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

Presented to Committee on Homeland Security
Subcommittee on Management, Investigations, and Oversight
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Good Afternoon Congressman Carney and members of the Committee. Thank you for the opportunity to comment on Geisinger Medical Center's emergency preparedness efforts. My name is John Skiendzielewski and I am an emergency medicine physician and Director of the Emergency Medicine Service Line for the Geisinger Health System in Danville. I am joined today by Dr. Al Bothe, Geisinger Medical Center's Executive VP and Chief Medical Officer.

Geisinger Health System is a fully-integrated healthcare delivery system that includes a multidisciplinary physician group practice with system-wide aligned goals, successful clinical programs, a robust information technology platform, and an insurance product (Geisinger Health Plan). Geisinger's service area covers a 41-county region in central and northeastern Pennsylvania with a population of approximately 2.6 million. Research, education and community service are also integral parts of Geisinger's mission. Geisinger Medical Center in Danville is the system's flagship hospital. Geisinger Medical Center is the region's tertiary/quaternary care hospital. It is staffed by more than 350 specialists and subspecialists and is the education site for residents and fellows in 28 specialties. The medical center is home to a Level I trauma center with a pediatric designation, centers for heart, cancer and brain diseases, stroke and transplant programs and the Janet Weis Children's Hospital, Weis Research Center, and the Henry Hood Center for Health Research.

I would first like to discuss Geisinger's emergency preparedness efforts and then outline our efforts in conjunction with our community partners and conclude by offering several observations and recommendations.

Geisinger has a long and rich history of leadership in disaster planning that dates back at least 30 years. At that time, a regional 5-county disaster plan was developed, and exercises were conducted with a significant number of community partners. Within a 6-hospital consortium, there were annual drills of inter-hospital disasters, including triage exercises and inter-hospital communications.

Since 1998, we have participated in the East Central PA Regional Task Force (ECTF) that was formed in response to the threat of the use of weapons of mass destruction. This is one of nine regional task forces in Pennsylvania, originally known as Regional Counter-Terrorism Task Forces. The counties worked to define groupings by their natural mutual aid alliances. Each task force consists of representatives from

emergency medical services, law enforcement, emergency management agencies, fire/rescue, and hazardous material response teams. This is a partnership with various state and federal officials having regional responsibilities from such agencies as the Federal Bureau of Investigation, Bureau of Alcohol, Tobacco, and Firearms, Pennsylvania State Police, National Guard, Environmental Protection, and others.

Since 9/11/2001, we have adopted a command and response system known as the Hospital Incident Command System. This system is modeled after and integrated with the National Incident Management Framework. Funded through federal emergency funds, numerous employees have received disaster training as well as on response procedures for a wide variety of disaster types.

Our emergency management programs are focused on addressing a wide variety of potential disasters or incidents that may affect the medical community. These include natural disasters, man-made disasters, and technological events. We conduct an annual review of our hazard vulnerability by considering incident probability, impact on the facility and services, and the current preparedness level. We develop and modify our emergency response plans based upon risk determination that is ranked using this methodology. We have adopted a variety of response templates appropriate to the disaster events we might face. We drill and exercise our response to many of these situations each year. In addition to mass casualty/trauma events, a few other examples include handling radiologically-contaminated injured patients, decontamination of chemically-contaminated patients, as well as floods, blizzards and other internal and external disasters.

A number of emergency communication enhancement projects have been completed. These include the establishment of the statewide radio system linking hospitals and emergency response agencies and the establishment of the Facility Resource Emergency Database or FRED. These tools provide additional valuable key links to enhance communication and coordination activities during a disaster.

We have worked with both the state and federal government in relation to the strategic national stockpile program. This program is beneficial when disasters generate an increased need for supplies and medications beyond what may be available through normal vendor channels. One of the Pennsylvania Department of Health MSEC (Medical Surge Equipment Cache) portable trailers is based at Danville's Ambulance Service's station. In addition, we provide medical direction to Danville Ambulance and other EMS units (including ambulances, tactical police medical units, and police department defibrillator programs).

We have developed a detailed system-wide pandemic response plan. This plan remains in effect at this time due to the H1N1 pandemic. This information is also shared with surrounding hospitals and higher education institutions.

We continue to focus on increasing our surge capacity through development of alternate care-site plans. Also, we have focused on increasing our self-sustainability during a disaster.

We continue to serve as a non-metropolitan resource for patients from terrorist acts that may occur near us. With 5 medical helicopters, we can provide a redistribution function of critical patients from other areas to our tertiary/quaternary care centers.

We have developed and maintained effective relationships with our community partners, including local Fire, Police, EMS, County Emergency Management, Local Emergency Planning Committees, Hospital Support Zone Group, Regional Task Forces, and others. With regard to emergency preparedness, the region demonstrates a high level of collaboration rather than competition. We have participated together with community partners in joint planning, training, and exercise events. We have established memorandums of understanding or MOU's with the regional task forces. These documents provide guidelines for the sharing of equipment and staff in disaster situations. Within our task force, 16 hospitals have signed the MOU.

We have developed local hospital support zones. For example, the local zone that includes Danville involves 8 hospitals, emergency management agencies, visiting nurse agencies, the American Red Cross and others. This is a sub-set of the 7-county task force. The support zone serves as a valuable forum for sharing information, planning, and support activity. This group generally meets 4 times per year.

Based on our emergency preparedness experience I would like to offer the Committee several observations and recommendations to consider to help strengthen hospital disaster planning and response.

(1) Rural disaster planning and execution is significantly different from urban disaster planning and execution and poses significant and unique challenges. For the most part rural areas in the Commonwealth do not have large county-wide police, fire or EMS services. They are also dependent to a greater extent on volunteers to provide a wide range of response services making attendance at planning meetings and participation in drills and exercises problematical. Most small to mid-size rural hospitals do not have staff dedicated to emergency management nor do they have specific emergency management budgets.

Recommendation: Make additional planning and coordination funds available to address the specific emergency preparedness challenges faced by rural health providers.

(2) The current medical surge equipment caches include items with finite shelf-life. Items such as protective gear, medical supplies and battery powered sources have expiration dates that will increasingly require replacement of aging

stockpiles. Future emergency preparedness funding make be exhausted simply to keep supply and response equipment current.

Recommendation: Provide dedicated supplemental funding to account for aging equipment stockpiles that will need to be replaced.

(3) The current emergency preparedness grant funding formula that allocates funding to hospital providers does not account for the size of the facility's emergency department or if it has a trauma center designation. This "one size fits all" approach does not adequately direct emergency preparedness funding to larger facilities that would be expected to handle a larger proportion of disaster cases.

Recommendation: Amend the current funding distribution formula to account for the size of the hospital ED and for trauma center designations to appropriately direct additional disaster funding to larger facilities.

(4) Security measures and upgrades needed to deal with disaster surges in at-risk locations including access controls, surveillance cameras, biometric ID systems and related equipment are costly but have not been allowed as approved grant expenditures for several years.

Recommendation: Authorize security and infrastructure protection as acceptable expenditures under future emergency preparedness grants.

(5) One critical shortage in our region is the lack of specialized hospital facilities to care for burn patients. Currently, Geisinger and other hospital emergency departments are initially treating and stabilizing burn patients in preparation of transfers to recognized burn centers out of the region. We are in the process of developing and implementing an electronic intensive care unit ("e-ICU") program to link by telemedicine to the burn unit at Lehigh Valley Hospital. As the e-ICU program grows and reaches out to regional hospitals it will become a valuable asset in confronting any mass casualty disaster.

Recommendation: Provide evaluation and planning resources to consider the status of burn patients within the region. Provide seed funding for e-ICU programs to enhance image transfer capabilities, including connectivity to regional hospitals to expand surge capacity.

We appreciate the support and direction that has allowed us to enhance our disaster planning efforts over the recent years. We hope that our input here today helps in crafting future response capabilities to meet and mitigate the potential hazards and disasters that we may face in the future. Thank you. Dr. Bothe and I would be happy to answer any questions you may have.