital stays, the need to feed and to shelter some patients who could be discharged, and their families if they were there, and to transport other patients back to Louisiana. All of that was done at the hospitals' own expense.

Local patients were also affected by having to postpone or delay elective procedures because beds or staffing in those hospitals were not available due to the demands of the evacuated patients.

Another problem stems from reimbursement limits imposed by Medicare payment policies. Those alone govern hospitals' reimbursement for care provided to Medicare patients who are caught up in these evacuations. The agreement offers a fair approach to helping pay for the care for uninsured patients and Medicaid patients and even some insured patients, but Medicare patients are

left out. NDMS offers no reimbursement for them. They are simply Medicare's responsibility.

The policy fails to understand and to adjust for the idiosyncracies of Medicare's rules, especially those involving patient transfers and limits on covered day. Whatever Medicare reimburses is full payment, regardless of the extenuating circumstances. NDMS's unique Federal-State partnership shouldn't create such obstacles to hospitals' participation. However, it does just that.

The Little Rock hospitals have withdrawn from NDMS participation for now, but we believe there are broader implications. Most immediate will be the cost of evacuations from the Louisiana Gulf Coast to locations further away than Little Rock in the event of another hurricane. NDMS also stands to lose the experience in such patient movements that is available with the Little Rock hospitals, and they were highly praised for their work during the Hurricane Gustav event.

While losing 12 hospitals in Arkansas may seem insignificant to a program with over 1,800 participating volunteer hospitals nationwide, it is very possible that hospitals in other States might also later decide to withdraw their participation if the changes to the agreement are not made. That could severely limit NDMS's abilities to respond to disasters in the future.

We want to thank you for the opportunity to be here and to speak on this today and certainly will answer any questions that you have.

Senator PRYOR. Thank you very much, and let me go ahead and jump in. You mentioned that the Little Rock area hospitals have withdrawn from NDMS, at least for now, until some changes are made in the system. Of course, that concerns me about the overall integrity of the system, if you guys feel like it is just not a workable situation. But what sort of changes are you all suggesting to the Memorandum of Agreement?

Mr. CUNNINGHAM. We would like something in the agreement specifically regarding the repatriation or the return of patients from a host State to their home State. We would like to have those agreements in place, authorized, and signed prior to the event actually occurring. We would also like to see something in the plan regarding the establishment of Federal medical shelters, where patients who can be discharged have a place to go. In the case of Hurricane Gustav and then Ike as it came ashore later, we had patients from Louisiana who were ready to be discharged but who literally had no place to go.

Senator PRYOR. Right. OK. And also, you mentioned Medicare in——

Mr. CUNNINGHAM. Medicare is a very distinct problem. Under the NDMS agreement, Medicare is responsible for paying for care provided to Medicare patients, who again are caught up in these patient evacuations. That presents a problem on a couple of fronts. First is Medicare's policy regarding transfer of patients. Now, normally, if a patient is transferred from Hospital A to Hospital B, the transferring hospital gets a per diem, not the full Diagnosis Related Group (DRG) amount, and the receiving hospital does get the full DRG amount but then can discharge the patient.

In evacuations such as this, the patient actually goes from Hospital A to Hospital B and then theoretically back to Hospital A. Well, in a very short transfer, that doesn't present a real problem because the payment is made under arrangement. The transferring hospital and the receiving hospital agree to a payment.

In the case of Hurricanes Gustav and Ike, we found our patients having to stay very lengthy periods. Some patients were in the hospitals for 30 days or more. If you look at just the DRG limit—and let me make a clarification that in November, and this was sometime after the event itself, HHS did agree that those patients at hospitals in both States could bill those patients the full DRG amount. But that is not an overall umbrella policy. That policy has to be made on each individual event, such as if something else happened this year or next year, HHS would also have to say that policy was in place for that event, too. It is not an overall policy.

But the length of stay under the Medicare DRG system puts patients at a point where if they cannot be discharged—if they are ready to be discharged and cannot go anywhere, well, that is now considered medically unnecessary care. Medicare does not pay for medically unnecessary care, regardless of the extenuating circumstances. So our hospitals were left having to keep some patients who had no place else to go for lengthy periods of time without any Medicare reimbursement.

Senator PRYOR. Yes. I was going to follow up on that. So I am sure—I don't know how many patients came up during those hurricanes——

Mr. CUNNINGHAM. Well, there were 225 total——

Senator PRYOR. Two-hundred-and-twenty-five.

Mr. CUNNINGHAM. I can't tell you how many were uninsured or Medicare or whatever, but 225.

Senator PRYOR. I am sure there are different circumstances on every single one——

Mr. CUNNINGHAM. Exactly.

Senator PRYOR [continuing]. But am I correct in my understanding that some of them stayed in the hospital in the Little Rock area not because they needed the medical services anymore, because they just didn't have anywhere to go?

Mr. CUNNINGHAM. That is correct.

Senator PRYOR. And that does present all kinds of problems.

Mr. CUNNINGHAM. Absolutely.

Senator PRYOR. I mean, obviously, that is the least efficient place you want to have someone.

Mr. CUNNINGHAM. In addition just to the payment problems themselves, it created problems for local patients who had to postpone or delay elective procedures or admissions because staffing was needed to take care of the patients who were here from Louisiana.

Senator PRYOR. Out of the 225, do you know how many would fit into that category that they really had no more need for medical services, but because they just didn't have anyplace else——

Mr. CUNNINGHAM. Senator, I don't have that information. We could probably get it for you, but I don't have it right now.

Senator PRYOR. And it sounds like you are still in discussions with FEMA and HHS——

Mr. CUNNINGHAM. That is correct.

Senator PRYOR [continuing]. To try to get this resolved.

Mr. CUNNINGHAM. We are working with Dr. Yeskey. We have been trying to resolve some of these issues. But as of June 1, and this was not an easy decision for our hospitals, we feel like there were still enough concerns out there that merited their withdrawal from the system until a more definite plan of action, more written plan of action could be presented to us.

Senator PRYOR. I am not trying to put words in your mouth, but I am curious about your impression of this. Is that because the two agencies are being inflexible, or is it because you are dealing with two or more Federal agencies and it just takes a long time for them to make a decision?

Mr. CUNNINGHAM. I think your second assessment would be correct. I think it is just a complicated situation that could probably be improved with some additional work, some closer ties, and it sounds to me from the previous presentation like both agencies are working on that.

Senator PRYOR. And have they told you that they are willing to make some changes to the MOA?

Mr. CUNNINGHAM. They have indicated a willingness, but we have yet to see something in writing to the point that our hospitals feel comfortable enough that they would not be in the same situation, let us say, if a hurricane were to hit this year as they were when Hurricanes Gustav and Ike hit in 2008.

Senator PRYOR. And I don't know the working definition for everyone on what is medical care versus other——

Mr. CUNNINGHAM. Exactly.

Senator PRYOR [continuing]. Type of services that you provide, but give us a sense of things that you did for these patients that wouldn't be necessarily considered medical care. And I can think of a lot, but I am curious about what some of those might be.

Mr. CUNNINGHAM. Well, there were occasions, and we did work closely with the Arkansas Department of Health on this. If there were patients in the hospitals who were ready to be discharged and who did not have a way to get back to Louisiana, for instance, our hospitals worked in conjunction with the Health Department to try to find places, such as local hotels where they could put these people up for several days. They found themselves in a need to both feed patients and families if families had come with them, that sort of thing.

There were two hospitals that we are aware of who actually took it on themselves to take patients who were ready for discharge and transport them on their own back to Louisiana. Those are all non-medical costs and certainly are not the responsibility of the NDMS, but it would be good if, again, a closer tie between NDMS and FEMA, if there could be some agreement where we felt confident that in those cases where hospitals do have to provide non-medical care, that there was an avenue for reimbursement.

Senator PRYOR. It seems to me that you don't really get compensated for that non-medical care unless FEMA has——

Mr. CUNNINGHAM. Unless FEMA has a way to do it, we do not. That is correct.

Senator PRYOR. But it seems to me that they ought to consider that compensation, because most of those patients wouldn't have that except for these circumstances, right?

Mr. CUNNINGHAM. That is true, and there were extenuating circumstances here. We had a situation where we had Hurricane Gustav come on shore, and then about 2 weeks later Hurricane Ike came on shore.

Senator PRYOR. Right.

Mr. CUNNINGHAM. And you might think that this is a very unlikely scenario, but we would like to point out that in 2005, you had Hurricanes Katrina and Rita that came on shore very closely together, too. So it can happen and it has happened twice in the last 5 years.

Senator PRYOR. Let me ask you about something I think was in your written testimony—you maybe said it a few moments ago—but about the communication between FEMA and your local hospitals. My understanding is that there was some confusion, maybe contradictory information——

Mr. CUNNINGHAM. Well, it was very confusing. I know that we at the Hospital Association, along with most of our participating hospitals, were on daily calls with FEMA and NDMS about what exactly do we need to do? What is the process? When is the transport contractor going to be in place? How soon can they transport patients back? How long will that take, things like this. And there were many occasions where you literally got different information every day.

Senator PRYOR. And do you know why you were getting that? I mean, is that because maybe FEMA and/or HHS hadn't coordinated or they just hadn't thought through all the details?

Mr. CUNNINGHAM. Probably that. I guess for Arkansas, at least, the first case of this magnitude. I don't know what may have happened after Hurricanes Katrina and Rita. We did get a few patients in Arkansas. I think a lot of those went to other States. But regardless, the process of getting patients into the State into hospitals went very smoothly. The process of getting them out did not, and it may be that this is just something that we need to put more effort in, more planning, more practice, things like that.

Senator PRYOR. Again, not trying to put words in your mouth, but it sounds like what you are saying is that NDMS is something that we should continue, that it is important in a time of crisis——

Mr. CUNNINGHAM. Absolutely.

Senator PRYOR [continuing]. But it also needs to work well, and hopefully, lessons learned here would be some of the experience that the hospitals in the Little Rock area had that we just need to make sure these don't happen again, and hopefully you can get compensated for some of the things you did now. Is that fair to say?

Mr. CUNNINGHAM. Yes. I think, absolutely, you are correct. NDMS is a valuable resource. We need it to respond to emergency disaster events wherever they occur in the country. I think it is also set up and it is needed to take in civilian and troop casualties that might occur from conventional wars in other places or to respond in the event that somebody would actually use a weapon of mass destruction in the country, not to mention things like H1N1.

So it is very valuable. We want it to work. We want to be a player in it. We just feel like some changes are needed before we feel comfortable in making that step.

Senator PRYOR. Yes, and I am not critical of your decision to get out of it, at least temporarily, because given your experience, it is understandable. But it does concern me that it is sending a signal to other hospitals around the country——

Mr. CUNNINGHAM. Exactly.

Senator PRYOR [continuing]. To be careful before they sign onto something like this, because it is not as smooth as you might think on the front end.

Mr. CUNNINGHAM. And I think if Arkansas hospitals continue to be out and are out if something else occurs, then that puts the evacuation to another city even further away from the Gulf Coast, the Louisiana Coast, in particular, than Little Rock. For instance, Oklahoma City would be the next city, is my understanding. That is about an additional hour's flight to shuttle patients back and forth. If they were to leave, it could be El Paso, Texas, could be another city. But yes, there are some Federal costs involved here, too.

Senator PRYOR. Right. Well, thank you for your statement. Thanks for answering the questions. Thanks for coming up here for this. Did you have anything you wanted to say in closing?

Mr. CUNNINGHAM. I wanted to say that we certainly appreciate the opportunity to come and to review these concerns with you.

Senator PRYOR. Well, thank you for being here and thank you for your efforts. First, thanks for participating in the program and taking care of people. That is important. Hopefully, you will be the sort of catalyst for getting things worked out in the future to improve the program over time.

What we are going to do is we are going to leave the record open for 15 days, so it is very possible that other Senators and other offices will submit questions, if you would work with staff to try to get those answers back to us.

I again want to thank you and thank all our panelists for being here and participating in this.

With that, we will adjourn the hearing. Thank you for doing what you do.

Mr. CUNNINGHAM. Thank you.

[Whereupon, at 11:06 a.m., the Subcommittee was adjourned.]

APPENDIX

FEDERAL EMERGENCY MANAGEMENT AGENCY

STATEMENT OF

Robert J. Fenton, Jr.
Deputy Assistant Administrator
Response

Regarding

"A Review of Disaster Medical Preparedness: Improving Coordination and Collaboration in the Delivery of Medical Assistance during Disasters"

BEFORE THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
SUBCOMMITTEE ON STATE, LOCAL AND PRIVATE SECTOR PREPAREDNESS AND INTEGRATION

UNITED STATES SENATE

Thursday, July 22, 2010
Dirksen Senate Office Building
Room 342

VerDate Nov 24 2008 12:05 Apr 14, 2011 Jkt 58403 PO 00000 Frm 000025 Fmt 06601 Sfmt 06601 P:\DOCS\58403.TXT SAFFAIRS PsN: PAT

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Good morning, Chairman Pryor, Ranking Member Ensign, and other distinguished Members of the Subcommittee.

I am Robert J. Fenton, Jr., the Federal Emergency Management Agency's (FEMA) Deputy Assistant Administrator for Response. I am responsible for ensuring the delivery of coordinated and successful response operations in any environment across the Nation; integrating the federal interagency all-hazards disaster planning and response operations; deploying emergency response teams: and managing the disaster emergency communications programs. Previously, I served in various response and recovery leadership roles in FEMA's Region IX.

Since joining FEMA in 1996, I have played a role in many of our large response and recovery operations, responding to more than 50 federal disasters including 9/11, Hurricane Katrina, and the California wildfires. I also led interagency workshops to develop the National Incident Management System and the National Response Framework (NRF); and I conducted interagency training and exercises with Emergency Support Function (ESF) Departments and Agencies in preparation for disaster responses.

Thank you for the invitation to appear before you today to explain FEMA's roles and responsibilities in medical evacuation during disasters.

Defining Medical Evacuation

The movement of the general population from a dangerous area due to the threat or occurrence of a natural disaster or terrorist attack is called an emergency mass evacuation. The movement of patients in healthcare facilities and individuals in the community with medical needs, including those with mental health, behavioral health or substance abuse issues, is referred to as a medical evacuation. The protocols for each are different.

The fundamental authority for evacuations comes from state, tribal, or local governments; however, if a state, tribal, or local government determines that an evacuation is necessary, it may request, through appropriate channels, assistance from the federal government.

Department of Health and Human Services (HHS) and Medical Evacuations

The Secretary of HHS leads all federal public health and medical response to public health emergencies and incidents covered by the NRF. HHS serves as the Coordinator and Primary Agency for the NRF's ESF #8, "Public Health and Medical Services." More specifically, ESF # 8 provides the mechanism for coordinating federal assistance to supplement state, local, and tribal resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated federal response, and/or during a developing potential health and medical emergency. ESF # 8 also provides the framework for coordinating the transportation of seriously ill or injured patients from an impacted area to designated reception facilities and for directing the federal response in support of emergency medical triage and pre-hospital treatment, patient tracking, and patient distribution.

The NRF uses the National Disaster Medical System (NDMS) under ESF # 8 to support federal agencies in the management and coordination of federal medical response. Administered by HHS, NDMS is a statutory federal partnership that supplements, state, local, and tribal medical resources during public health emergencies, major disasters, emergencies, or military contingencies. The NDMS also has its own statutory authority, which allows it to deploy, whether or not in a Stafford Act incident, to support the medical response activities of state, tribal, and local governments overwhelmed in disaster situations – including medical evacuations – under its own statutory authority. Each of the NDMS federal partners has specific responsibilities in the event of an evacuation.

If an incident occurs that requires medical or public health expertise but the President does not declare a major disaster or emergency under the Stafford Act for the event, the Secretary of HHS may assume responsibility for coordinating the health and medical services provided by all federal departments and agencies. Such action by HHS is likely to precipitate the activation of the NRF and ESF # 8.

HHS may determine it is appropriate to declare a public health emergency under its authority, when the HHS Secretary determines that a disease or disorder presents a public health emergency, or a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. In an event where the state, local, or tribal authorities determine an evacuation of medical patients is needed and local transportation resources are not sufficient to satisfy the demand, pursuant to the NRF, ESF #8, and its own authorities, HHS may provide support to state, tribal and local authorities. With respect to medical evacuation, HHS may request support from the Department of Homeland Security (DHS)/FEMA in providing transportation assets, including accessible transportation for populations with medical needs.

FEMA's Medical Evacuation Planning and Preparedness Activities

FEMA's support to and involvement in medical evacuation planning and preparedness activities falls into two key areas:

1. In support of state, local and tribal governments, FEMA is working with these governments on an ongoing basis to provide guidance on incorporating medical evacuation planning into their emergency operations plans, as well as providing technical assistance to facilitate their medical evacuation planning. Many of the grant programs administered by FEMA can be used to support evacuation-related activities, including: the Homeland Security Grant Program, the Urban Area Security Initiative, the Metropolitan Medical Response System, and the Regional Catastrophic Preparedness Grant Program. The Regional Catastrophic Preparedness Grant Program in particular promotes planning for both evacuations and the reception of evacuees, and it emphasizes the need to work with potential host communities to develop agreements prior to incidents.

2. On the federal level, FEMA is developing federal-level catastrophic disaster response plans in partnership with states and local communities that include evacuation and medical evacuation elements. This planning includes critical current and future disaster response operational analyses, preparation of contingency and concept of operations plans, and crisis

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action planning to ensure that FEMA can lead and improve national all-hazard disaster responses. It also provides national and regional operational planning guidance and coordination; ensures coordination of operational level execution of all-hazard contingency plans; provides forecasting and analysis of potential events; supports operational planning at the regional level; and leads the development of DHS and FEMA hazard-specific contingency plans.

FEMA's Medical and Patient Evacuation Support

Many Federal Departments and Agencies have resources and expertise that are critical to life-saving operations, and provide significant support to the local response and recovery process. The Stafford Act authorizes FEMA to direct other federal departments and agencies to utilize their own resources in support of state, tribal, and local assistance efforts. Title 44 of the Code of Federal Regulations contains regulations for implementing disaster assistance programs under the Stafford Act and regulations on the contents and processes for Mission Assignments (MA). FEMA uses the MA as the interagency process to task and reimburse other Federal Departments and Agencies to provide essential direct assistance. The MA cites funding, provides managerial controls, and provides guidance on completing the task at hand.

Under the Stafford Act, FEMA, through the Federal Coordinating Officer (FCO), receives requests for resources from state, tribal, and local governments to address numerous unmet needs. FEMA uses MAs to task the appropriate department or agency to provide support to the governmental entity. In anticipation of, or in response to, a Presidential declaration of a major disaster or emergency, FEMA can issue MAs to support medical response and evacuation activities. FEMA typically assigns NDMS to deploy under ESF #8 to support the medical response activities of state, tribal, and local governments overwhelmed in disaster situations. FEMA, HHS, the Department of Defense (DOD), and the US Coast Guard have worked together to develop Pre-Scripted Mission Assignments (PSMA) that are specifically available to request medical support capabilities. For example among the multiple PSMAs related to medical support:

- HHS: the PSMA tasks HHS to provide medical evacuation of seriously ill or injured patients in support of disaster operations;
- DOD: the PSMAs requests DOD to make available deployable temporary medical facilities for use in evacuations, and to provide aircraft and personnel to support medical patient evacuation in support of ESF # 8;
- US Coast Guard: the PSMA tasks the Coast Guard to provide aircraft transportation for medical cargo and personnel evacuation.

In support of patient and medical evacuation, FEMA also administers a contract that is used in support of ESF # 8 to provide ambulance and para-transit services in support of medical evacuations. FEMA has responsibility for the administrative aspects of the contract but HHS has operational control when it is activated in support of ESF # 8.

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FEMA's Public Assistance (PA) and Individual Assistance (IA) Programs under the Stafford Act Supporting Medical Evacuation

Sections 403 and 502 of the Stafford Act authorize federal agencies to provide assistance, including emergency medical care, in order to reduce or eliminate immediate threats to life and property resulting from an emergency or major disaster.

When the emergency medical delivery system within a designated disaster area is severely compromised or destroyed by a disaster event, FEMA may reimburse state, tribal, and local governments and certain private non-profits for the cost of extraordinary emergency medical care and medical evacuation expenses under the PA Program. Assistance for emergency medical care and medical evacuations of disaster victims from eligible public and private nonprofit hospitals and custodial care facilities may be available. State, tribal, and local governments lacking the capability or resources to perform or contract eligible emergency medical care or medical evacuation work may request Direct Federal Assistance from FEMA.

Medical care costs are limited to emergency medical care. Costs incurred once a disaster survivor is admitted to a medical care facility on an inpatient basis are not eligible for reimbursement from the FEMA PA Program or Direct Federal Assistance. However, if an evacuation is required, there may be eligible costs incurred by an eligible applicant (state/local/tribal governments and certain private non-profit organizations) in the evacuation and transportation of patients, such as the use of emergency medical service personnel or ambulatory services. FEMA is prohibited by Section 312 of the Stafford Act from approving funds for reimbursement for services that are covered by any other source of funding; therefore, costs covered by, for example, private insurance, Medicaid, or Medicare are not eligible for reimbursement from FEMA.

At the local level, patients may travel to sites established by NDMS via personal or local transportation assets for evaluation and treatment by NDMS medical teams at the sites. Patients who require care beyond the local capacity or that were provided care at NDMS sites may be further transported via NDMS or DOD assets to an NDMS, DOD or VA Federal Coordinating Center (FCC). The FCC may then send the patient forward to an NDMS-participating civilian medical facility. Once evacuated patients are released from an FCC facility, FEMA, working with HHS, coordinates with federal, state, tribal, local, and voluntary agencies to provide further assistance to the evacuated patients, including their return.

If an event causes the President to make a major disaster declaration, which includes IA programs, FEMA may provide eligible disaster survivors who register for Federal assistance with the full range of approved IA Programs such as the Individual and Households Program (Housing and Other Needs Assistance), Crisis Counseling and Training Program, Disaster Case Management Program, Disaster Unemployment Assistance Program, and Disaster Legal Services Program, as well as referrals to the Small Business Administration for low interest loans.

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Closing

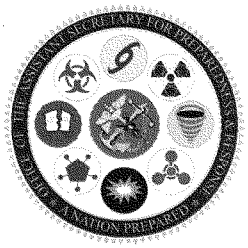
We know that some future disasters may seriously threaten and damage local medical facilities. With the appropriate preparation and coordination of Federal agencies, working together with states, localities, tribes, and voluntary agencies, we can meet the great challenges presented to the public in these instances where mass medical evacuations are required.

I am pleased to answer any questions you may have.

Testimony
Subcommittee on State, Local, and Private Sector Preparedness and Integration
Committee on Homeland Security and Governmental Affairs
United States Senate

The Key Role of NDMS in Disaster Response

Statement of
Kevin Yeskey, M.D.
Deputy Assistant Secretary for Preparedness and Response
Director, Office of Preparedness & Emergency Response
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services



For Release on Delivery
Expected at 10:00 am
Thursday July 22, 2010

Good morning Chairman Pryor, Ranking Member Ensign, and Members of the Subcommittee. Thank you for the opportunity to discuss the National Disaster Medical System (NDMS) and the key role it plays in our nation's response to disasters. I have been a part of NDMS since 1987, as a team physician and Team Commander. I have also served as the Chief Medical Officer for NDMS and have deployed to numerous incidents as part of NDMS.

NDMS remains one of the most significant federal medical response resources and has a long history of responding to natural and man-made disasters in this country. Most recently, NDMS responders were deployed to Haiti to provide care for victims there. Additionally, NDMS patient movement and definitive care functions were activated to evacuate and care for victims brought to the U.S. NDMS is also an organization that continues to evolve and improve as it learns from previous responses through a robust corrective action program instituted at HHS.

HHS may activate the NDMS to provide aid to victims of a public health emergency or to be present at locations at risk of a public health emergency. Under the National Response Framework (NRF), HHS is the lead federal agency for Emergency Support Function #8 (ESF#8): Public Health and Medical Services. NDMS is an integral part of our response capability that can be activated by HHS to provide assistance through ESF#8 of the NRF for incidents in which the Department of Homeland Security assumes overall Federal incident

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management coordination responsibilities in accordance with the NRF and HSPD-5. HHS may also activate the NDMS to provide assistance in accordance with our own authorities if necessary. Further, through interagency agreements under the Economy Act or other applicable authorities, HHS may activate the NDMS for incidents where other Departments, such as the Department of State, have the lead responsibility for providing assistance. Teams from NDMS provide health care, deceased victim identification, patient movement, and veterinary care.

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NDMS was conceived in 1981 as an evolution of the Civilian–Military Contingency Hospital System developed by the Departments of Defense (DOD) and Veterans Affairs (VA) to care for casualties exceeding the capacity of DOD and VA hospitals. NDMS is an interagency cooperative effort among HHS, DOD, VA, and DHS. Through the partnership of these federal agencies, in conjunction with States, private sector institutions and medical professionals appointed to federal service, NDMS developed the capabilities for medical response, patient evacuation, and hospitalization in times of disasters. NDMS has been managed by HHS since its inception, except for a four-year period (2003-2006) when it was transferred to DHS. In 2007, it was returned to HHS as a result of the Department of Homeland Security Appropriations Act, 2007, and the Pandemic and All Hazards Preparedness Act. It is now part of in the Office of the Assistant Secretary for Preparedness and Response (ASPR), Office of Preparedness and

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Emergency Operations. The ASPR, under section 2811 of the Public Health Service Act, has the authority to activate NDMS.

Currently, NDMS has 7,856 employees who are intermittent federal employees and are used intermittently for federal deployments, authorized training, and day-to-day activities required to manage the 95 response teams within the system. NDMS also has approximately 1,700 participating hospitals that agree to receive patients during disasters and upon activation of the NDMS. When HHS requires patient evacuation, the DOD moves patients to one or more pre-designated locations. These locations are called Federal Coordination Centers (FCC).

There are 72 FCC locations nation-wide. The FCCs work with local and state emergency management and health departments to coordinate the distribution of patients to non-federal NDMS-participating hospitals. Participating hospitals are recruited by the FCCs and all of them sign a memorandum of understanding with NDMS that outlines the duration of treatment and the payment schedule for NDMS patients. Hospitals agree to seek reimbursement from NDMS only after seeking reimbursement from all other payors, such as health insurers or TRICARE, except another Federally recognized payer of last resort, such as Medicaid. For Medicaid patients and patients who do not have health insurance coverage the NDMS reimbursement rate is equal to the Medicare payment amount for definitive care plus 10 percent. For patients with health insurance who are not Medicare or TRICARE beneficiaries, NDMS will pay the difference

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between the amount paid by the health insurance coverage and the amount payable at 110% of the Medicare payment amount. In other words, currently NDMS reimburses after private insurance and before Medicaid, up to 110 percent of the Medicare payment amount. NDMS does not reimburse hospitals for Medicare beneficiaries.

NDMS has three components: medical care, patient movement, and definitive care. Medical care is provided by Disaster Medical Assistance Teams (DMATs), which are staffed by federal intermittent employees with an indefinite appointment. These employees are activated as needed and are paid when deployed during times of response. In addition to the DMATs, NDMS has other more specialized teams, including the Disaster Mortuary Operational Response Teams (DMORTs) and National Veterinary Response Teams (NVRTs), which perform deceased victim identification and animal health care, respectively. Our International Medical Surgical Response Team (IMSURT) provides critical care and life-saving surgery for victims. NDMS teams provide both acute and primary care in field facilities and also can augment local hospitals.

NDMS is structured to respond quickly. In response to the Haiti earthquake, NDMS deployed over 1,200 personnel beginning within 24 hours of the request for assistance, and remained engaged for over six weeks. DMATs are placed on a rotating call schedule that enables us to maintain a ready roster of teams and equipment available for deployment on short notice.

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The second component of NDMS is patient movement, for which collaboration with DOD and VA is essential. DOD has the lead for providing air assets for movement out of the affected area. DOD staff establish points of embarkation, provide medical care at the airhead, and provide aircraft and medical staff for the transport of patients to be evacuated. In addition to the DOD resources, FEMA has established a national ambulance contract. This contract provides ground ambulances, air ambulances, and para-transit buses for short distance patient evacuation. The ambulance contract was developed to address a gap analysis conducted jointly by FEMA and HHS in preparation for the 2006 hurricane season. The ambulances provided through this contract are incorporated into states' emergency response to support local evacuation efforts. Following evacuation and hospitalization, HHS is responsible for returning patients to their home state and utilizes private contractors to perform that function.

The final component of NDMS, definitive care, is defined as the provision of inpatient hospital services in NDMS-participating hospitals to patients affected by a disaster. Bed availability is assessed via bi-monthly bed counts conducted by VA and DOD. Civilian hospitals participate on a voluntary basis and agree to provide available beds when requested by NDMS. Patient distribution is coordinated by the local FCC in conjunction with the state and local emergency management departments.

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Recent Improvements to NDMS

Since NDMS has returned to HHS, it has been called upon to respond to hurricanes, earthquakes, floods, ice storms, and a variety of National Special Security Events (NSSEs), including the 2009 Presidential Inauguration. NSSEs provide an important way for teams to train and practice while providing service during real events, an important efficiency measure. In 2010 alone, NDMS has deployed over 1,700 personnel. In addition, NDMS activated two Federal Coordination Centers to accept evacuated patients from Haiti. NDMS implemented a corrective action program that reviews every response and exercise to identify ways to improve the capability to respond to future disasters as well as operational efficiency and cost-effectiveness. We learn from every event.

Logistics changes

HHS has taken several actions to enable responding teams to deploy faster when activated and to reduce costs. A major action has been the consolidation and restructuring of our team and regional warehouses. This has resulted in increased standardization of equipment caches, has improved maintenance of the equipment and supplies and has decreased waste. HHS has established two regional warehouses and has consolidated nine smaller warehouses into other existing warehouses which have resulted in an annual savings of over $900,000. Over the next two years, additional warehouses will be consolidated to maximize

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standardization and enhance our readiness and efficiency. The additional consolidation will result in an annual savings of $1.8M.

Medical equipment and supply caches are also being modularized so they can be deployed in more scalable and mission appropriate configurations. Caches for pediatric care and critical care are already under development.

Team Changes

NDMS team structure is undergoing substantial changes that will enable NDMS to respond more effectively. The DMAT structure has been modularized to enable greater flexibility for response. Sixteen new teams have been created to expand the depth of response capability. We have also been working with various professional organizations to roster specialists in pediatrics, surgery, and critical care. These medical and surgical specialists will be deployed when their specific skills are required.

NDMS has also supported HHS Service Access Teams (SAT), which serve as patient case managers for patients evacuated to NDMS hospitals. The SATs track patients from the point of debarkation through hospital discharge. They arrange post-hospital medical follow-up care and coordinate the disposition of patients after discharge, including transportation back to their originating medical care facility, long-term care, home of record or a temporary location until they can

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be received in their home state. The SATs were successfully deployed to Atlanta and Tampa for NDMS patient reception during the Haiti response.

Patient Movement

HHS has convened the Senior Leaders Council on Patient Movement, which consists of senior-level personnel from the VA, DOD, and DHS. This group provides a mechanism to coordinate activities across the NDMS partnership regarding the evacuation of victims, their tracking through the system, and their return.

NDMS has developed the Joint Patient Assessment and Tracking System (JPATS) as a means of tracking patients as they move through the NDMS. JPATS complements our electronic medical record (EMR), which has been used for several years in NDMS. The JPATS and the EMR represent a more effective way to manage clinical information and to more effectively transfer patient information through the echelons of medical care in a disaster. We have also used data obtained from the EMR to perform near "real time" surveillance of specific diseases and to assist in determining the demobilization of our teams. JPATS enables NDMS to better track patients as they are evacuated and to convey that information to hospitals and families. The NDMS FCCs have been trained in JPATS and used the system in the Haiti response. NDMS has plans to train hospitals on JPATS so they, too, can use it when they receive NDMS patients.

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Twice in the past, HHS has put in place contracts for returning patients and is in the final stages of contract negotiations to put in place a longer term mechanism to return patients to their home/hospital once the affected area is safe and the patient is medically able to return. It is our intent to have a contractor on retainer that can be engaged when its services are needed.

The 2008 Hurricane Season – Gustav and Ike

HHS greatly appreciates the contributions made by Little Rock, Arkansas to victims of Hurricane Gustav. We also have great respect for the Arkansas Hospital Association for raising concerns about our performance during the 2008 hurricane season. They have challenged us to do better and have been collaborative in helping us achieve a higher standard of response. NDMS recognizes that there were difficulties with the return of patients from Arkansas to Louisiana after Hurricane Gustav. Little Rock hospitals maintained responsibility for patients long after their medical needs were addressed. The mitigating circumstances of Hurricane Ike were partially responsible for delays in returning patients to Louisiana. However, not all problems were a result of Ike's impending impact. In our corrective action process, several issues were identified and changes have been implemented that should all but eliminate those problems from recurring.

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To date, ASPR leadership has met with the Arkansas Hospital Association three times, most recently in May 2010. Regional ASPR staff have communicated with them and the Arkansas Department of Health, as well.

We are working with the Department of Veterans Affairs and local offices to determine a suitable place for an HHS-staffed Federal Medical Station in Little Rock, Arkansas, which would serve as a temporary medical facility for patients who were ready for discharge but unable to return home. HHS has also worked with Louisiana to establish a 250-bed Federal Medical Station in northern Louisiana, which will serve as a temporary receiving location for patients discharged from Arkansas hospitals if the patients are not able to return to their home of record or starting location. We will deploy our SATs early to assist in the case management of evacuated NDMS patients. As mentioned previously, we are awarding a standing contract that will make non-emergent medical transport available to return evacuated patients to their homes or other receiving facility.

We are confident that the improvements made to NDMS and the newly implemented efforts dedicated to improving patient return will minimize recurrence of delays experienced by Arkansas hospitals in the 2008 hurricane season. NDMS has been a responsive and valuable national resource for over 25 years. We are committed to a continuous improvement process that will enable NDMS to remain flexible and responsive to current and new threats. Thank you for allowing us the opportunity to participate in this hearing. I am happy to answer any questions you may have.

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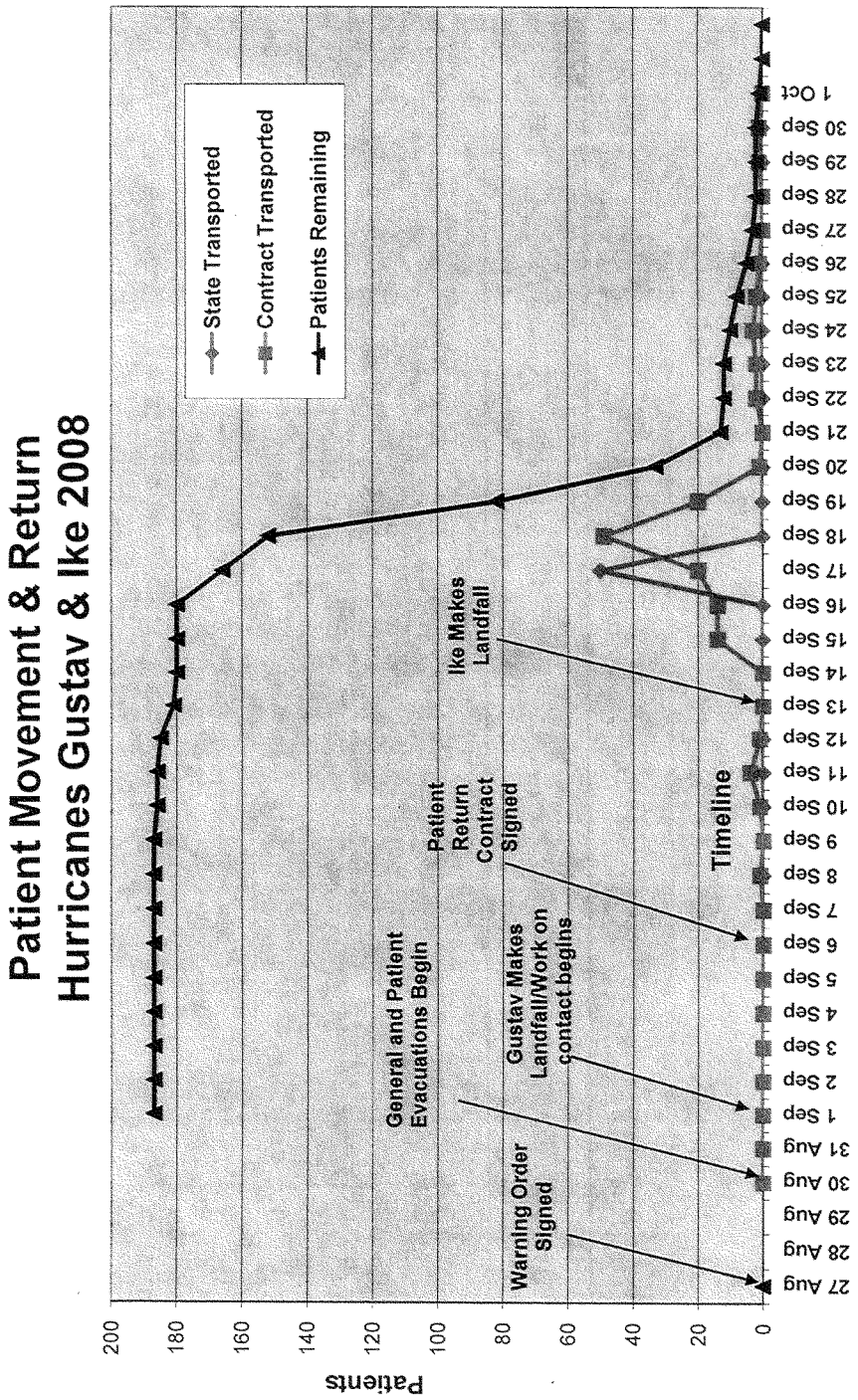
Patient Movement & Return
Hurricanes Gustav & Ike 2008
State Transported
Contract Transported
Patients Remaining
Warning Order Signed
General and Patient Evacuations Begin
Gustav Makes Landfall/Work on contact begins
Patient Return Contract Signed
Ike Makes Landfall
Timeline
Patients
200
180
160
140
120
100
80
60
40
20
0
27 Aug
28 Aug
29 Aug
30 Aug
31 Aug
1 Sep
2 Sep
3 Sep
4 Sep
5 Sep
6 Sep
7 Sep
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Arkansas Hospital Association
Written Comments for the
Ad Hoc Subcommittee on State, Local, and
Private Sector Preparedness and Integration
Homeland Security Committee
U.S. Senate
Dirksen Office Building
July 22, 2010

Introduction:

Thank you, Mr. Chairman and members of the committee.

My name is Paul Cunningham and I am the Sr. Vice President of the Arkansas Hospital Association in Little Rock, Arkansas.

I am here today speaking on behalf of a dozen hospitals located in and around the Metropolitan Little Rock area which were, until June 1 of this year, voluntary participants with the National Disaster Medical System (NDMS) and were a part of the only activations in the NDMS' 25-yr. history of civilian hospitals for the combined purposes of patient evacuation and definitive medical care following disasters that occurred on U.S. soil.

During the most recent activation in 2008, our hospitals identified several problems in the system and we have been working for almost two years to resolve those issues, but without measurable progress.

The NDMS serves as a single integrated national medical resource for responding to mass casualty events. The original purpose was that NDMS would be available and employed to care for a massive number of casualties resulting from domestic disasters in any area of the country, such as a hurricane or earthquake, and also would be a reserve stateside resource to provide medical care for injuries suffered by civilians and troops in an overseas conventional war.

More recently, that purpose has been expanded to include the response to care for even greater numbers of casualties that could occur if ever a weapon of mass destruction is deployed as part of a terrorist somewhere in America. For that reason, the NDMS must be a key component of an overall Homeland Security strategy.

We believe this newest threat, which all Americans hope never occurs, makes it essential that the problems discovered during Arkansas' experience be addressed and corrected in order to strengthen the NDMS and ensure that it is a viable Homeland Security resource with capabilities to better respond to any type of future mass casualty events wherever they might occur in our country.

The Issue:

Almost two years ago, NDMS participating hospitals in and around Little Rock took in and cared for 225 patients who were included in an evacuation from southern Louisiana prior to the landfall of Hurricane Gustav. Our hospitals continued that care for nearly a month, or more in some cases, waiting for Gustav, and then Hurricane Ike, to clear the area to allow the return of those patients to their home state. During that time, it became clear that the NDMS

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Memorandum of Agreement with its hospitals needs substantial revisions to make the program more viable for future events.

Efforts to get our concerns addressed date back to late September 2008. Other issues arose in 2005, when Arkansas' NDMS hospitals were placed on alert in the wake of Hurricanes Katrina and Rita, but received only a few patients from among the 1,800 who were evacuated by NDMS from Louisiana at that time. Many problems identified during the NDMS evacuation from New Orleans after Katrina were later dealt with, and that attention resulted in a smoother process when patients were transferred from hospitals along the LA Gulf Coast to Little Rock facilities in 2008, prior to Hurricane Gustav.

The failure to make similar progress in getting the concerns identified during the 2008 activation addressed prompted the Little Rock area hospitals to withdraw their NDMS participation last month, on June 1.

While there has been progress during the past few months, working with HHS Assistant Secretary of Preparedness and Response, Dr. Nicole Lurie, and Dr. Kevin Yeskey, Deputy Assistant Secretary, Office of Preparedness and Emergency Operations, there has been no specific action to address our proposed revisions that were submitted in June 2009, with hopes that at least some of the changes could be incorporated before the 2010 hurricane season began last month, on June 1. They were not.

While the Little Rock hospitals want to do the right thing by working in conjunction with the NDMS to care for inpatients subject to unexpected emergency evacuations from other states, they can't do so if it means placing patients in their own community or their own organizations at risk when doing so.

Operating under the existing Memorandum of Agreement during the 2008 activation, hospitals encountered situations which put the health of local patients in jeopardy by creating a need to postpone their elective admissions and procedures for days and weeks while trying to accommodate patients from Louisiana who experienced extended stays beyond their control.

At the same time, hospitals that are already laden with financial challenges related to inadequate payments from all sources, found themselves battling with NDMS, HHS and CMS to recoup even a portion of their costs associated with their good faith efforts.

The Memorandum of Agreement between the NDMS and its participating hospitals needs to be revised because the success of the federal/state partnership hinges on an arrangement which creates no obstacles to hospitals' voluntary participation. The array of problems incurred by Arkansas hospitals during NDMS patient evacuations in 2008 ought to be sufficient grounds to conclude that the current MOA fails to meet that standard. We think our suggestions are reasonable and would resolve many of those concerns.

NDMS Purpose

As you know, the NDMS was created in 1983 by Executive Order of President Ronald Reagan with the intent to:

- Create a system whereby civilian hospital beds could be used in the event of a disaster within the U.S. and
- Create Disaster Medical Assistance Teams (DMATs) who could respond to those disasters.

Originally, the system was placed under the administrative authority of DHHS' Public Health Service and assigned two specific missions:

- Primary: Backup medical support for DoD and VA during conventional overseas conflicts
- Secondary: Supplement state and local emergency resources during disasters and emergencies

After 9/11, the mission was expanded to include medical response to terrorist attacks.

NDMS remained there a part of the PHS until 2002, when Congress gave it statutory legitimacy under the *Public Health Security and Bioterrorism Preparedness and Response Act of 2002*, and transferred it from DHHS to FEMA; then, in early 2003, FEMA (along with NDMS) was moved to the Department of Homeland Security.

After Hurricane Katrina in 2005, NDMS moved again on January 1, 2007 via the *Pandemic and All-Hazards Preparedness Act of 2006* and was placed under DHHS once more with a new mission to *"Lead the Nation in preventing, preparing for, and responding to the adverse health effects of public health emergencies and disasters"*

Currently, NDMS located in the DHHS Office of Preparedness and Emergency Operations (OPEO) which reports to Assistant Secretary for Preparedness and Response (ASPR) Nicole Lurie, M.D. It includes around 1,800 U.S. hospitals and 100,000 beds; although in any given year the actual involvement typically is very small.

NDMS Activations

NDMS deployments may only be activated by the President via a Stafford Act declaration, or by DoD, or by the HHS Secretary. These activations include three program components:

- **Deployable medical response teams** for the deployment of response teams that provide assessments of medical and health needs, primary and emergency medical care, health and medical equipment and supplies, victim identification and mortuary services, veterinary services, and other auxiliary services at the site of an emergency. Examples of NDMS response teams are DMATs—disaster medical assistance team, DMORTs—disaster medical disaster mortuary operational response teams, and DVATs—disaster veterinary assistance teams. (3, 4-6) Incidentally, NDMS documents curiously define the term "auxiliary services" as "mortuary services, veterinary services, and other services.
- **Patient evacuation** involves communication, transportation, and a medical regulating system by NDMS to evacuate patients from a mobilization center near the disaster site to reception facilities where they may receive definitive medical care, and to communicate evacuation information to federal, state, and local authorities. The first time the NDMS was used for evacuation of a very large number of patients from hospitals and nursing homes was during the Hurricane Katrina disaster.
- **Definitive medical care** (through NDMS Hospitals) is the component for providing public health emergency, medical treatment or services beyond emergency medical care, initiated upon inpatient admission to an NDMS hospital and provided for injuries or illnesses resulting directly from a specified public health emergency, or for injuries, illnesses and conditions requiring non-deferrable medical treatment or services to

maintain health when such medical treatment and services are temporarily not available as a result of the public health emergency. Definitive medical care is provided through a nationwide network of voluntarily participating, pre-identified, private and federal hospitals. The NDMS reimburses the private hospitals that provide the care, but only partially, subject to the availability of funds.

While there have been numerous NDMS activations over the years, there have been only three activations involving a combination of the Patient Evacuation and Definitive Care components. All were non-Department of Defense activations, two related to Hurricanes Katrina/Rita (2005) and Hurricanes Gustav/Ike (2008), and one following the earthquake in Haiti earlier this year.

Background to Arkansas Experience

Arkansas' NDMS facilities went on alert August 30, 2008, when patients from hospitals in New Orleans and other points in south Louisiana were evacuated to safer places as Hurricane Gustav bore in on the Louisiana Gulf Coast. Eventually, 225 Louisiana hospital inpatients were transported by NDMS to Little Rock and dispersed among 12 Central Arkansas hospitals. Fewer than 10 patients were evacuated to Oklahoma, the only other state involved in the evacuation.

The evacuations, transfers and placement of Louisiana patients into the Little Rock hospitals went relatively smoothly. Most of Hurricane Katrina's lessons from three years earlier were learned well.

Problems began to surface when Gustav had tracked away from southern Louisiana. Although, NDMS had resolved most issues associated with evacuating patients from Louisiana into Arkansas, the details for moving those same patients back to Louisiana were seemingly overlooked. That failure had several consequences that were made worse by the approach of Hurricane Ike quick on the heels of Gustav. By that time, even in cases where there was a way to send patients back to the original transferring hospital, many Louisiana facilities refused to take them back because another hurricane was headed for landfall.

Generally, the problems encountered can be separated into two categories: repatriation and reimbursement.

Repatriation

On August 31, 2008 Hurricane Gustav was predicted to hit the Louisiana Gulf coast within 36 hours. At that time, the State of Louisiana requested activation of the National Disaster Medical System to evacuate hospitals in the storm's path. Eventually, around 225 patients from various Louisiana hospitals were received at 12 hospitals in the central Arkansas area which had agreed by signature of a memorandum of agreement to accept evacuation patients through the NDMS.

This marked only the second time that NDMS had been used to move patients in such a manner. The numbers of patients received in Little Rock at the time compares to the Hurricane Katrina/Rita response for the cities of Atlanta (200) and Dallas (588). Arkansas hospitals received about 30 patients during that 2005 disaster.

When Gustav had cleared the targeted areas in LA, Arkansas' NDMS facilities were ready to discharge the patients and "repatriate" them to LA and the transferring hospitals there. That is when our hospitals first realized that the MOA with does not include repatriation of transported patients. Although the US Air Force is directly involved with evacuation of patients from a

disaster area to a host state, it is not an NDMS resource for getting those same patients back to their home states.

At that time, there was no signed agreement in place with the NDMS contractor, Careflite, which was supposed to return the patients to Louisiana hospitals when it was safe to do so and the patients and their families were ready to return. Once a contract was signed, the contractor apparently did not have sufficient resources to mass transport such a large number of patients (and family members who had made their way to Arkansas and were staying in the hospital with them), in a short span of time, nor was there an interagency agreement with FEMA to support medical transportation for patient return. The brief window was soon closed.

Two weeks into the event weather conditions in Louisiana deteriorated again due to the September 13 onset of Hurricane Ike, extending the patients' stays in Arkansas hospitals even longer.

By the time Hurricane Ike tracked away from LA, almost four weeks after the initial patient evacuation from LA, most patients still remained in Arkansas hospitals. The first patients under the Careflite contract were taken back to LA on September 15. The contractor reported that the company would fly 24 hours a day and transport up to ten patients a day. At this rate, it was estimated take up to eleven days to get the patients home. Instructions from HHS and Careflite changed almost daily, making it confusing for patients, hospitals, and their families.

The delay also increased the workload on hospitals trying to serve the patients to ensure a safe discharge plan for them. Hospitals were forced to make other arrangements in many cases. Those included choices about whether to move the Louisiana patients to local shelters or hotels, or return them to Louisiana using methods outside what was to be provided by NDMS.

Arkansas hospitals were dramatically impacted by this event both in the amount of costs incurred (for much of which they were never compensated), changes in surgery schedules for local patients to accommodate the evacuated patients for longer-than-intended stays and staffing additions, as well as countless hours expended by each hospital's discharge staff trying to arrange for these patients to be discharged.

The delay and NDMS' inability to return patients to LA caused our hospitals to incur unexpected expenses related to commercial air transportation, ambulance transports, rehabilitation care when the patient should have been sent back to their originating hospitals long before they made it to rehab, doubling of staff to meet the needs of patients, medications sent with patients in ambulances, and family members' costs (non-medical meals, clothing and accommodations).

Local patients also suffered the effects of the repatriation problems from having to postpone or delay elective procedures because beds or staffing were not available due to the demands of evacuated patients. The unexpected costs also affected Medicare patients who were among the medical evacuees.

Many of them surpassed their limit of medically necessary days, meaning Medicare would not pay for any care rendered beyond that point. Others may still have been in need of hospital care, but surpassed their benefit period allowable days. (Medicare covers up to 90 days in a hospital per benefit period and offers an additional 60 days of coverage with a high coinsurance. These 60 reserve days can be used only once during a beneficiary's lifetime.) It is reasonable to assume that some may have chosen to dip into their "banked" lifetime reserve days due to the circumstances, forever wasting those covered days.

It is our understanding that ASPR officials are working with FEMA on an interagency agreement to support medical transportation for patient return. Their goal is to have multiple vendor contracts in place well ahead of a disaster. That would be helpful, but it has not been done yet.

Reimbursement

The NDMS agreement is clear regarding reimbursement and offers a reasonable approach for helping to pay for the care of uninsured patients, those on Medicaid and even patients with private insurance coverage. But it fails to understand and adjust for the idiosyncrasies of Medicare rules, particularly those involving patient transfers.

The MOA stipulates that NDMS reimburses up to 110% of the amount Medicare would pay for hospital inpatient care provided to NDMS-evacuated patients who have no health-insurance coverage and whose coverage is limited to Medicaid or other payers of last resort.

For individuals with private coverage (e.g., employment-based coverage), the NDMS Reimbursement Program may make a secondary payment to cover the difference between the full NDMS payment amount and the other payer's (or payers') allowance(s). (Except, NDMS does not cover deductibles and coinsurance associated with patients' private coverage.)

However, if an evacuated patient is covered by Medicare or TRICARE, the hospital must bill the applicable program(s) and accept that reimbursement as full payment. The policy leaves payment for care provided to Medicare patients involved in such evacuations subject to Medicare payment rules, regardless of exigent circumstances. If Medicare doesn't pay, then hospitals are left to absorb the costs, as balance-billing is prohibited, except in specific situations.

Medicare's rule regarding temporary patient transfers, such as those which can occur during evacuation periods, creates a major payment issue. Typically, for transfers between hospitals, the transferring hospital is paid based upon a per diem rate, not the full DRG rate. The payment to the final discharging hospital is made at the full Medicare rate. That works, because the patient does not return to the first hospital.

But, in cases where the patient goes from Hospital A to Hospital B and then back to Hospital A, the full payment still goes to the final discharging hospital (A), while there is no provision to pay an additional amount to the receiving hospital which later returns the patient to the first facility. In those cases, payment to Hospital B is made "under arrangement" with Hospital A. In other words, Hospital B can expect only an amount negotiated with Hospital A for the care provided. During emergency evacuations, there is little time for those negotiations.

In Arkansas' case, HHS eventually ruled that both the hospitals in Arkansas and Louisiana could be paid the full DRG amount for Medicare patients involved in the evacuation, but those decisions did not come until well after the fact. It was not until mid-November that the Arkansas Hospital Association learned that CMS, via authority granted the HHS Secretary through the Stafford Act, had reconsidered its position that its "....policy is that payment is 'under arrangement' only for brief evacuations where the patient returns to the originating hospital. In these cases, we believe the patient has only been temporarily moved to another hospital to allow the emergency to subside and it is still responsible for and directing the patient's care." CMS went on to state, "We have understood that in the AR/LA situation, the evacuating hospital has transferred care to the receiving hospital for an extended stay and the receiving hospital would receive a transfer payment up to the full DRG amount."

Unfortunately, that is not a general policy covering all such situations. HHS must decide whether it applies in each individual emergency event.

The decision came only after Arkansas officials made pleas with CMS to remedy the problem. The lengthy delay could have been averted had Arkansas received a Stafford Act declaration and a so-called §1135 waiver as a disaster area, allowing for such Medicare flexibilities, or, more expeditiously, had Arkansas as a host state been covered for the flexibilities under Louisiana's waiver.

Another problem relates to Medicare's DRG payment system, which limits payment for an admission to a predetermined amount, depending on the patient's reason for being hospitalized, regardless of how long the hospitalization takes.

Following Hurricanes Gustav/Ike, many Medicare patients who were evacuated from Louisiana were hospitalized in Little Rock facilities well beyond their DRG length of stay. Medicare could not reimburse anything for those extra days, unless the patient reached "outlier" status. Nor did Medicare pay for any days that were determined to be medically unnecessary, despite the fact that the patient(s) could not be discharged to home or any other setting, in most cases.

The NDMS payment criteria seem to be the function of policy decisions rather than law or regulation, according to the NDMS Federal Coordination Center Guide (July 2007), which states, "Compensation for NDMS related claims will be paid at rates *contracted* at the time of the disaster for the disaster related Diagnoses."

Other than the shortage of funds, there does not appear to be any reason why NDMS could not also pay for care provided to Medicare (or TRICARE) patients, but which goes beyond the Medicare or TRICARE limits in normal situations (i.e. inpatient days beyond the medically necessary covered days in cases where patients can't be discharged to their home or a post-acute service.)

Ideally, it would make sense to move toward a single policy designed for covering medical costs associated with massive evacuation or disaster responses for all patients. In addition, although NDMS is not responsible for non-medical costs incurred during evacuations, it should work more closely with FEMA to facilitate a process for reimbursing those costs.

It's interesting to note that following the earthquake in Haiti last January, NDMS guaranteed reimbursement to hospitals in Florida, where many injured Haitians were transported for care, at 110% of the Medicare rate for those patients. It seems that international patients are afforded more regard than is extended to Medicare patients, America's senior citizens, who are evacuated for care.

Timeline of Arkansas Efforts to obtain MOA changes:

Following a series of meetings and debriefings about the Gustav/Ike experience, the Arkansas NDMS hospitals initiated actions to obtain changes in the Memorandum of Agreement to be effective before the 2010 hurricane season.

June 5, 2009: Phil Matthews, President, Arkansas Hospital Association, wrote to Rex Oxner, Emergency Management Director for Region VI (and copied to the Assistant Secretary for Preparedness and Response) requesting revisions to the NDMS Memorandum of Agreement and suggesting termination of the NDMS MOA.

August 7, 2009: HHS, CMS, ASPR, OPEO officials met with Arkansas hospital representatives to discuss revisions to the NDMS MOA and reimbursement problems with Hurricane Gustav/Ike patients. Hospitals felt very positive after the meeting that they had been heard, changes would be made and reimbursement issues would be resolved.

August 27, 2009: Mr. Matthews wrote a second letter to Mr. Oxner (and copied to federal officials) stating that hospitals were pleased with actions at August 7 meeting, therefore rescinding their threat of termination of NDMS MOA for the 2009 hurricane season.

Virtually nothing happened during the ensuing period, except that hospitals were finally reimbursed for all NDMS reimbursable expenses (although it took 1.5 years to accomplish this). We received no word that action was being taken on the MOA or other issues raised.

On or about March 1, the AHA contacted our ASPR contact in Region VI asking about MOA. This started some conversation about a possible meeting to discuss issues.

April 7, 2010: Arkansas Metro (NDMS) hospitals passed a motion saying that without resolution on the requested revisions to the NDMS Memorandum of Agreement, the Metropolitan Hospital Association of the Arkansas Hospital Association will rescind their agreement with NDMS effective June 1, 2010.

April 12, 2010: Dr. Nicole Lurie, Assistant Secretary for Preparedness and Response, Emergency Managers for Region VI, and HHS Field Supervisor, Regional Emergency Management, met with Arkansas hospitals to continue discussion. Hospitals were told that no changes would be made to the MOA this year, but that there was a possibility of a "side letter" to "offer an assumption of responsibility and a level of protection for Arkansas hospitals" written in the next few weeks. However, the letter would have to go through ASPR/HHS legal channels, therefore a "status report" on the letter would be written within two weeks.

April 15, 2010: AHA president Phil Matthews wrote to Dr. Lurie, "While Little Rock area hospitals want to do the right thing in assisting with care for inpatients subject to unexpected emergency evacuations from other states, they can't place patients in their own community, or themselves, at risk when doing so. The MOA must get closer attention because the success of NDMS' federal/state partnership hinges on an agreement which creates no obstacles to hospitals' voluntary participation. With that said, please accept this letter as official notice of the Metropolitan Little Rock hospitals' intent to withdraw from NDMS participation, effective June 1, 2010."

May 6, 2010: Dr. Kevin Yeskey, Deputy Assistant Secretary, Office of Preparedness and Emergency Operations, meets with Arkansas NDMS hospitals to review issues and report progress. He states that the MOA can't be changed at this time.

May 17, 2010: Dr. Yeskey issues a side-letter indicating actions that his office can take to resolve many of the issues encountered during Gustav/Ike.

May 24, 2010: Phil Matthews responds to Dr. Yeskey, noting areas where more specific details are needed to convince the Arkansas hospitals to continue NDMS participation.

June 1, 2010: Dr. Yeskey responds to address questions raised by Mr. Matthews.

June 25, 2010: Mr. Matthews send a letter to Dr. Yeskey asking the following:

1. That transportation contracts be signed and in place.

2. That NDMS have a written plan of action for a Federal Medical Shelter clearly stating that if Arkansas hospitals cannot transport patients back to their original hospital or community, NDMS will be responsible for setting up the transfer to Louisiana, or that NDMS will set up and staff a FMS in Little Rock.
3. Additional details about access to patient tracking information.
4. That a meeting be held between service access teams and Arkansas hospital case managers to develop communication lines and build relationships before a disaster occurs.
5. That Dr. Yeskey continue a dialogue with CMS regarding reimbursement options for non-covered Medicare days.

Ramifications of Arkansas Action:

The withdrawal by Metro Little Rock hospitals from NDMS could have broader implications for the program. Most immediate will be the cost of evacuations. Currently, if patients are evacuated from LA, (a strong probability for any hurricane headed for the Louisiana coast line after the issues which occurred during and after Hurricane Katrina in 2005) they are taken to Little Rock, a short one-hour flight from practically any point in southern LA. Not have those resources puts Oklahoma City as the primary evacuation destination, adding another hour to the flight time. El Paso, TX is the next default city and it is further removed than OKC.

NDMS also stands to lose the experience in such patient movements available with the LR hospitals, and there is a possibility that hospitals in other states may also end their NDMS participation if the Agreement is left as is.

Recommendations: Overall NDMS Funding and Operations

NDMS currently operates on an annual budget appropriation of approximately $60 million. According to a 2008 report from an NDMS Assessment panel (http://www.hhs.gov/aspr/omsph/documents/nbsb-ndms-rpt-0809.pdf) the funding level for NDMS is inadequate to support even the current level of the NDMS operation. Every effort should be made to secure adequate, sustained increased funding for the NDMS so it may successfully accomplish its national mission.

The assessment recommended that a minimum of an initial 15 per cent increase in budget should be sought, especially with the increased expectation that NDMS "lean forward" for improved response to potential disasters. Many members of the Panel felt that NDMS would require at least a doubling of its budget to properly achieve its expected level of function. As part of increased funding, serious consideration should be given to performing a systems analysis of the various complex NDMS logistics and systems operations with the intent of improving the efficiency and decreasing the cost of many of these components.

Recommendations by the Center for Biosecurity (http://www.upmc-biosecurity.org/website/resources/hearings/2006/20060405allhazardsmedprep.html) include modifying the Stafford Act to allow for direct reimbursement of hospitals for uncompensated costs and extraordinary hospital care in the event of major catastrophes.

- Hospitals' revenues will decrease dramatically during a pandemic or in other catastrophes, even though they will be experiencing record-high patient volumes. Hospitals will need to provide care to many patients who are uninsured and/or unable to

pay; at the same time operating costs will be extraordinarily high. According to the AHA, the average hospital has only 41 days of cash on hand. Many hospitals would have insufficient cash reserves to survive a severe pandemic or other crisis that significantly interrupts operations for weeks.

- Under current healthcare reimbursement schemes, hospitals lose money on nearly every illness-related hospital admission—especially those, like pneumonia, that are likely to result from flu. Normally, hospitals offset these losses with profitable elective procedures, but these elective cases will be among the first services to be cancelled or deferred in an attempt to respond to the demands of flu patient care during an epidemic.

Reimbursement should continue at 110% of the Centers for Medicare and Medicaid Services' rate. Failure to consider this would severely jeopardize the continued good-faith efforts of the private health care industry to provide immediate post-event care for disaster victims.

Arkansas Request

The Arkansas Hospital Association is seeking assistance in getting NDMS to agree to all or part of its suggested changes to the MOA (attached

At a minimum, our hospitals need NDMS to agree to the following actions:

1. Have contracts for moving patients back to their home state signed and in place prior to an emergency event. This is a huge part of the problem. We appreciate the movement that ASPR has made towards that end, but feel that the contract *must* be in place or our hospitals will continue to be in the same situation as they were in 2008.
2. A written plan of action for the Federal Medical Shelter to be operated in Little Rock during NDMS evacuations clearly stating that if Arkansas hospitals cannot transport patients back to their original hospital or community, NDMS will be responsible for setting up the transfer to Louisiana, or that NDMS will set up and staff a FMS in Little Rock. That written statement would greatly ease our hospitals' concerns about having no option but to keep patients who cannot be discharged to another accountable healthcare organization or setting.
3. Specifics about training Little Rock hospital personnel on patient tracking and allowing them access to the NDMS JPATs.
4. NDMS' commitment for a meeting between the SATs and Arkansas hospital case managers to develop communication lines and build relationships before a disaster occurs. The AHA would be willing to coordinate such a meeting as early as possible.

In addition, if NDMS can't fully cover Medicare patients, then it should agree to reimburse hospitals for the non-covered services provided to Medicare patients up to the same maximum allowed for uninsured, Medicaid and privately insured patients, 110% of the Centers for Medicare and Medicaid Services' rate for all. Failure to consider this would severely jeopardize the continued good-faith efforts of the private health care industry to provide immediate post-event care for disaster victims.

If that absolutely can't be arranged, we ask that HHS and NDMS continue working with CMS regarding reimbursement options for non-covered Medicare days, especially in those cases when a patient is ready for discharge, but must remain in a hospital due to mitigating circumstances.

According to Medicare rules, hospitals are permitted to issue notices of non-coverage to Medicare beneficiaries if the hospital believes that the care a beneficiary is receiving, or is about to receive, wouldn't be covered because it would not be medically necessary, would not be delivered in the most appropriate setting, or would be custodial in nature. On the effective date as specified in this hospital-issued notice of non-coverage (HINN), the hospital may balance bill the patient for the medically unnecessary care.

We believe that, assuming such HINNs are issued by the hospital and signed by the patient, and if the MOA allows for it, then hospitals would be able to bill NDMS (and NDMS pay) for the uncovered days.

The NDMS needs to be a reliable resource for responding anytime, anywhere to mass casualty events in the U.S. It also must be able to stand as a reserve stateside resource to provide medical care for injuries suffered by civilians and troops in an overseas conventional war, or for even greater numbers of casualties that could occur if ever a weapon of mass destruction is employed as part of a terrorist act somewhere in America.

Our intent in trying to amend the NDMS Agreement is meant to safeguard those capabilities.

We hope you agree and will encourage HHS and NDMS to work in tandem with other disaster response groups and with us to make its policies governing patient evacuation and definitive medical care activations less burdensome.

We sincerely appreciate your efforts to move this discussion forward and to look for ways to improve the system both for the impacted state and host state. We look forward to your response and the hope that once again Arkansas hospitals will participate in NDMS patient movement.

U.S. Senate Committee on Homeland Security and Government Affairs
Ad Hoc Subcommittee on State, Local, and Private Sector Preparedness and Integration

Hearing on "A Review of Disaster Medical Preparedness: Improving Coordination and Collaboration in the Delivery of Medical Assistance during Disasters"
July 22, 2010

Submitted: August 5, 2010

Chairman Pryor, Ranking Member Ensign and other Members of the Subcommittee, the Roundtable on Critical Care Policy applauds your commitment to improving the federal government's collaboration and coordination with the private sector to deliver medical assistance during a disaster. We share the Committee's concern that there may be weaknesses in the current federal preparedness and response systems, at least with respect to the delivery of optimal and efficient care for the critically injured and ill, and look forward to working with you to identify ways to improve federal medical response efforts during a health emergency.

When a natural disaster strikes or a pandemic—such as the H1N1 virus—sweeps the nation, the demands on critical care increase exponentially. The nation's ability to respond effectively to such an event depends, in large part, on a strong and adaptable critical care infrastructure. However, the current critical care delivery system faces significant challenges that could potentially impair the nation's ability to maintain an effective medical response. The Roundtable on Critical Care Policy believes that strengthening our critical care infrastructure is an integral component to improving the delivery of health care during an emergency.

Background

Established in 2009, the Roundtable on Critical Care Policy provides a collaborative forum for leaders in critical care and public health to forge and advance a common federal policy agenda to improve the quality, delivery, and efficiency of critical care in the United States. Critical care medicine is the care of patients whose illnesses or injuries present a significant danger to life, limb, or organ function. Each year, five million Americans are admitted into traditional, surgical or neo-natal intensive care units (ICUs)[1], and nearly 80 percent of all Americans will experience a critical care injury or illness as a patient, family member or friend of a patient.[2]

[1] Society of Critical Care Medicine. Critical care statistics in the United States. http://www.sccm.org/AboutSCCM/Public%20Relations/Pages/Statistics.aspx.
[2] [2] Society of Critical Care Medicine, Critical care questions. http://www.myicucare.org/Critical_Care_Questions/Pages/default.aspx.

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Despite the significant role critical care medicine plays in providing high-quality health care—particularly during a medical disaster—critical care is often not recognized as unique and distinct within the continuum of health care delivery. Yet, providers of critical care require specialized training, the care delivered in the ICU is technology-intensive, treatment is unusually complex due to what may be a patient's system—or multiple system—challenges or failures, and the outcomes often have life or death consequences.

Critical Care Delivery System

One of the first steps following a disaster is to immediately evaluate the condition and capacity of the area's health care facilities and availability of medical supplies. However, neither the federal government nor the critical care community currently have reliable and consistent means for assessing the state of existing critical care capacity and resources in the United States on a regional or local basis. A better understanding of our critical care infrastructure on the federal level would help identify areas that need to be strengthened, and inform decision making during a disaster on how to optimize critical care resources.

To appropriately care for the critically injured or ill in the aftermath of a disaster, the government must also be able to activate a sufficient number of medical providers—including doctors, nurses, respiratory therapists and pharmacists—whose specialized training prepares them to care for these patients. The Roundtable is encouraged by Dr. Kevin Yeskey's testimony before the Subcommittee that the Department of Health and Human Services (HHS) is working to recruit more critical care providers to the Disaster Medical Assistance Teams (DMATs). We believe it is integral to the success of the federal government's organized medical response that these teams are comprised of critical care providers.

Expanding the critical workforce must also be a priority within federal health care workforce initiatives. Multiple studies have documented that the demands on the critical care workforce are outpacing the supply of qualified critical care practitioners. Simply put, if there are not enough qualified health practitioners to meet the day-to-day demands of critical care, there are surely not enough to accommodate a surge created by a catastrophic health event, thereby posing a serious obstacle to effective preparedness.

Lastly, our nation's ability to care for the seriously injured or ill, either in a disaster or in other circumstances, is contingent upon much-needed research on the availability, appropriateness, and effectiveness of a wide array of medical treatments and treatment modalities for this patient population. Recent health care initiatives have simply not recognized critical care research as a priority, and we believe this may jeopardize the nation's ability to find innovative and cost-effective treatments for the critically injured or ill.

Summit

This July, the Roundtable convened for the second annual National Summit on Critical Care Policy in Washington, D.C. The Summit brought together thought-leaders from a variety of linked fields to consider specific, detailed recommendations to advance the quality, safety and delivery of critical care in the context of national preparedness, innovation and comparative

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effectiveness, and end-of-life care. The discussions held at the Summit yielded tangible and important recommendations that aim to improve our nation's critical care infrastructure. The Roundtable's Board of Directors is currently finalizing these recommendations and looks forward to sharing them with this Committee.

Thank you for the opportunity to comment on this important issue.

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