



**Testimony**  
**Subcommittee on Management,**  
**Investigations, and Oversight**  
**Committee on Homeland Security**  
**U.S. House of Representatives**

**“Is the Medical Community Ready if Disaster Or Terrorism Strikes: Closing the Gap in Medical Surge Capacity”**

*Statement of*  
**Gregg A. Pane, M.D., M.P.A., C.P.E., F.A.C.E.P.**  
*Director, National Health Care Preparedness Programs*  
*Office of Preparedness and Emergency Operations*  
*Office of the Assistant Secretary for Preparedness and Response*  
*U.S. Department of Health and Human Services*



**For Release on Delivery**  
**Expected at 11:00am**  
**Monday, January 25, 2010**



## **Coordination with the Department of Homeland Security**

HHS supports DHS in its role as the lead for the integrated federal response under the National Response Framework (NRF). Within the NRF, HHS is responsible for coordinating the Emergency Support Function (ESF) #8 – Public Health and Medical Services and ASPR has been designated by HHS as the office to coordinate the federal public health and medical assistance to state, local, territorial and tribal jurisdictions during an emergency

ASPR works closely with the Department of Homeland Security's Office of Health Affairs (OHA) and the Federal Emergency Management Agency (FEMA). At the Headquarters level, ASPR and OHA have weekly telephone meetings to discuss issues and activities of mutual interest. During times of response, DHS and FEMA participate in the ESF#8 teleconferences and they send liaison officers to the HHS Operations Center. HHS also sends liaison officers to the FEMA National Response Coordination Center and to the FEMA Regional Response Coordination Center in the affected area. At the Regional level, HHS has regional emergency coordinators who work closely with the FEMA Regional Administrators to coordinate federal preparedness and response activities within the region. HHS and DHS continue to work on coordinating our grant assistance to States. We have an established working group which is coordinating the programmatic aspects of our respective grants programs. Within each of these important coordination mechanisms, Federal interagency partners also report their activities for group discussion and integration.

## **Regional Emergency Coordinators**

HHS has worked diligently to partner with state, tribal, territorial, and local officials to enhance their level of preparedness and to ensure they can see how HHS will respond to disasters. ASPR Regional Emergency Coordinators work with state/tribal/territorial officials from the Departments of Health, Emergency Management, and Homeland Security to coordinate and enhance preparedness within the region. HHS Centers for

Medicare & Medicaid Services (CMS) regional representatives also take an active role at the local level for hospital preparedness.

To better serve Hospital Preparedness Program (HPP) recipients, ASPR began hiring regional coordinators for the HPP program last year and is scheduled to have a coordinator in each of the 10 HHS regions by the end of this fiscal year.

### **Enhancing State and Local Preparedness**

The Department has awarded over \$350 million in funding to the State of Pennsylvania through the ASPR Hospital Preparedness Program (HPP) and the Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness Program (PHEP). Funding has been allocated for the upgrading of state and local medical surge capacity, including hospital emergency care, communication, exercises and fatality management. A summary of FY 2009 funding provided to Pennsylvania under these programs is below:

| <b>Program</b>                               | <b>FY09 Funding</b> |
|--|---------------------|
| Hospital Preparedness Program                | \$14,103,046        |
| ESAR-VHP in PA                               | \$60,000            |
| Public Health Emergency Preparedness Program | \$22,975,362        |

### **Hospital Preparedness Program**

The Hospital Preparedness Program (HPP) is a program dedicated to enhancing medical surge capacity (<http://www.hhs.gov/aspr/opeo/hpp>). Funding allocations are made through formula cooperative agreements to states based on population, and through competitive grants. HPP funding comes from annual appropriations, as well as certain supplemental appropriations, including \$90 million from the Supplemental Appropriations Act 2009 (P.L. 111-32) and the Emergency Supplemental Appropriations Act to Address Hurricanes in the Gulf of Mexico and Pandemic Influenza, 2006 (P.L. 109-148). Generally, HPP funding is dedicated for hospital emergency facilities,

communications, exercises, and fatality management. Priorities for Medical Surge that were evaluated as part of the state plan review are as follows:

- States have the ability to report available beds which is a requirement in the 2006 Hospital Preparedness Program Cooperative Agreement;
- Effective use of civilian volunteers as part of the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and Medical Reserve Corps (MRC) programs;
- Planning for Alternate Care Sites;
- Development of Health Care Coalitions that promote effective sharing of resources in surge situations, and
- Plans for providing the highest possible standards of care in situations of scarce resources. ASPR partnered with the HHS Agency for Healthcare Research and Quality (AHRQ) in the development of a *Community Planning Guide on Mass Medical Care with Scarce Resources*.

### **HPP Demonstration Project**

Beginning in September 2007, as part of the HPP program discussed above, an HPP demonstration project called the *Healthcare Facilities Partnership of South Central Pennsylvania*, was initiated in Hershey, Pennsylvania. The Partnership was designed to improve surge capacity and to enhance community and hospital preparedness for public health emergencies in defined geographic areas within the South Central Pennsylvania region and was successful in achieving the following goals:

1. Enhanced situational awareness of capabilities and assets in the South Central Region of Pennsylvania;
2. Develop and pilot test advanced planning and exercising of plans in the Region;
3. Complete written Medical Mutual Aid Agreements between health care facilities in the Region, with a special emphasis on hospitals;

4. Develop and strengthen Partnership relationships through joint planning, frequent communication, simulation, and evaluation of preparedness;
5. Ensure National Incident Management System (NIMS) Compliance, including for the 14 new NIMS activities, for all hospitals in the Region;
6. Develop and test a plan for effective utilization of ESAR VHP volunteers.

The Partnership provided exercise solutions through the development and facilitation of three high fidelity simulations. To date it has provided simulation training to over 1,000 personnel within the 17 institutions in the subject areas of: Pandemic Influenza Epidemic, Blast/ Mass Casualty and Hospital Evacuation. It also promoted mutual collaboration and problem solving with the acute care hospitals through frequent exercises.

Recognizing the importance for continued training and evaluation in the areas of preparedness, the Partnership will use a mobile training and evaluation vehicle, called "Lion Reach" to provide a multitude of training opportunities for the south central Pennsylvania region. The Lion Reach training vehicle will support the partnerships ongoing efforts to sustain the gains already achieved.

### **ESAR-VHP**

The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) is a national program intended to help health professionals volunteer in public health emergencies and disasters and to ensure the availability of volunteers for quick exchange between jurisdictions. The ESAR-VHP program is working to establish a national network of systems, each maintained by a State or group of States, for the purpose of verifying the credentials, certifications, licenses, and hospital privileges of health care professionals.

ESAR-VHP in the State of Pennsylvania is known as the State Emergency Registry of Volunteers in Pennsylvania, or SERVPA, which is fully operational. Pennsylvania meets the ESAR-VHP compliance requirements and works to continue adopting and implementing the *Interim ESAR-VHP Technical and Policy Guidelines, Standards, and Definitions*.

### **Public Health Emergency Preparedness Program**

From FY 2002- FY 2009, the Public Health Emergency Preparedness (PHEP) program has provided \$245 million to the state of Pennsylvania. This amount includes targeted funding to support medical surge and the public health workforce. The PHEP may be found at [www.bt.cdc.gov/cotper/coopagreement](http://www.bt.cdc.gov/cotper/coopagreement).

Generally, this program has greatly increased the preparedness capabilities of public health departments:

- All states can receive and evaluate urgent disease reports 24/7, while in 1999 only 12 could do so.
- All states now conduct year-round influenza surveillance.
- The number of state and local public health laboratories that can detect biological agents as members of CDC's Laboratory Response Network (LRN) has increased to 110 in 2007, from 83 in 2002. For chemical agents, the number increased to 47, from 0 in 2001. Rather than having to rely on confirmation from laboratories at CDC, LRN laboratories can produce conclusive results. This allows local authorities to respond quickly to emergencies.
- All states have trained public health staff roles and responsibilities during an emergency as outlined in the Incident Command System, while in 1999 only 14 did so.
- All states routinely conduct exercises to test public health departments' ability to respond to emergencies. Such exercises were uncommon before PHEP funding.

PHEP has helped to improve the preparedness capabilities of the state of Pennsylvania through the following initiatives:

*Citizen Education and Preparedness Outreach Campaign (CEPOC)*

The Pennsylvania Department of Health (PA DOH), Office of Public Health Preparedness (OPHP) along with the Pennsylvania Emergency Management Agency (PEMA) and other state agencies worked together to implement a multi-year CEPOC. This CEPOC is designed to reach all Pennsylvanians and provide all-hazards public health education information. The focus of the PA DOH CEPOC is to mitigate mortality and morbidity and minimize public health infrastructural damages during a manmade or natural event.

The Pennsylvania Emergency Management Agency (PEMA), with support from the Pennsylvania Department of Health (PA DOH) and other state agencies, created a centralized emergency planning resource repository that provides consistent preparedness messaging in the Commonwealth, called READYPA. READYPA provides direction and information to citizens and communities on the importance of being prepared by highlighting personal preparedness strategies. The theme of the campaign is: Be Informed, Be Prepared, and Be Involved. A phone line, 1-888-9-READYPA, was launched in January 2009.

*Special Medical Needs Response Plan*

Pennsylvania drafted a Special Medical Needs Response Plan -- a comprehensive, standardized special medical needs response plan with a county and regional approach that is completely integrated into Pennsylvania's emergency response program. It is designed to guide local response efforts, identify the population, their location and their needs and resources for an effective and timely emergency response. Temple University has pilot tested the draft Special Medical Needs Evacuation and Response template and Special Populations Planning Guide for first responders. The guide is

designed to be a tool for local responders in developing a localized plan specific to the communities they serve. With this tool, the local, regional, and state response agencies will have a framework to further assist in developing localized plans for their target communities with special needs, including providing adequate staffing during an emergency, and allowing sufficient time to train the responders

## **Communication**

HHS employs a variety of mechanisms to ensure that communications with states remains operational at all times. Most of our communications are directed to the state Health Departments who then distribute that information to local organizations. Our Regional Emergency Coordinators are in regular communications with their state counterparts. Our HPP leadership conducts monthly calls with their grant recipients, usually the state HPP project officer, monthly. During responses within a state, ASPR increases the frequency of the communications with the states. We have liaison officers in the state EOC. After responses, we conduct after action sessions to assess our response and we invite state/local representatives to provide input.

With regard to communications with clinicians, HHS conducts teleconferences with providers who can then speak with subject matter experts. For example, during the ongoing H1N1 pandemic, CDC conducted calls with providers to answer questions regarding the disease and its treatment. ASPR held teleconferences with critical care clinicians to discuss the care of patients who required intensive care. HHS also conducted calls with CMS to inform hospitals about their options regarding alternate care sites and other capacity expanding mechanisms.

Other mechanisms to communicate with our state, local, tribal, and territorial partners incorporate electronic means. CDC has both the Health Alert Network, which sends out electronic notices of health related issues of interest and the Epi-X program, which

notifies state epidemiologists of disease outbreaks of interest and provides an electronic bulletin board for them to hold discussions.

Both CDC and ASPR have websites which contain updated information on preparedness and response. Individual providers, as well as the general population have access to critical information relating to preparedness and response.

### *HAvBED*

HHS also has developed a mechanism to maintain situational awareness of hospital status. The "Hospital Available Beds in Emergencies and Disasters" (HAvBED) was developed by HPP in conjunction with the Agency for Healthcare Research and Quality as a means of collecting surge bed status in the time of a disaster. Use of this system (or compatible systems) is required by the Hospital Preparedness Program. Originally, this system required reports of available beds, including a count of available adult and pediatric general beds and ICU beds, to State and HHS emergency operations centers within four hours of request. During the H1N1 pandemic, the system was modified to collect information that might indicate healthcare system stress, as reflected by emergency department status and anticipated supply shortages. This information has been collected weekly. Within 48 hours of collection, information is analyzed and any concerns are passed back to state Health Departments through the RECs for action.

The declaration by the President of H1N1 as a national emergency, coupled with the Secretary's Declaration of a Public Health Emergency, provides authority under section 1135 of the Social Security Act, to temporarily waive legal provisions or modify certain Medicare, Medicaid, CHIP, and HIPAA requirements if necessary, in order to provide hospitals with needed flexibility in emergency or pandemic situations to deal more effectively with patient surge needs rather than restrictive paperwork. This move has been welcomed by local hospitals, many of whom can now make requests of CMS for 1135 waivers in the event that increased patient loads due to H1N1 affect the

availability of health care items and services. These requests are reviewed by CMS within 24 hours and can be granted retroactively to the beginning of the emergency period (that is, back to October 23, 2009) if necessary.

### **Homeland Security Presidential Directive-21**

Homeland Security Presidential Directive (HSPD)-21, "Public Health and Medical Preparedness," established a National Strategy for Public Health and Medical Preparedness. The Strategy aims to improve the Nation's ability to plan for, respond to, and recover from public health and medical emergencies and calls for the continued development of a robust infrastructure -- including healthcare facilities, responders and providers -- which can be drawn upon in the event of an emergency. HSPD-21 also requires the "establishment of a robust disaster health capability requires us to develop an operational concept for the medical response to catastrophic health events that is substantively distinct from and broader than that which guides day-to-day operations."

To this end, HHS has also led the development of the National Health Security Strategy (NHSS), the first comprehensive strategy focusing specifically on protecting people's health in the case of an emergency ([www.hhs.gov/aspr/osp/nhss](http://www.hhs.gov/aspr/osp/nhss)). Called for in PAHPA, the NHSS is designed to strengthen and sustain health and emergency response systems and build community resilience thereby enhancing medical surge capacity at all levels of community. The NHSS calls for active collaboration among individuals, families, and communities (including private sector and all governmental, non-governmental, and academic organizations) to implement strategies to prevent, protect against, respond to and recover from any type of large-scale incident having health consequences.

The National Health Security Strategy addresses additional steps that must be taken to ensure that adequate medical surge capacity, including a sufficiently sized and competent workforce available to respond to health incidents; a sustainable medical

countermeasure enterprise sufficient to counter health incidents is fostered; and increased attention to building more resilient communities and integrating the public, including at-risk individuals, into national health security efforts. HHS is also leading the development of an NHSS Implementation Plan to identify the steps that are needed to enhance medical surge capacity.

### *Emergency Care Coordination Center*

The Emergency Care Coordination Center (ECCC) was established in response to the Department's identification of the pressing needs of the nation's emergency medical system ([www.hhs.gov/aspr/oepo/eccc](http://www.hhs.gov/aspr/oepo/eccc)). The ECCC takes a regional approach to assist and strengthen the U.S. government's efforts to promote federal, state, tribal, local, and private sector collaboration and to support and enhance the nation's system of emergency medical care delivery. It is a collaborative effort involving the DoD, DHS, Department of Transportation and Department of Veterans Affairs. Its vision is exceptional daily emergency care for all persons of the United States and its mission is to promote federal, state, local, tribal and private sector collaboration to support and enhance the nation's emergency medical care.

The ECCC strengthens our Nation's ability to respond to mass casualty events. The ECCC assists the US Government with policy implementation and guidance on daily emergency care issues and promote both clinical and systems-based research. Through these efforts, ASPR and its federal partners will improve the effectiveness of pre-hospital and hospital based emergency care by leveraging research outcomes, private sector findings and best practices. The ECCC promotes improved daily emergency care capabilities to improve the resiliency of our local community healthcare systems.

## **Conclusion**

Our work to enhance medical surge continues to move forward. The responsibility for medical surge capacity is shared at the local, state and federal levels and includes private as well as public partners. HHS has provided funding and guidance to our Pennsylvania State partners and we have actively engaged in workshops and exercises with our State and local partners to advance preparations. With the leadership and support of Congress, we have made substantial progress. The threats to public health remain real, and we have much left to do to ensure that we meet our mission of a nation prepared.