Still not prepared

Healthcare system has made major gains in disaster readiness in decade since 9/11, but experts cite significant shortcomings

By Paul Barr
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The country's healthcare system has made significant strides in its preparedness for hurricanes, acts of terror and other disasters since the attacks of Sept. 11, 2001. Nonetheless, hospitals and other providers are not as ready as they should be for large-scale emergencies, experts say.

Though hospitals and public health administrators have greatly improved in their planning and preparations for dealing with a disaster in the decade since Sept. 11, there are still some areas that need enhancement, especially in communication between hospitals and public health departments, in the management of personnel during a crisis, and in ensuring there is enough hospital surge capacity.

Since Sept. 11, healthcare organizations have developed a better understanding of systems of response, are better equipped to deal with disasters than they were before the attacks, and have a broader awareness top-to-bottom of what to do during a crisis.

Healthcare providers, federal organizations such as Homeland Security Department's Federal Emergency Management Agency, and state officials got an early thumbs-up for their preparations last month in anticipation of Hurricane Irene and their response in May to the tornado that destroyed a large section of Joplin, Mo., including one of the city's two hospitals. But experts warn that there are definite areas needing improvement and dwindling funds to pay for that improvement.

"Are we better off? Undoubtedly. Are we where we need to be? Not even close," says Donald Donahue, director of the health policy and preparedness program at the Potomac Institute for Policy Studies, Arlington, Va. The country has yet to be tested in needing to care for a large number of patients in a short amount of time, and the system would likely
fail that test, Donahue says. "If there was truly a huge influx of patients, we would be trembling," he says.

The mood in Congress is decidedly different than it was in the years immediately after Sept. 11. As the nation collectively rushed to respond to the lessons learned in New York, Washington and Pennsylvania, where hijacked planes were flown into the World Trade Center in New York, the Pentagon in Washington, and into a field in southwestern Pennsylvania, a slew of money was directed to emergency preparedness.

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Slowly that money has dwindled over the years, and now some in the healthcare industry believe the cutting has gone too far. Funding grants through the Hospital Preparedness Program, administered by HHS' Office of the Assistant Secretary for Preparedness and Response, reached a peak in each of federal fiscal 2003 and 2004 at $498 million, but for the current fiscal year, ending Sept. 30, the figure has fallen to $353 million, according to HHS.

Likewise, funding for public health emergency preparedness, through the Public Health Emergency Preparedness Cooperative Agreement, peaked in fiscal 2003 at $970 million and has fallen to $633 million for the current year, according to the Centers for Disease Control and Prevention, which administers the program.

But experts in the provider community say that more federal money for healthcare preparedness is still needed. “Just because the federal government is giving less money doesn't mean it's less important or less urgent,” says Christopher Cannon, international administrator of Yale New Haven Center for Emergency Preparedness and Disaster Response, a division of Yale New Haven (Conn.) Health System that provides statewide, regional and national emergency preparedness leadership to hospitals, other providers, emergency medical services and the public health community. “Just because Osama bin Laden is no longer with us doesn't mean terrorism is no longer with us, because it is,” Cannon says.

A report released last week by the Trust for America's Health pointed to a number of problems in healthcare emergency preparedness that are further threatened by declining
federal funds, among them caring for victims of a disaster.

“Surge capacity, the ability of the medical system to care for a massive influx of patients, remains one of the most serious challenges for emergency preparedness,” according to the report’s summary, echoing a report from the organization released in December 2010.

“There are numerous ongoing surge capacity issues around response in primary-care settings beyond just hospitals including … alternative-care sites, coordinating volunteers to help and providing them with adequate liability protection, and regional coordination,” notes the summary of the new report, called Remembering 9/11 and Anthrax: Public Health’s Vital Role in National Defense.

The report also points to other areas of weakness, such as the lack of “enough workers, particularly experts, to effectively respond during public health emergencies,” the ability to work with communities about ways to cope with and recover from a disaster or public health emergency and gaps in vaccine and pharmaceutical research, development and manufacturing.

Funding cuts have already affected preparedness efforts, and threaten to move preparedness backward instead of forward, officials are saying.

“Continued funding is necessary for ongoing preparedness in each of our states,” says Kathy Knight, a registered nurse who is director of the Northeastern Maine Regional Resource Center (part of Eastern Maine Medical Center, Bangor, which in turn is part of Eastern Maine Health System, Brewer), director of the EMHS Center for Emergency Preparedness. She is also director of the Northeastern Maine Medical Reserve Corps, a volunteer group that’s part of the national Medical Reserve Corps, created in 2002 by President George W. Bush as part of the government response to Sept. 11.

Some members of Congress are working to at least maintain level funding for emergency preparedness by reauthorizing sections of two laws, the Pandemic and All-Hazards Preparedness Act of 2006, known as PAHPA, and the Project Bioshield Act of 2004. PAHPA concerns healthcare industry readiness, while the Project Bioshield Act aims to foster the development of chemical, biological, radioactive and nuclear medical countermeasures so the nation could better respond to such attacks, according to a House Energy and Commerce Committee memo on the subject.

The reauthorization bill, the Pandemic and All-Hazards Preparedness Reauthorization Act of 2011, remained in that House committee with Congress in recess, but if passed would maintain funding at fiscal 2011 levels, according to the memo.

Even a steady level of funding may not get readiness levels to where they need to be, with elements of preparedness still lacking at current levels. Potomac’s Donahue says responses to recent events such as the Joplin tornado and the H1N1 influenza pandemic in 2009-10, while generally considered successful, would have likely failed if the facts were a little different.
While not taking away from their efforts, Donahue says emergency management officials in Joplin were able to get a mobile hospital set up quickly mainly because one happened to be in the state for an exercise. He says that if the tornado had hit St. Louis and taken out multiple hospitals in addition to the damage to homes, the reaction would have been much slower and less effective.

Meanwhile, H1N1 did not have that much of an effect mainly because the virus was weak, not because preparedness was good. “The flu sort of fizzled out; it wasn't as deadly,” Donahue says. Indeed, only about 27% of Americans were vaccinated for H1N1, according to Trust for America's Health. Even worse, only about 37% of healthcare personnel were vaccinated for H1N1 as of mid-January 2010, according to the CDC.

Moreover, Donahue says there's not a huge amount of coordination taking place between healthcare organizations. He says the government's all-hazards approach, which seeks to prepare for all kinds of disasters, is appropriate, but providers need to work more closely together.

Yale New Haven's Cannon notes that good communication during a disaster includes such little things as using the same horn signals when doing a search and rescue. Different organizations in the same region have been known to give a different meaning to, say, a two-horn blast, he says. “There's no common lexicon,” he says. “We've still got a long way to go,”

He also says more could be done to prepare for events such as the Joplin tornado or Hurricane Katrina in 2005. “What happens when the hospital becomes the disaster site?” he asks.

**Private investment**

Cannon and others also point to the major advances that hospitals and the healthcare system have taken since Sept. 11. “There really has been a tremendous amount of progress made,” he says. The federal money spent on readiness “has been a very good use of funds.”

One not-for-profit system in Texas has jumped into disaster preparedness with both feet and its own wallet. Memorial Hermann Healthcare System, Houston, operates amid two potential major threats—hurricanes and terrorism—and has spent years and roughly $200 million of its own money preparing for the worst.

Memorial Hermann’s preparations run the gamut, from purchasing satellite phones and radios to requiring employees to check off on what their general disaster responsibilities are each year when signing up for benefits, says Marshall Heins, chief facility services officer.
With Houston and nearby areas integral to the petrochemical industry, the region is considered a higher-risk terrorist target. That, coupled with the hurricane threat because of the city's location on the Gulf Coast, prompted the eight-hospital system to take strong preemptive action. The first goal is to protect patients and staff and then to be a resource for the community, he says.

In addition to improved communications capabilities, Memorial Hermann has purchased decontamination systems, added two information technology data centers and even contracted for the system and employees to buy gasoline during a shortage if needed.

Hospitals can run multiple days without power, a key point given that early on government resources may be stretched thin. “When (an) event occurs, we need to be self-sufficient and self-supporting” until the government can help, Heins says. Part of that includes access to ground water, which provides water pressure for important aspects of care, he says.

Heins says that in addition to the roughly $200 million spent over the past 10 years on the effort, the system got about $100 million in FEMA grants. “I think we've made tremendous improvement since 9/11,” he says.

In Maine, Knight says that among many areas of improvement since Sept. 11 has been the development of the volunteer Medical Reserve Corps. “It's an extremely successful program,” she says. The program, which she helps manage in Maine, allows different regional units to allocate resources where it's believed they will be most needed in disaster management or a public health crisis. The Medical Reserve Corps operates in all 50 states and the District of Columbia.

Jeanne Ringel, director of public health systems and preparedness initiative for RAND Health and senior economist for its parent RAND Corp., Santa Monica, Calif., says hospitals and health systems have greatly ramped up their participation in emergency preparation exercises and in the future may be subject to a new kind of exercise.

Ringel says RAND is working with HHS on the possible creation of a “no-notice” disaster exercise pilot project. Though still in its early stages, the idea would be for communities to undertake exercises without knowing the details of the disaster ahead of time, she says. They might know the exercise is coming but not know the exact scenario.

Another reason why hospitals are now better prepared when disaster strikes is that the Joint Commission requires hospitals to participate in at least two exercises each year—at least one of them live—as part of beefed-up accreditation requirements for emergency preparedness that went into effect in stages in 2008 and 2009.

In 2009, the subject was given its own chapter in its hospital accreditation manual—a move designed to catch attention in the C-suite. “The whole intent was to bring leadership in right from the beginning,” says George Mills, senior engineer in the standards interpretation group of the accreditation and quality organization.
The disaster preparedness community also will get more direction from the Homeland Security Department, which was charged with developing and submitting the first edition of the National Preparedness Goal by Sept. 25 under a policy directive issued by President Barack Obama on March 30. The directive also calls for the creation of “an integrated set of guidance, programs and processes” that will enable the country to meet its National Preparedness Goal, called the National Preparedness System, according to FEMA's website. And by March 30, 2012, the secretary of Homeland Security must submit the first national preparedness report based on the national preparedness goal, according to the directive.

HHS, which oversees much but not all of healthcare disaster-response efforts, described some of its successes in its support for passage of PAHPA in July to the House Energy and Commerce Committee by describing its role in preparedness successes.

“Since the passage of the (original) act, HHS has implemented a number of initiatives to strengthen its preparedness and response activities,” Dr. Nicole Lurie, HHS' assistant secretary for preparedness and response—her office is known as ASPR—wrote in her testimony.

As examples, Lurie highlighted the release of the National Health Security Strategy, a blueprint for preparedness and response, in December 2009, and the Public Health Emergency Medical Countermeasures Enterprise Review, a plan for a “nimble, flexible infrastructure to produce (medical countermeasures) in the face of any attack or threat including a novel, previously unrecognized naturally occurring emerging infectious disease,” in August 2010.

But without more funding, overall preparedness is likely to suffer, officials warn.

“Those kinds of cuts mean we're going to lose people, we're going … to lose many of the investments we've already made,” says Jeffrey Levi, executive director of Trust for America's Health. “The bad news is we've built up all this capacity and now we're undermining it.”