

Is the Medical Community Ready if Disaster or Terrorism Strikes:
Closing the Gap in Medical Surge Capacity

*Testimony to the House Committee on Homeland Security's Subcommittee
on Management, Investigations and Oversight*

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Respectfully Submitted by:
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TO: Members of the US House of Representatives Committee on Homeland Security:

Thank you for your invitation to testify. My name is Michael O'Keefe and I serve as CEO at Evangelical Community Hospital in Lewisburg, PA, Union County.

I understood our charge today is to discuss the steps that area hospitals have taken to prepare in the event of either a natural disaster or an act of terrorism. Specifically, are local hospitals ready? What challenges exist regarding our current medical and surgical capacity? And, can we identify ways to improve coordination among affected organizations?

First, I want the Subcommittee on Homeland Security and the State and Federal taxpayers to be assured that the resources that have been allocated for preparedness, especially since 9-11, have not been wasted. Since that time, there has been much attention paid and advances made in the application of technology, surge capacity, security, communications and collaboration between and among state, regional and local agencies and organizations.

I. PRE 9/11 CONDITIONS

Regional Counter Terrorism Task Forces

The inception of the Regional Counter Terrorism Task Forces actually began in 1999. Through funding from PEMA, the nine regional statewide groups began to conduct meetings and explore ways to coordinate and acquire equipment and supplies that would have interoperability within the counties. In the North Central region hospitals and other agencies were not included in the early stages. PEMA monies were primarily used to fund meetings for the county emergency management coordinators, not to purchase supplies or expand outreach to other agencies.

Hospitals

Prior to 9/11 Evangelical Community Hospital had little focus on terrorism. The concept of preparing for a chemical, biological, radiological, nuclear explosive (CBRNE) event was extremely remote. The hospital, relatively speaking, had no personal protective equipment (PPE) for such an event. There was no facility, fixed or portable, for mass decontamination nor were any plans in place or exercises done. It is probably safe to assume that most rural hospital were in similar situations.

In addition, the means for mass communication were poor. During inter-hospital disaster drills the priority complaint was always lack of communication. The category that was rated the most important, yet rated the lowest. In those pre 9/11 drills the mass casualty event was always some type of wreckage and occasionally a small amount of hazardous materials was included.

Exercising for chemical, biological, radiological, nuclear explosive (CBRNE) was never considered.

II. POST 9/11

Expansion of the North Central Counter Terrorism Task Force

After 9/11 the regional task force realized the need to include more agencies and to give them a more prominent role. Committees were formed around law enforcement, fire, search and rescue, hazardous materials, hospitals and pre-hospital services, training and equipment. Each committee appointed a chair that reported to an executive board.

After the creation of the Department of Homeland Security, funding for the regional counter terrorism taskforce came from the federal government and no longer from the state agency, even though funds are still distributed through PEMA. This federal funding allows a large amount of dollars to come into the individual regions. A small amount is used for administration and the remainder is dedicated to the purchase of equipment and supplies for each of the previously mentioned committees. This can be a complicated process.

Equipment purchased includes such items as decontamination trailers, mass casualty trailers, hazardous materials trailers, prime movers. Just recently oxygen generators were purchased for each mass casualty trailer. There is a state of the art mobile Incident Command Post for the region. There is a mass fatality trailer and high tech hospital monitoring and detection equipment.

Supplies have been purchased that meet the specific need of each committee. In addition to supplies, personal protection equipment (PPE) has been provided to outfit the many region wide responders who may be dispatched.

Training is the second pillar necessary for a reliable response. In the years just after 9/11 it was evident that materials for response were greatly lacking and most of the funding was applied to those needs. Training was not the main concern. However, in the past two years North Central Regional Task Force has devoted a substantial amount of their budget to supporting training. Region wide drills can be extremely costly. None the less, consultants were hired to develop and manage major exercises. These included two Strategic National Stockpile drills. A mass casualty drill has been contracted for the spring.

This has all resulted from the focus of the Department of Homeland Security since 9/11. Preparedness has indeed been enhanced.

Hospitals

After the creation of the Department of Homeland Security, funding streams were made available to other agencies in addition to the equipment and supplies that were available through the regional task forces. The PA Department of Health receives federal monies that are distributed to each of the state's hospitals. Previously known as the HRSA Grant, the grant is now known as the Hospital Preparedness Program or HPP. Since its inception in 2003 Evangelical Community Hospital has purchased "level B" and "level C" personal protective

equipment (PPE). There is enough “level C” to suit 40 Emergency Department staff for response to a CBRNE event. Evangelical Community Hospital now has 6 level III hazardous materials technicians certified through the HPP grants and enough “level B” PPE to outfit all of them. There are additional level C hazardous materials techs working as paramedics but most of them were pre 9/11.

Funding has also enabled Evangelical Community Hospital to build a state-of-the-art fixed decontamination facility. It has a dedicated HVAC system that extends to an isolation room in the Emergency Department. This will protect the Hospital from secondary contamination. It includes a holding tank to capture possible contaminated water and product that will drain during the decontamination process. As stated, Evangelical Community Hospital now has a certified team to manage decontamination operations. Decontamination surge capacity can also be increased by mutual aid with the local fire department, the county EMA and the Bureau of Prisons at Lewisburg. That provides additional certified man power along with a 9 station portable decontamination system.

Prior to 9/11 Evangelical Community Hospital had no pharmaceutical stockpile in the event of a pandemic. Through HPP funds the Hospital pharmacy now maintains a cache large enough to support the hospital’s staff and their immediate families. Once again, this contributes to our surge capabilities by enabling more staff to respond. A large cache of antibiotic is also on hand to protect staff in the event of bio-terrorism attack.

A mandate from the Pennsylvania Department of Health requires recipients of the HPP Grant to have surge capacity for 20% of their census. With 133 licensed beds, Evangelical Community Hospital exceeds that goal with 27 beds available. The hospital has purchased enough beds and cots for mass care, as well as supplies designed to supplement a surge. We have also designed plans to surge up to 170 casualties above census.

One percent of HPP funds are required to be spent on training and exercises. This year’s grant funding provides \$450.00 for training. Evangelical Community Hospital far exceeds the \$450 allocated for training when executing just one drill. Our hazardous materials drill held annually during the Little League World Series involves Evangelical Community Hospital staff and coordinates with nine other agencies including the Red Cross, PEMA, Lewisburg Board of Prisons, Union County EMA, Bucknell University, local Fire Departments and local businesses. This type of coordination and outreach by a small rural hospital was never even considered prior to 9/11.

Other areas that have vastly improved since 2001 are communication and technology. As previously stated, communication is always the most critical yet poorest performing function of disaster preparedness. Since 9/11 the hospital has acquired the 800 MHz radio along with “biokey”. That system is located in the hospital’s relatively new command center. Additional med radios have been purchased to aid pre-hospital services in a surge response. At no expense to the hospital. Evangelical Community Hospital, along with all PA hospitals, now subscribe to technological communication systems such as Realtime Outbreak Disease Surveillance (RODS), Facility Resource Electronic Data (FRED), Infection Surveillance (PA Neiss), and mass reporting (PA Han). Hospitals have also acquired a Telephone Priority Service (TPS).

III. WHERE DO WE STAND TODAY

Response Reliability

Since 9/11 hospitals have been provided an opportunity to obtain a large inventory of supplies and equipment. Hospitals in the NCTF have been given the privilege of training and exercising with some of this inventory.

However, a critical concern is response reliability. Real time response in disasters such as Katrina have shown that 50% to 80% of responders and healthcare workers will not report to work if there is a perceived threat to their immediate families. Responder support must not be assumed or taken for granted.

For example, when Evangelical Community Hospital sets up a nine-station decontamination system we are prepared to handle approximately 100 casualties in an hour. But there are never enough responders to work all nine stations. Our decontamination rate is cut dramatically. Would this occur in a real CBRNE event? It is a difficult question to answer. Without enough responders all the equipment, supplies and technology go unused. Careful planning breaks down and a course for failure begins to spiral.

There is no easy solution. Response reliability stands as the most critical yet most questionable unmet need. Hospitals are much better prepared in the categories of supplies, equipment, pharmacy caches, communications, etc. If there is a topic of concern that Pennsylvania needs to focus upon today, it is finding a solution to response reliability.

In closing, on behalf of Evangelical Community Hospital and our Director of Environmental Safety and Security, I am confident that the Hospital is committed to disaster preparedness, as well as execution should disaster or terrorism strike. We remain steadfast in our partnerships and collaborations with state, county and township officials, as well as with our membership in the North Central and East Central Task Forces.