

Is the Medical Community Ready if
Disaster or Terrorism Strikes: Closing
the Gap in Medical Surge Capacity
U.S. House of Representatives
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Oversight

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I would like to thank Chairman Carney and committee members for the opportunity to provide this testimony regarding the medical community and medical surge capacity. This topic is at the fore front of our emergency preparedness efforts at Susquehanna Health. I am representing Susquehanna Health in Williamsport which is made up of Williamsport Hospital, Divine Providence Hospital and our Critical Access Hospital, Muncy Valley. Our emergency preparedness planning has a long history of understanding the serious consequences of disasters and being at the forefront of disaster preparation. In 1989 we opened the regions first hazardous materials decon center and it has been in continual state of readiness since. Hurricane Gustav hit Louisiana in September, 2008 and Susquehanna Health sent personnel to aid in hospital evacuations the days before and after the storm hit. Our Prehospital Medical Director and emergency room physician, Dr. Greg Frailey provided medical direction for our team. Dr. Frailey is one of our regional experts with the following experience: twenty-five years as a naval flight surgeon and primary responsibilities to preplan for Mass Casualty Incidents, A medical specialist with Pennsylvania Task Force One, the regional medical director in Lycoming, Tioga, and Sullivan County, and instructs Advanced Trauma Life Support, International Trauma Life Support, PEMA blast injuries, forensics, and crush injury classes and many others. In 2009 the Department of Health purchased portable hospitals to assist regions in their readiness. We were the first in the state to set up and use the portable hospitals to prepare for the biggest threat to our region in regards to mass casualty: the Little League World Series. Every August, Williamsport is in the International spotlight which carries a heavy responsibility for our emergency preparedness team to accurately forecast and take the necessary steps to mitigate potential man-made or natural disasters. Little League World Series more than doubles the population of Williamsport and a Mass Casualty Incident (MCI) is a very real danger that we must consider.

We're here today to outline several key areas that would be relevant to your House Subcommittee. In many ways Susquehanna Health is prepared to deal with a mass casualty incident that happens in our community. Annually, we meet with our community partners to identify external vulnerabilities and update our emergency operations plan to mitigate these threats. Our surge capacity is assessed and mass casualty plans are updated at this time as well. Surge beds are identified in our clinical data systems including pre-defined locations throughout our three hospitals. Full scale exercises and drills identify our areas for improvement and best practices. Assistant Secretary for Preparedness and Response (ASPR) grant funding helps us mitigate our identified needs regarding supplies and equipment. Our planning efforts also identify our own internal vulnerabilities.

Our two emergency departments serve over 60,000 patients a year with 43 treatment rooms. Susquehanna Health has started a major construction project that will nearly double our emergency department treatment capacity. Our geographic location as a regional population center in the heart of a large rural tract implies that we will only be able to depend on ourselves to service our population during the initial stages of an MCI. Lycoming County contains over 1200 square miles of territory. Our closest trauma center is 45 minutes away by ground. During a Mass Casualty, we, and many other rural facilities, will be challenged to maintain nurse to patient ratios, particularly during a sustained incident such as a pandemic. In July, 2009, Pennsylvania initiated a ban on mandatory over time. While this is

lauded as a positive step forward in protecting health care workers and patients, its wording places burdens on emergency preparedness.

In response to the many factors affecting health care organizations nationally, hospitals are becoming “leaner” in staffing thereby reducing any depth for initial and sustained MCI operations. Any expectation of rural hospitals to staff alternate care sites during an MCI is unrealistic and would further deplete our nurse to patient ratios and jeopardize patients and staff. Many hospitals, SH included, use a just in time supply inventory system due to limited storage space and as a cost savings measure. This limits us even further during a sustained mass casualty incident. In general, open space to expand services into is limited throughout our hospitals. Specialty centers within hospitals have their own unique regulations that further limit our available spaces. Severe weather and mountainous terrain are identified as hazards and can also be contributing factors delaying aid to our region in a disaster. Our finite community resources force us to plan on little to no law enforcement or security available during an MCI. Lack of immunity from prosecution to physicians and other healthcare providers may further limit our response to a disaster for fear of prosecution.

This statement also holds true in regards to our rural hospitals receiving casualties from a disaster in a large population center. If an MCI happened in a large population center and we were asked to receive patients from it, we would have time to prepare ourselves and set up our surge beds, create real-time staffing plans, and work with our community partners. Our limitations to offer assistance would include our liability concerns, and the ban on mandatory overtime. Would we be able to mandate staff overtime if the disaster was declared in another community and didn’t directly affect us? Additionally, with few exceptions, there is no current memorandum of understandings between our regional hospitals and others around the state.

The information and direction coming from the federal government helps to define the expectations for MCI preparation. The Center for Domestic Preparedness in Anniston, Alabama offers high quality and targeted training on the impact of disasters on hospitals and other organizations. SH has sent 40 staff for training at the CDP and continues to schedule our leadership to prepare us for the future and stay up to date on the latest trends and best practices. The National Incident Management System (NIMS) courses help tie our national disaster response to the local efforts of all agencies involved and helps define everyone’s responsibilities. The NIMS concept is very broad based and offers a defined framework for response. It also leads to confusion at the local level and Federal agencies give conflicting guidance on matching training to positions in healthcare organizations. Much of the NIMS training is geared towards the fire service. We have made great strides towards full NIMS integration with our community partners but further development is needed to adapt NIMS to healthcare organizations.

Healthcare looks to the state and federal government to help satisfy our unmet needs during a disaster or MCI. What can the state and federal government do to help?

- Currently we are under the conflicting purview of many regulatory agencies to include the Joint Commission, Department of Health, PEMA, FEMA, DHS, HHS, and CMS, all with independent

views, and competing interests. Give Healthcare an equal voice in these organizations to ensure that healthcare needs are anticipated and met.

- Immediate clinical and support staffing during an MCI
- Financial support to stockpile medications and equipment for an MCI and rapid delivery of additional medical supplies
- Rapid and Mass airlift capabilities with the ability to handle critical patients
- Rapid deployment of an incident management team or liaisons to hospitals in the initial hours of a disaster with the authority to request federal resources
- National phone banks/information hotlines to assist overburdened hospital staff during an MCI or disaster. Rural hospitals will not have the physical capability to handle the volumes of phone calls associated with an MCI
- Ease EMTALA regulations during a disaster that is not federally or state declared
- Provide funding for Information Technology emergency communication initiatives to support the transfer of patients, and, give care to patients not known to the healthcare entity.
- Insure all rural hospitals have employee mass notification systems in place
- Provide federal templates for health care emergency operations plans and mass casualty incident management to be adopted at the state and local levels
- Provide funding, mandates, and direction to local healthcare (not necessarily associated with hospitals) in the planning for mass casualty care. For example: medical offices, surgery centers, GI centers, eye centers all have nursing, physicians, and other healthcare workers, but won't necessarily make themselves available to help a hospital if there is a disaster since they are not mandated to do so.

In closing, I would like to thank Chairman Carney and committee members for the opportunity to provide this testimony and Congressman Carney's staff for their assistance and guidance. Susquehanna Health considers itself fortunate to be able to maintain a high degree of emergency preparedness, but we also acknowledge the obstacles we face as a rural healthcare system with finite human and material resources at hand. Our efforts in planning and hazard mitigation can only sustain us in the short term and we will look to our state and federal officials for a rapid and coordinated response to assist us should the need arise.