Preparedness Must Permeate Health Care

Yet Still Has a Long Way to Go

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In the aftermath of the Boston Marathon bombings, the city activated a coordinated response plan among several hospitals, public health and emergency responders.[1] Hospitals immediately prepared to receive traumatic injuries, and, although 264 individuals were injured in the bombings, no one died after the three on-site fatalities.

This kind of response was made possible by the Hospital Preparedness Program (HPP). The program, administered by the Assistant Secretary for Preparedness and Response in the Department of Health and Human Services (HHS), provides funding and technical assistance to prepare the health system to respond to and recover from a disaster. (See interview with Nicole Lurie, MD, page 57.)

Before September 11, 2001, hospitals often had emergency operations plans, but without (or with very little) guidance or oversight from outside emergency response or public health agencies at the local, state or federal level. The Hospital Preparedness Program began in response to the 2001 terrorist attacks, and it was intended to partly address this haphazard approach by focusing on bioterrorism and helping individual hospitals purchase supplies such as beds, personal protective equipment and stockpiles of pharmaceuticals.[2]

However, with passage of the Pandemic and All-Hazards Preparedness Act in 2006, the Hospital Preparedness Program shifted toward a capabilities approach to medical disaster response, focusing on such areas as personnel management, interoperable communications and bed tracking.[3] In so doing, the program began to foster a health-systemwide, all-hazards approach. As research continues, threats change and federal funding declines, the program is further evolving to build the capacity of health care coalitions by helping establish regional collaborations among health care organizations, providers, emergency managers, public sector agencies and other private partners.

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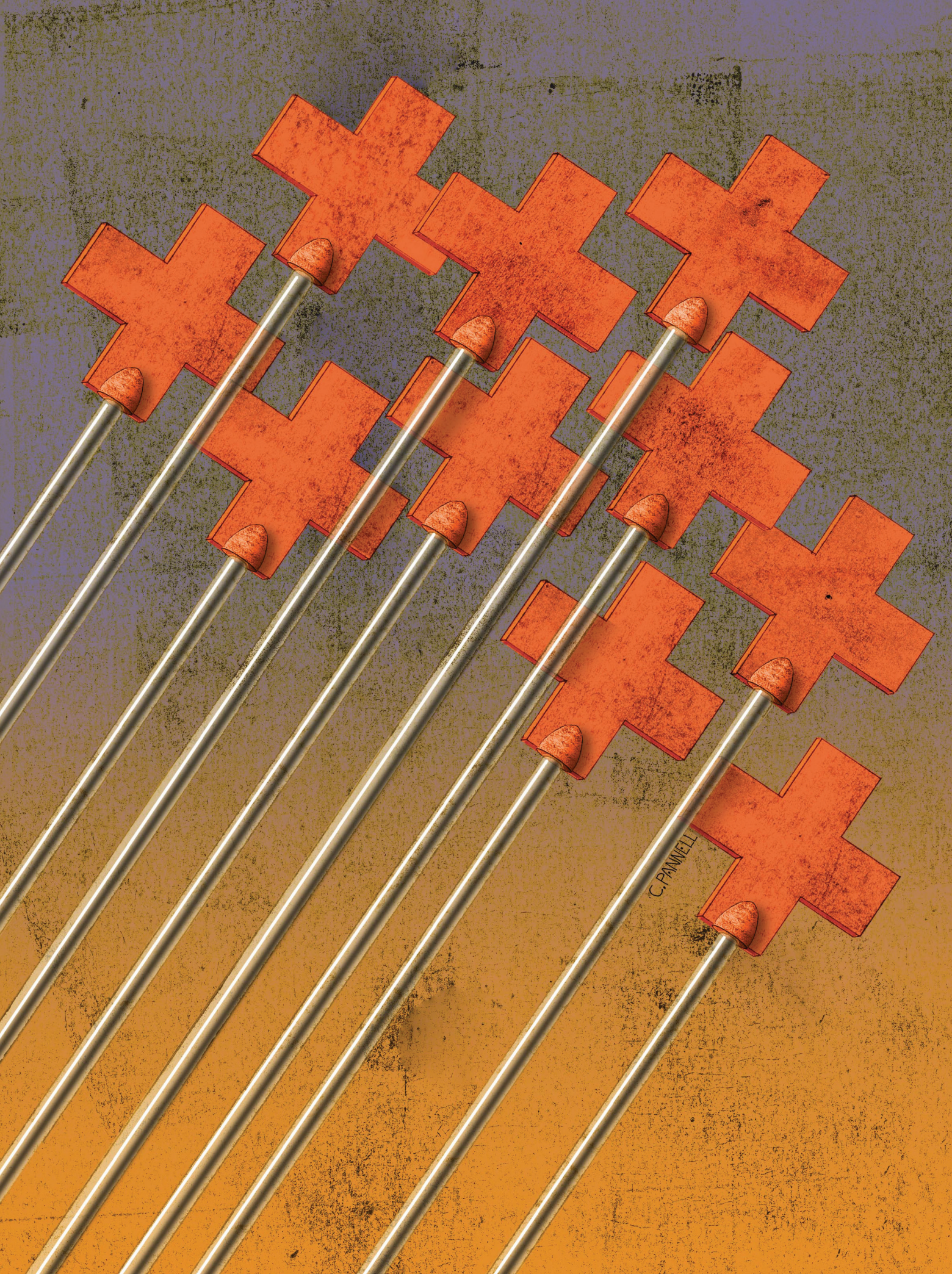
By bringing these coalitions together, the program is improving health system preparedness and recovery, medical surge capacity, emergency operations coordination, fatality management, information sharing, responder safety and health and volunteer management capabilities. For example, the Hospital Preparedness Program supports hospitals in developing interoperable communications systems, tracking available hospital beds across jurisdictions and sharing assets, such as mobile medical units, communally. In total, the preparedness program has made significant progress in preparing the health system for a disaster, and events over the past two years have shown its impact.

In 2011, 30 percent of Joplin, Mo., including St. John's Regional Medical Center, was destroyed by a tornado. Hospital Preparedness Program planning and resources enabled St. John's to evacuate patients and supported nearby Taney County in setting up a mobile medical unit in Joplin — a M*A*S*H*-like 14-tent facility with 60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beds, critical equipment and a surgery center. In addition, neighboring hospitals were better able to receive evacuees and residents injured by the tornado.[4,5]

In 2012, the Hospital Preparedness Program helped Texas hospitals and mobile medical units provide on-site medical care to firefighters battling widespread wildfires. In Kentucky, after hospitals and mobile units were damaged by tornadoes during 2012, health care coalitions supported by the Hospital Preparedness Program were critical in maintaining medical care for patients.[6,7]

And in 2013, in the town of West, Texas, the Hospital Preparedness Program and resources enabled nearby hospitals to implement surge plans to receive patients injured in a fertilizer plant explosion.[8] Hospitals moved lower-acuity patients to other facilities to prepare for patients, and electronic bed-tracking and communication systems helped coordinate resources and convey essential information.[9]

Without the Hospital Preparedness Program planning and resources in place before these disasters, it's certainly possible — if not likely — more people would have suffered and more lives been lost. Unfortunately, vital support to these grant programs is being quickly eroded. Appropriations for the program decreased from $426 million in Fiscal Year (FY) 2010 to $375 million by FY 2012. The Obama Administration has proposed a 32 percent cut — to just $250 million — for the program in FY 2014, which would begin on Oct. 1, 2013, if approved by Congress.

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Not surprisingly, every state and territory received cuts in Hospital Preparedness Program grants from FY 2012 to FY 2013. As additional cuts occur, preparedness activities and the capabilities of preparedness program coalitions decrease. Not only do budget cuts affect the total number of coalitions that are funded, but they also affect the ability of funded coalitions to respond effectively.

Quite simply, to ensure that our nation's hospitals can respond as effectively as they did in Boston, Joplin, Texas, Kentucky and thousands of other cities and states that faced tragedies, the Hospital Preparedness Program should receive funding of at least $375 million for FY 2014 — the amount authorized by Congress in the Pandemic and All-Hazards Reauthorization Act.

Even with diminished resources, the program continues to improve its effectiveness. In June 2013, the Hospital Preparedness Program released its first set of true performance measures, requiring health care coalitions to demonstrate not just the existence of plans, but the ability to implement those plans during a disaster. The program should continue to strengthen these measures and publicly report, on a state-by-state basis, the results of these measures over time.

The Hospital Preparedness Program also now includes an increased focus on behavioral health planning, often an afterthought during an emergency. As noted by Jack Herrmann, who, in 2001, was New York State disaster mental health volunteer lead for the American Red Cross, "The psychological impact I knew was big not only for those directly involved, but for people like myself that were called to respond. I had been involved with disaster work before, but I never fully appreciated the emotional impact that disasters, such as acts of terrorism, can have, even on the most experienced disaster response professionals. This was a real awakening of my own vulnerabilities. Professionally, it became clear how important it is to prepare and train individuals to work in a disaster environment."[10]

While vital, the program's funding is just one portion of the health system — as such, alone, the program cannot influence the entire health system to incorporate preparedness. Therefore, the nation must seek out every opportunity, in the Affordable Care Act and elsewhere, to build preparedness into the health system.

There are many ways to do so. For instance, preparedness should be a requirement of every Accountable Care Organization's (ACO) mission, and, where applicable, ACOs should coordinate with health care coalitions as part of the Hospital Preparedness Program. Preparedness could be promoted in ACOs through performance measures; surge capacity and bed availability requirements; requirements to integrate an ACO's health information technology system to interface with public health and larger systems to track community concerns while protecting patient privacy; and requirements to include emergency preparedness in their evalu-

ation of the health needs of their beneficiaries within the context of the larger population.

As ACOs and the use of electronic health records increase, they should make as part of their mission providing better situational awareness of the patient population, which would allow for quicker detection of disease and better identification of vulnerable populations. Every ACO and electronic health record system should be interoperable and able to communicate with the larger public health system.

Further, while some health care coalitions incorporate outpatient and non-acute facilities in planning activities, it is by no means universal. For example, in a disaster or pandemic, care will not always be provided by hospitals. In fact, nursing facilities could end up being key locations for receiving non-acute patients and also care for a population that is particularly vulnerable to a disaster. Yet, currently there are no specific programs to bring nursing homes up to speed. The nation must more fully incorporate long-term care, skilled nursing care and outpatient facilities (including transport between them) in all disaster planning.

In addition, hospitals should consider a role in preparing a community for a disaster as part of their community benefit to maintain nonprofit status. For instance, hospitals should know who in the patient population is dependent upon medication, dialysis or other regular treatments. The hospitals can make communication and planning for the care of these patients during a disaster part of regular discharge planning. By keeping such chronically ill individuals out of the hospital during a disaster, it will free up vital bed space for acute patients.

Hospitals also must take a more proactive role in population health, including proven community prevention programs aimed at helping people get and remain healthy and reducing chronic conditions. The aftermath of Hurricane Katrina provides a strong reminder of the importance of improving the underlying health of a community — 55.6 percent of displaced individuals had a chronic disease, such as hypertension, hypercholesterolemia, diabetes or pulmonary disease, that compounded the challenges of evacuation and support.[11] Quite simply, a healthier population is a more resilient population.

With passage of the Affordable Care Act, patient payment has been increasingly tied to quality measures. These measures should go further to help the nation fight pandemics and other mass casualty events. For example:

- The National Quality Forum (NQF) and Centers for Medicare and Medicaid Services (CMS) could align with Hospital Preparedness Program measures for health care coalitions.

Every ACO and electronic health record system should be interoperable and able to communicate with the larger public health system.

- Health facilities can help fight antibiotic resistance (and prepare for an infectious disease outbreak) through reducing overprescribing of antibiotics.
- Health care providers can lead by example (and prepare for a flu outbreak) by getting fully vaccinated every year.

Maintaining and supporting the Hospital Preparedness Program is critical for the nation to be able to respond to a disaster and save lives. Without consistent and dedicated funding, the level of success that jurisdictions facing terrorist attacks and extreme, catastrophic weather events have had will not be sustainable.

In addition, the nation has to go beyond just supporting hospitals when it comes to preparedness. A truly prepared community is one that has made preparedness part of every aspect of the health care system — from community health to electronic health records to nursing homes to child care centers. There are many different ways disasters can strike, and there should be many different ways a community is prepared to respond and save lives.

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NOTES

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