

**Statement
of the
American Hospital Association
before the
Homeland Security Committee
of the
U.S. House of Representatives**

April 9, 2018

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit comments on emergency preparedness and lessons learned from Hurricane Harvey.

On August 25, 2017, Hurricane Harvey made landfall on San Jose Island, Texas, south of Houston, as a Category 4 hurricane. After striking land, Harvey weakened to a tropical storm and, for two days, dropped heavy rainfall, causing widespread flash flooding. Over the course of a week, the storm caused record-breaking destruction, with more than 60 inches of rain and entire communities destroyed by flooding. Tragically, the storm caused 90 deaths and an untold number of injuries, both physical and psychological.

The nation witnessed the best of humanity as neighbors saved each other from floodwaters, emergency officials plucked stranded citizens from the roofs of their cars and homes, and strangers came to one another's rescue. Throughout the storm and its aftermath, the women and men of Houston's hospitals tended to their patients and provided care, even when their own families were being ravaged by the storm. These heroes cared for premature babies and patients just out of surgery during the worst of the storm and subsequent flooding. When hospital personnel could no longer operate due to safety concerns, they evacuated their patients to safety. Whenever possible, they kept the hospital doors open throughout the storm, even when they had to ration supplies to ensure every patient received high-quality care. These hospital heroes saved



lives under the most difficult circumstances. We are incredibly proud of the women and men that provided care for those in need before, during and after Hurricane Harvey.

LESSONS LEARNED FROM HURRICANE HARVEY

Hurricane Harvey was atypical in that it morphed into a massive storm in a very short amount of time. In previous hurricanes, communities have had more time to prepare and evacuate. It also moved slowly rather than quickly passing over the Houston area, allowing record rainfall to pile up and cause severe flooding.

While Hurricane Harvey was atypical, the lessons learned from the storm are not. We have discovered similar findings from other storms in other states and in previous storms in Texas. While we have seen vast improvement in emergency preparedness since Hurricane Katrina in 2005, there remain issues that have yet to be resolved.

Summaries of some of the main lessons learned by hospitals during Hurricane Harvey follow.

1. Lack of Availability of General Population Shelter Facilities to Take Medically Fragile People

During Hurricane Harvey many people with medical needs, such as those requiring dialysis or those who are ventilator-dependent, were turned away from shelters because the shelters were not equipped to handle their medical needs. This population turned to hospital emergency departments, despite not requiring acute medical attention, which stressed hospital resources, including personnel, food and linen.

The lack of shelters for medically fragile populations has been a consistent challenge for hospitals during emergency situations. While there are laws that require general population shelters to be staffed and equipped to meet the needs of medically fragile populations, such as having the ability to provide dialysis and medical oxygen, the reality is that general population shelters rarely have these capabilities. There needs to be focused attention, planning and resources by local, state and federal government, and key partners to ensure that general population shelters are staffed, funded and equipped to be able to meet the needs of medically fragile populations in the future.

2. Inappropriate Reliance on Hospitals as Shelters

As people were rescued from floodwaters, hospitals were used as evacuation sites by emergency officials and ordinary citizens. The large number of people seeking shelter, in addition to the hospitals' existing patient populations, compounded by a shortage of hospital staff and the length of the storm, created serious resource challenges for hospitals and imposed additional burden on the limited number of hospital employees who were able to get to work.

The use of hospitals as shelters for the general population has been a consistent challenge for hospitals in emergency situations. Key partners need to educate their communities about appropriate evacuation sites before and during a storm.

3. Availability of Security

The availability of adequate security varied for hospitals during Hurricane Harvey. For those without adequate security, there were concerns about safety. With incredible demand for private security across the entire region, hospitals faced logistical challenges obtaining private security. This also has been an issue for hospitals during previous disasters that needs to be addressed with appropriate stakeholders.

4. Delivery of Supplies

Hospitals have a limited availability of supplies on hand at any given time. While they are used to having three to four days of “ride out” provisions, hospitals were challenged during Hurricane Harvey due to the amount of rainfall, which made many hospitals inaccessible for five to seven days. Key community stakeholders throughout the country need to convene to develop strategies for delivering necessary supplies during emergencies.

5. Communication

During Hurricane Harvey, there were communication failures and challenges with state and federal officials and the military. There was confusion about which hospitals were operational and which ones were evacuating, creating problems with resource allocation and placement of patients. In addition, there was confusion about hospital employees being exempt from mandated curfews due to being “essential” when traveling to and from work. In some circumstances, police turned away much-needed hospital personnel when they were traveling to work, even though these hospital employees had proper identification. Communication has been a consistent problem during previous emergencies. Local, state and federal government and the military need to work with key stakeholders to ensure clear, timely and consistent communication during disasters.

6. Effective Use of Volunteers and Donations

Coordinating the extraordinary outpouring of volunteers and donations during Hurricane Harvey was a challenge for hospitals. Getting credentials checked was an onerous manual process for out-of-state medical professionals and there were questions about the scope of liability protection for all medical volunteers. In addition, there were logistical challenges for the massive amounts of food, clothing, toys and other items donated. Key stakeholders need to make the volunteer registry more robust so that volunteers from out of state can be effectively used during an emergency. States need to address and make clear the liability protections afforded to volunteers. In addition, planning for donations of large quantities of goods needs to be completed in advance at the local level, including a plan for clearly communicating which goods are needed.

7. Recovery

When entire communities are devastated by a disaster, there are significant needs for mental health services. Engaging with local social workers, chaplains, psychologists and other mental health providers to assist the community is paramount. In some instances, mental health providers from outside the community will be needed. Hospital employees face the strain of being separated from family and being in the middle of a highly stressful

emergency, with unknown outcomes and dramatic episodes. In order to reduce anxiety and burnout, hospital employees must be offered mental health support in a timely manner.

Other important recovery measures include flood mitigation, building inspector guidelines for those hospitals that are recovering from flooding and ensuring public health threats are mitigated.

Financial support is also critical in the recovery from disasters. In addition to the increased costs incurred as a direct result of the disaster, hospitals have lost revenue from closures, interrupted billing and claims filing, cancelled patient care services and decreased patient flow.

8. Stafford Act Modernization

The Stafford Act of 1988 was designed to bring an orderly and systematic means of federal disaster assistance for state and local governments in carrying out their responsibilities to aid citizens.

The act prohibits investor-owned hospitals from qualifying for Federal Emergency Management Agency (FEMA) assistance. During Hurricane Harvey, numerous investor-owned hospitals provided critical resources to their communities and other not-for-profit hospitals, including taking in evacuated patients. The allocation of FEMA assistance should not be determined by the status of a hospital. The AHA strongly recommends that the Congress modernize the Stafford Act to allow all hospitals to recoup financial losses from a disaster.

PRIORITIES FOR 2018 REAUTHORIZATION OF THE PANDEMIC AND ALL-HAZARDS PREPAREDNESS ACT

Congress recognized hospitals' and health systems' critical role during disasters in the Pandemic and All Hazards Preparedness Act (PAHPA) by creating the Hospital Preparedness Program (HPP), the primary federal funding mechanism for emergency preparedness. Since 2002, the HPP has provided critical funding and other resources to aid hospitals' response to a wide range of emergencies. The HPP has supported greatly enhanced planning and response; facilitated the integration of public and private-sector emergency planning to increase the preparedness, response and surge capacity of hospitals; and improved state and local infrastructure that help hospitals and health systems prepare for public health emergencies. These investments have contributed to saving lives during many emergencies, including Hurricane Harvey, the Boston Marathon bombing, the Ebola crisis and hurricanes in New York, Florida and Puerto Rico.

Reauthorization of PAHPA must occur by Oct. 1, 2018. Below we outline our priorities for future investment to help prepare and equip our health care system in advance of disasters and public health emergencies.

1. Preparedness Programs Should Be Authorized at Sufficient Levels

The HPP and Public Health Emergency Preparedness (PHEP) programs are key to the foundational capabilities of health care and public health preparedness, respectively. These programs must be resourced at sufficient levels to ensure every community is prepared for disasters. In particular, HPP's highest level of appropriation was \$515 million; yet, in recent years, the program has eroded to only \$255 million, a vastly insufficient level given the task of preparing the health care system for a surge of patients, continuity of operations, and recovery. Following a year in which the nation experienced record-setting natural disasters, and with projection of an increase in the severity and frequency of extreme weather events, we must do everything we can to ensure that the health care system has the resources needed to prepare for and respond to future disasters. In order to keep pace with the ever-changing and growing threats faced by hospitals, health care systems and their communities, the AHA recommends that HPP be authorized to at least \$515 million per year. Furthermore, as the Centers for Medicare & Medicaid Services emergency preparedness rule goes into effect, the Department of Health and Human Services (HHS) expects as many as 50,000 health care facilities to seek inclusion in health care coalitions. This level of authorized funding would allow rebuilding of the program as it transitions from capacity building to operationalizing health care coalitions. The AHA has endorsed H.R. 4776, the Hospital Preparedness Program Reauthorization Act of 2018, which would increase the level of authorized funding for the HPP to \$515 million for fiscal years 2019-2023, doubling its current level of appropriated funding. We strongly believe that this investment would go a long way to help better prepare and equip our health care system nationwide in advance of future disasters and public health emergencies.

2. Preparedness Programs Should Be Nationwide

The HPP and PHEP must continue to provide funding to all existing awardees – all states, territories/freely-associated states and four directly-funded large cities. There has been no evidence that drastically changing the program's formulas would provide any meaningful benefit or that the current formula is flawed. On the contrary, greatly reducing or eliminating funding from some jurisdictions puts other states at risk: those states that border the eliminated state would take on additional burden from the unmet public health and medical needs in neighboring communities. Further, funding formulas that lean too heavily on risks from prior natural disasters ignore universal risks, such as an influenza pandemic or other outbreaks, and unpredictable threats such as acts of terrorism and mass shootings. Because disasters can and do occur everywhere in the U.S. states and territories, all jurisdictions must be properly resourced in order to have an adequate level of preparedness for all hazards.

3. Preparedness Programs Should Remain Distinct

The HPP and PHEP programs should continue to be aligned and coordinated but should be maintained as separate, distinct programs. The two programs serve a different but complementary purpose. PHEP, administered by the Centers for Disease Control and Prevention (CDC), builds the capacity of state and local health departments to prevent, detect and respond to emergencies. HPP, administered by the Office of the Assistant Secretary for

Preparedness and Response (ASPR), prepares the health care delivery system to provide essential care to patients by ensuring continuity of care during disasters. Both programs are needed to save lives and protect the public from emergency-related illnesses and injuries and each should remain under the jurisdiction of the agency that currently oversees its administration.

4. Broadening the Definition of Eligible Awardees under the HPP

The AHA supports introducing competition into determining HPP's awardees in order to permit HHS to fund innovation and improve the nation's health security. In addition to states' and directly funded cities' public health departments, we recommend that state and local hospital associations, as well as academic medical centers, be permitted to apply to serve as the awardee for their jurisdiction. This will allow HPP to fund those entities that present the most innovative approaches to health care delivery system readiness. A second benefit of introducing competition is the potential to address the misalignment between HPP's health care mission and its current awardees' public health mission. While most of the HPP's public health department awardees work well with their private-sector health care delivery system counterparts to enhance preparedness and response, others struggle to work collaboratively with the private health care system that they also regulate. Through this proposal, private health care entities or hospital associations that have the organizational capacity and initiative to lead sector-wide preparedness and response activities also would be able to compete for HPP funds for their state or jurisdiction, not just health departments.

5. Improving the Efficiency of the HPP through Limits on Awardee-level Direct Costs

According to data collected by ASPR, public health department awardees have taken an average of 21 percent of the HPP award off the top for direct costs (i.e., personnel, fringe, and travel), in addition to their indirect costs, for overseeing award and subcontracts. Some awardees have taken far more than 21 percent of the HPP award for their direct costs. Further, ASPR has reported that high-performing awardees tend to have lower awardee-level direct costs (ALDC). With the substantial reductions in HPP appropriations in recent years, we are concerned that this level of skimming of limited program funds for ALDC leaves inadequate amounts for use by health care coalitions and health care providers to meet the critical capabilities of the HPP program. We support the efforts that ASPR's team has undertaken during the current project period to ensure the appropriate use of HPP funds. In particular, for the 2017-2022 HPP project period, we are pleased that ASPR is improving the efficiency of the program and better supporting its partners in health care by limiting ALDC to no more than 18 percent of the HPP cooperative agreement award, which will gradually decrease to 15 percent by the last HPP budget period. The AHA supports permanently capping the ALDC to 15 percent of the HPP award moving forward.

6. Immediate Response Fund

A pre-approved standing fund of emergency resources that would speed the public health response to disasters is necessary. We support the following principles in an immediate response fund for public health emergencies: such a fund should supplement and not supplant

existing, base public health and preparedness funds; it should not preclude supplemental emergency funding based on the scope, magnitude and duration of the emergency at hand; and it should come with a mechanism to automatically replenish funds. Such a fund should be used in the short-term for acute emergencies that require a rapid response to save lives and protect the public. The Secretary of HHS should administer the fund, with congressional oversight, to ensure relevant agencies receive dollars when needed for response.

7. Medical Countermeasures

The Public Health Emergency Medical Countermeasures Enterprise strategy and implementation plan should be strengthened to require coordination with state and local entities to ensure the products being developed reach the end users in a timely and well-coordinated manner. Several programs created in previous authorizations have been successful and should be maintained, including emergency use authorization, the Strategic National Stockpile and the Shelf-Life Extension Program for state and local stockpiles.

8. Environmental Health

Environmental health is a branch of public health that examines all the physical, chemical and biological factors external to a person and incorporates the assessment and control of those environmental factors that can potentially affect health. Environmental Health professionals are extremely important in all-hazard emergency preparedness response, recovery, and mitigation due to their understanding of how disasters impact the environment. Environmental health professionals function in areas of controlling disease-causing vectors, food safety inspections, safeguarding drinking water, preventing chemical and radiation exposure, protecting the public from bioterrorism, and ensuring healthy working and living environments. Environmental health workforce should be included in the national health security strategy and workforce development.

9. Planning for Whole of Community

HHS should move away from an “at-risk individuals” definition to a more functional approach, including the functional needs of children and persons with disabilities. The current statutory definition of and references to “at-risk individuals” throughout PAHPA are insufficient at improving the preparedness and response of communities to each of the populations encompassed by that term. HHS (ASPR and CDC) should develop a strategic plan for addressing each of the key sub-population groups, e.g., pregnant women, children, and individuals with access and functional needs. PHEP and HPP must ensure awardees are engaging in meaningful planning and coordination with each of these subpopulations and the institutions that serve them.

10. Advisory Committees and Experts

The National Advisory Committee on Children and Disasters should be reauthorized and utilized as an important resource for the Secretary of HHS. Federal representatives should be

ex officio, non-voting members, and the committee should incorporate additional expertise, such as mental and behavioral health and children with special health care needs. The National Preparedness and Response Science Board (previously called the National Biodefense Science Board) also should be reauthorized and strengthened to serve as a resource for the Secretary. CDC's Children's Preparedness Unit (CPU) should be authorized to ensure the unit becomes permanent. CPU should provide technical assistance to PHEP awardees to assist with their plans.

ALWAYS THERE, READY TO CARE – THE 24/7 ROLE OF AMERICA'S HOSPITALS

Hospitals are at the center of every emergency that our nation confronts, from natural disasters to deadly diseases to biological warfare, terrorism and radiological and nuclear events. Readiness is an imperative for America's hospitals, one of the cornerstones of their essential commitment to safeguard the health of the public.

The women and men of America's hospitals are critically important resources in responding to a disaster. It is when communities are pushed to the limits, such as when Hurricane Harvey hit, that we recognize that these everyday heroes' dedication to their patients and communities is beyond measure. We applaud their 24 hours a day, seven days a week commitment and dedication.