Written Testimony of

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Mr. Chairman and members of the committee, my name is Peter Ginaitt, R.N., EMT-Cardiac. I serve as the Director of Emergency Preparedness for the Lifespan Health System and recently retired as a professional firefighter/EMT with the City of Warwick Fire Department after 21 years of service. Also, I served in an elected position as a State Representative from District 22 in Warwick for over 16 years until retiring from public office to assume my current position at Lifespan. My concentrations in public policy were both environmental protection and healthcare.

I would like to thank you for inviting me to testify today to discuss the challenges that lie ahead of healthcare in preparation for the potential of emerging biological threats as well as the need to be better prepared for the "all hazards" approach of preparedness within the healthcare community.

While I would like to report that I feel we as a country are sufficiently prepared to handle a major biological outbreak, or even further, are ready to handle the influx of victims if a catastrophic event were to impact Rhode Island and Southern Massachusetts, I feel I cannot report complete success. I do however feel strongly that we have made major advancements in our levels of preparedness and are better off today then ever in the past.

Lifespan

Lifespan, Rhode Island's first health system, was founded in 1994 by Rhode Island Hospital which includes its pediatric division Hasbro Children's Hospital and The Miriam Hospital. A comprehensive, integrated, academic health system, today Lifespan partners also include Bradley Hospital and Newport Hospital.

As a not-for-profit organization, Lifespan is overseen by a board of volunteer community leaders who are guided by its mission to improve the health status of the people it serves in Rhode Island and Southern New England. The mission of Lifespan is to improve the health status of the people whom we serve in Rhode Island and New England through the provision of customer friendly, geographically accessible and high value services. We believe that this can best be accomplished within the environment of a comprehensive, integrated, academic health system.

In September of 2007, Lifespan President George Vecchione and senior leaders recognized the need to be better prepared for any threat that existed. The Office of Emergency Preparedness was developed and an emergency preparedness council of CEO's and senior leaders was developed. Preparedness within hospitals underwent a paradigm shift and emergency preparedness and protection of our facilities to protect the delivery of patient care became paramount. Recognizing the need to assist and coordinate, the office of emergency preparedness continues to develop its role of system support and resource building.

In my role as Director of Emergency Preparedness, I serve as the Principal Investigator for a Hospital Preparedness and Healthcare Facilities Emergency Care Partnership Grant through HHS and under the Assistant Secretary for Preparedness and Response". The program administered will better prepare our state in the event of a disaster through the implementation of a robust patient tracking system that will track all EMS patients every day from the scene to the hospital, this program will be the first of its kind in the United States. The need for patient tracking was identified after the Station Nightclub fire on Feb. 20, 2003 in West Warwick, Rhode Island where over 400 people were attending a rock concert. A fast moving fire caused ninety-six immediate fatalities and hundreds were sent to or self transported to area hospitals. Four victims subsequently died in hospitals making this the fourth deadliest fire in our countries history. The findings were referenced in the After Action report assembled by the Titan Corporation in the months following that deadly blaze and recommendations made for the tracking of patients. The program will also develop voice and data communications systems for healthcare and proposed alternate care sites, a current system who's frailties were evidenced during and after Hurricane Katrina when communications failed. Lastly, the program will promote Incident Command adoption and training to promote better unified responses within the state of Rhode Island.

While pandemic planning continues to actively occur within all of the state's hospitals, it does present an ongoing challenge that requires constant planning and exercising in this and other areas. They continue to be better prepared as the state and federal government have requested but challenges are frequently discovered. The Lifespan system hospitals take particular pride in the planning efforts given to prepare for such an even as they work diligently to develop robust plans to deal with any "all hazard" event.

Rhode Island

The successes to date in pandemic preparedness in Rhode Island have been successful due to the partnerships and working relationships within the State and the New England region. As partners here today at this very table, I must acknowledge the hard work and efforts on behalf of Dr. David Gifford, Director of the Rhode Island Department of Health. Dr. Gifford has been challenged with the task of pandemic preparedness and with the cooperation of the Center for Emergency Preparedness and Response (CEPR) under his leadership, hospitals have been provided an incredible amount of support through resource allocations and pandemic cache development. On-going sub committee work dealing with all aspects of the pandemic influenza and our state's response continue as plans develop.

Major General Robert T. Bray, the states Adjutant General and State Homeland Security Advisor continues to work diligently in the development of plans to respond to catastrophic events within our state, including the support for a pandemic outbreak. This agency has made tremendous strides towards a robust response within this state to an event under an "all hazards" scenario utilizing resources within our state military services and emergency management agency.

And also, Mr. Thomas Kilday, as outlined within his testimony, I am sure you will notice that Mr. Kildays has assumed many roles which include healthcare response prior to his emergency management career as Homeland Security Program Manager. This broad knowledge provides a clear and educated perspective to the very events we are here to discuss today.

In Rhode Island, we have strived to develop an integrated and coordinated system for the benefit of the public health and for the health our healthcare system. We have worked towards a response to a pandemic response which has been both enlightening and do a degree somewhat daunting. The development of ten healthcare coordinating service regions in the state through the Department of Health have been identified as an effective method of addressing the expected influx of patients throughout the state of Rhode Island. These hospitals would utilize the Hospital Incident Command System and would manage healthcare within a prescribed region of the state. They would each report directly to the Department of Health which would be the coordinating entity for all ESF-8 activities.

While these regional plans are aggressive and require us to utilize all of the healthcare resources we as a state posses, we clearly understand that the scope of response will most likely overwhelm us as single facilities. We are better preparing by the use of shared resources, but we also recognize that the available on hand resources may not be adequate if the event is as large as predicted. Many of the challenges we predict we will experience include:

Emerging Issues

As in any mass casualty, the ability to deliver customary care to everyone is just not possible. Hospitals today face increased census numbers and the availability of clinical space continues to be a challenging issue. Our challenges to these extraordinary situations should take into consideration our ability to:

- Be compatible with day to day operations
- Be applicable to a broad spectrum of event types and severities
- Be flexible through a graded response for the circumstances faced with
- Be tested, to determine where gaps and improvements are needed

In the planning phase for any hazard where a mass casualty situation could exist, it is imperative that the healthcare systems remain functional and the ability to deliver acceptable quality of care to preserve the greatest number of lives be preserved.

This philosophy is made more challenging with the need to allocate scarce resources in a manner that will optimize the saving of lives. The challenge, however, is the allocation of these resources in a fair, open and transparent way while maintaining a safe, infection free environment for the delivery of care.

These challenges have been discussed throughout this country and a solid understanding seems to be in place but no real tangible cure to this challenge has been offered. Hospitals willingly accept challenges every day and even more so as the impacts of reduced reimbursements effect hospitals, increased uncompensated care requirements impact our community hospitals and our daily patient census numbers hit record levels. Hospitals attempt to optimize care through the sharing of resources and even attempt to merge operations in a further attempt to maintain their high levels of quality care through resource sharing and functioning under economies of scale.

It has been a practice to plan within a facility but further encouraged to integrate these facility level plans into regional systems. The systems continue to build there plans through an expanded involvement of private and public community stakeholders. The need for a unified response continues to be stressed since individual preparedness will stress rapidly during a major event. These plans must also be consistent with and integrated into Federal, State and Local plans.

As with any major change in policy or practice, an adequate legal framework must be further developed, endorsed and placed into action due to the requests placed upon facilities when activating any regional plan of care. These should include rapidly instituted executive orders declaring a disaster with the enabling language to support altered standards of care. These changes either through executive order or statutory change must be clear and concise for ease of communication and implementation and should further be free of confusion through interpretation of meaning. As with any disaster, these directives should also take into account the need to accommodate the demands of varying sizes of events and should not be primarily based on catastrophic levels of need.

These altered standards of care need to also take into consideration that a reduction in the workforce will further complicate and compound the stresses in healthcare during major events. While identifying the needs of hospitals and the expected volumes of patients in both the clinical settings within the hospital as well as the activation of an alternative care site, personnel will play a major role in the operational successes and/or failures of these types of events. Estimates vary around the 50% staff reduction numbers. This degree of clinical care reduction will further stress the actual healthcare delivery system and will require that we operate under different ratios to care for people. The expectation for current standards of care, while we will strive to achieve these expected levels, will most likely be during these labor and care intensive periods while experience large staff reductions and increased patient numbers.

Hospitals face daily diversion of patients due to increased volumes within their facilities. Managing these influxes are extremely complicated while also maintaining the quality of care within each facility. With the addition of alternate care sites, it is extremely difficult to predict the actual impact that will be felt within the system. While the state has adopted a memorandum of understanding between all hospitals to share staff and resources, a statewide or regional event would render that agreement useless, not to

mention that the capacities of these other hospitals are already stressed with their own patient census.

Hospitals have experienced tragedies in the past and through planning and a professional level of employees, responses have always been effective, well coordinated and resulted in good patient care. However, the unexpected event that stresses an entire healthcare system do to sheer volume or resource limitations could be tantamount to the proverbial "house of cards".

We must continue to build on these plans but also the need to address the needs of these patients. The simple stock piling of supplies needs to be further addressed by the federal government. The hospitals simply cannot support major stockpiling of resources with limited storage as well as limited to no funding to support these cache's of pandemic and all hazards supplies. If these resources are identified as essential, and I support that premise, assistance must be given by other agencies to purchase and support their delivery during a time of necessity and guarantee timely delivery of the same. The following continue to make planning problematic and they remain outstanding challenges.

We must move towards a clear and understandable goal within the federal government and support that goal with a plan of funding and implementation. Funding cycles must be beyond a single year and progressive build out of a system of resource and staff support must be clearly delineated. While grant funding is essential, working under unrealistic time parameters with a hope of an extension or face loss of grant funding is all too often counter-productive and often results in quick fixes. Multi-year funding, while federally problematic to manage, is the only real answer to building the structural framework for a system saving response. We clearly understand that the plans will always be labeled with the word "draft" since it will be a constantly improving tool. We realistically also comprehend that any reliable plan of action will take years to appropriately accomplish but building towards those goals through planning and implementation is where we will succeed.

Beyond funding, I would further recommend that the federal government establish a smaller department within HHS or DHS to provide hands on technical support **in** each of the states and regions that have realistic and attainable goals. I am not suggesting that this be the solution, but any interaction beyond paid consultants will be beneficial. Hospitals will respond well to systematic integration into a well formatted structure of needs. I see the need to have designated federal directors assisting the state governments and healthcare with the guidance necessary to achieve our goals and objectives. I further see the need for regular interaction with all regional partners while these systems further develop. I understand that this is currently being performed but see the need to better organize and deal with the "All Hazards" response.

As stated earlier in this testimony, I feel strongly that the federal, state and local plans and responses are better than ever before. Hospitals statewide are better prepared and truly understand the impact that could face them if a major event ever occurred. It is

further reinforced by The Joint Commission who accredits these facilities through recurring surveys and new standards currently placed in the survey tool. These new standards in place require increased readiness compliance in 2008 and expected newer standards for January 2009 will only strengthen hospitals preparedness and overall responses.

Please accept my thanks for the opportunity to present this testimony before this sub-committee and I remain available for questions.