

**STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

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Mr. Chairman, members of the committee, distinguished guests:

My name is Jerry Mothershead. I am an Emergency Physician. I am an assistant professor at the Uniformed Services University of the Health Sciences and a Physician Advisor for Battelle Memorial Institute. I am also a retired Naval Officer with over 15 years experience in disaster medicine, biodefense, and homeland security. For the past several years, I have served as a technical advisor to the Department of Veteran's Affairs Emergency Management Strategic Healthcare Group Technical Advisory Committee. I am honored by this opportunity to discuss my personal views on the health and medical sector role in preparedness and response to bioterrorism attacks, and what part in these initiatives VA might play in support of the overall national effort. Before discussing the VA in specific, I would like to provide a few general observations concerning disasters, preparedness, and the current state of healthcare in the United States.

America's Healthcare Experience with Large Scale Disasters producing Mass Casualties is Limited

Disasters in America have typically been non-progressive, sudden impact, defined scene events characterized by property and economic losses far out of proportion to injuries and deaths. Only a handful of events occur annually that result in total casualty counts in excess of 50. Most victims have minor injuries not requiring hospitalization. Of those seriously injured but salvageable, over 95% are rescued by local volunteers and responders and treated within 24 hours. Less than 15% of all victims are admitted to hospitals. With notable exceptions, resources of most U.S. health care facilities have not been exceeded, few suffered staff shortages, and fewer still reported supply shortages. Most facilities have been able to return to normal or near-normal operations within 48 hours of the disaster.

The disasters currently contemplated - resulting in large numbers of casualties that would exceed our health care capacity include pandemic contagious disease such as influenza, some types of bioterrorism such as a large aerosol release of anthrax, nuclear detonation, or release of large amounts of radiological material, toxic industrial materials, large magnitude earthquakes, or weaponized chemical agents. In terms of the ability to produce live, treatable casualties, these events are orders of magnitude greater than this country has witnessed in over 100 years. In even small scale events of these types, we could see thousands of deaths, tens of thousands of casualties requiring both acute and long term care, unfathomable numbers of psychological casualties, displaced populations, and loss of health care facilities and providers. The only non-combat related public health emergency in this country that has approached this magnitude was the Spanish influenza pandemic of 1918. Over 500,000 Americans died in four months. Approximately 1 in 3 Americans were affected. In Philadelphia, 3,000 died and 12,000 became ill in one week.

No community or collection of communities in America has the resources to absorb the surge in patients produced by these types of catastrophes, and a tiered national response including

local/regional, state, and federal resources , will be required, acutely and quite likely for a sustained period of time.

Health care in the United States is already in crisis.

Burgeoning costs of per capita services, reduced reimbursements and an increasing uninsured population effectively cut any fat from the health care industry. We have shifted a great many services from the in-patient to the out-patient setting. Over 500 hospitals (10%) and 1,000 Emergency Departments,(25%) have closed in the past decade. The demands for healthcare, however, have grown. During that time, visits to Emergency Departments have increased nearly 20%. ED overcrowding is most severe in areas with large populations, where 1 in 10 hospitals report diversion 20 percent of the time. Waiting times in Emergency Departments may at times exceed 24 hours, and it is not uncommon to see admitted patients “boarded” in the departments because of lack of inpatient rooms. This is our current reality.

Market forces have affected federal institutions as well, with closure of military facilities in excess of those linked to the Base Realignment and Closure, and many beneficiary services have been shifted to the local economy. The VA Capital Asset Realignment for Enhanced Services program (CARES) may result in similar closure of many its facilities.

The net result is that we have little true sustainable national excess capacity and cash-strapped hospital systems have few surplus funds to invest in disaster preparedness. Without significant change, this will most likely worsen in the future.

Preparedness of the public health and medical sector is a public safety function which must be funded as an equivalent to other public safety disciplines.

It is my contention that medical disaster preparedness and response must be recognized as a public safety function, and therefore is a governmental responsibility which must be appropriately subsidized. Until public policy changes to address this reality, we have little chance of adequate preparedness.

Disasters are low probability-high consequence events. Pre-event actions are an insurance policy. However, there is a cost involved, and resources expended in pursuit of disaster preparedness are no longer available for current, day-to-day issues that collectively also have consequences. I would therefore respectfully suggest that any mandates for change be accompanied by the appropriate resources to accomplish those changes.

Efforts to improve bioterrorism and disaster preparedness have accelerated, but much remains to be done.

In an August 24th New York Times article on hospital preparedness, Dr. Irwin Redliner, director of the National Center for Disaster Preparedness at the Mailman School of Public Health at Columbia University, stated "The fundamental fact is that this country is not ready to handle a significant terrorist event." Although I might have not stated it quite so harshly, I would in general agree with Dr Redliner's statement and other issues in that article.

The past three years have witnessed the greatest reorganization of the executive branch of the federal government since World War II. Bioterrorism-related funding, executive orders, and legislation have increased exponentially as well. Many existing programs and departments, from the federal to local level, have been bolstered. Many new programs have been developed, and virtually every health related organization and agency at all levels have established new

offices directly linked to homeland security. Comparatively speaking, massive amounts of money have been earmarked for biodefense research and technological development, including vaccines, medical surveillance, supplies, pharmaceuticals, and other materials, training programs, protective equipment, and personnel. There is no doubt in my mind that, as a nation, we have definitely increased our efforts in improve health and medical capabilities to respond to catastrophic disasters.

We still face many challenges. Many programs have not yet reached full maturity. We have yet to implement environmental and epidemiological surveillance systems with the requisite sensitivities to ensure the earliest possible detection of attack. Much research remains to field pharmaceuticals and vaccines against the greatest threat agents. We have virtually no reserve capacity for acute or long term health care and mental health services for the potential numbers of surviving victims of large scale attacks by weapons of mass destruction or severe pandemics. Education and training in disaster medicine and the clinical aspects of bioterrorism has still not been universally institutionalized. We have yet to solve the post attack environmental surety problem. And the list goes on. Funding for the health and medical sector has improved, but by no means has solved the fiscal dilemmas.

The role of the Department of Veterans Affairs in bioterrorism preparedness and response could be expanded

VA, DoD, and DHHS facilities and health professionals represent a national asset in the Global War on Terrorism and for response to disasters of any sort that reach the threshold of a national emergency. With over 150 hospitals, 900 additional clinics, domiciliaries, and other facilities, and full and part time staff numbering well over 200,000, VA operates the largest integrated health care system in the United States. VA facilities exist in every state and several of the territories. If DoD and DHHS health and medical resources are included, practically no community is far removed from a significant federal health footprint.

All disasters are local events. If you accept the premise that, faced with an overwhelming disaster, emergency responders should utilize all available resources, then VA facilities must be considered local assets that should be utilized for the good of the community as a whole.

Many VA facilities have already collaborated with other health care systems. At the local level, federal facilities must be allowed to more fully integrate into the entire health care system during disasters. Today, most federal health care facilities do not even participate in their local trauma systems. The cooperative trauma system that exists between the City of San Antonio, TX, Brooke Army Medical Center, and Wilford Hall Air Force Medical Center is a model of federal-civilian collaboration that should be studied for more wide-spread application.

- In those locations where the Metropolitan Medical Response Systems are operational, federal facilities must be full and active partners.
- In those communities without such systems, federal facilities should assume a leadership role in development of similar unified health care systems approaches to disaster response.
- Epidemiological data must also be integrated across jurisdictional lines if such initiatives as syndromic surveillance are to achieve their full potential for early identification of outbreaks and accurate epidemiological projection. Lack of information sharing between VA, DOD, and civilian facilities within the same community hampers this tool's potential value.
- In general, federal healthcare facilities are more physically secure than their civilian counterparts. Regional disaster cache storage or the staging, storage and distribution of national stockpiles at secure VA facilities should be considered. Many VA facilities already store additional caches for department use, and through partnerships with the Strategic

National Stockpile Program, have developed logistical and maintenance procedures applicable to regional or local stocks as well.

The National Disaster Medical System (NDMS) combines Federal (DoD, VA, DHHS, and DHS/FEMA) and non-Federal medical resources into a unified response that is designed to meet peacetime disaster needs as well as combat casualties from a conventional armed conflict. VA's principal role in the NDMS is the management of the Federal Coordinating Centers (FCC). Of note is that membership in NDMS is restricted to civilian hospitals. Federal facilities may in general receive eligible beneficiaries only. There are 66 FCCs and approximately 1500 member hospitals, covering less than 10% of the geography and including only about 30% of the hospitals in the United States. In addition to expanding the roles of FCCs to provide better situational awareness of medical threats, vulnerabilities and capabilities for their areas of responsibility, increasing their numbers, enlarging geographic coverage, and inclusion of more civilian facilities, may be worth pursuing. Initiatives such as these will require close collaboration with state public health and emergency management agencies.

The federal government has an interest in assisting community medical systems in all phases of emergency management. Headquarters level involvement can be directive, facilitative, supportive, or interactive. Some areas for consideration include:

- Education and training. VA already has a defined role in medical education and training, of both its staff and of health professional students and residents. Significant amounts of training are currently being performed. I would observe that the other federal health and medical partners, academic institutions and professional organizations have also independently developed training, and much of this is remarkably similar. Three years after 9-11 and we still do not have a competency-based, tiered national standard curriculum for education in the clinical and operational medical management of victims of terrorism and weapons of mass destruction, nor do we have an organized national education program. It is time that we develop such a program and institute it nationally. DHS, VA, DOD and DHHS should collectively serve as the leadership backbone for this initiative.
- Standards of performance. Lack of explicit standards and benchmarks allows a great deal of subjectivity to drive decision making processes. Unpublished data suggest that hospitals may in general overestimate their readiness capability significantly as compared to outside objective criteria, even when those criteria are known to them. It is the responsibility of leadership to institute standards of performance and measures of effectiveness for programs it oversees. Although there are many stakeholders in the standards-setting process, certainly the federal health sector has a duty to be part of that process. I would further offer that if the healthcare industry is to be expected to meet these standards, it is incumbent on the federal health partners to collectively set, and meet, the benchmarks to which all should aspire.
- Leveraging purchasing power. As the largest provider of health care in the United States, the VA has an immense purchasing power, currently being used in the Strategic National Stockpile Program. Extension of this program to provide conduits for community health care systems may conserve limited local funds and promote standardization.
- Response team development. If one looks at a table of mobile response teams, medical or otherwise, it is a veritable alphabet soup of acronyms. NDMS has DMATs and DMORTS, DoD has SPRINTS, SMARTS and BATs, the VA has the MERRT and EMRTs. Each agency has its own concept of response team size, composition, roles, responsibilities, and operations. Collective review of these teams in emergency response may be in order.

Certainly the VA would have an important role in such a venture. Certainly, with the need for redundancy and geographic placement of these teams, VA should consider expanding its limited participation to date. This will of course require incentives for increased enrollment in the Disaster Emergency Medical Personnel System, which has not achieved its full potential.

- Development of programs and job aids to help VA facilities do their jobs better. While the VA is doing this, it could potentially do more. An example would be in exercise support. The VA already participates in national and regional exercises. Exercise design, development, scheduling, logistics, execution, and evaluation can be greatly enhanced through the establishment of a Comprehensive Public Health and Medical Emergency Exercise Program. I view this also as a headquarters responsibility.

These are but some of the areas in which the VA may progress toward enhancing its capabilities and roles in bioterrorism and disaster preparedness and response. I would finally say that further, more intimate collaboration with the other principle federal health sector partners at all levels and on all common issues would facilitate a more cohesive, integrated health and medical strategy and which would strengthen our defensive and response posture.