Testimony
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Responsible Resource Management at the Nation's Health Access Agency: Bioterrorism and Hospital Preparedness

Statement of

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Good afternoon, Mr. Chairman and members of the Committee. I am Joyce Somsak, the Health Resources and Services Administration's (HRSA) Associate Administrator for the Healthcare Systems Bureau in the Department of Health and Human Services. Thank you for the opportunity to testify today concerning responsible resource management at HRSA, the nation's health access agency.

My remarks will be focused on Bioterrorism and Hospital Preparedness, one of the programs within the Healthcare Systems Bureau.

HRSA recently announced the latest round of grants for its National Bioterrorism Hospital Preparedness Program (NBHPP). This is the fifth consecutive year that HRSA has provided funding for the program, which was created after the terrorist attacks of September 11, 2001.

Since then, the NBHPP has delivered over $2 billion to hospitals and health care systems in all 50 states, as well as five territories, three freely associated states and four large metro areas: New York City, Chicago, Los Angeles County and Washington, D.C.
This year HRSA has awarded $460 million to these jurisdictions to strengthen the ability of hospitals and other health care facilities to respond to bioterror attacks and other public health emergencies. Hospitals play a critical role in both identifying and responding to any potential terrorist attack or infectious disease outbreak.

During the first four years of the program, states used grant funds to develop surge capacity (increased volume of patients) to deal with mass casualty events, such as expanding the number of hospital beds and developing isolation capacity at hospitals. Other priorities included identifying additional health care personnel who could be called into action in the event of an

emergency, as well as establishing hospital-based pharmaceutical caches for hospital personnel and associated EMS.

Recipients also used the funds to increase coordination of disease reporting among hospitals and local and state health departments and to improve coordination and communication between public health laboratories and hospital-based laboratories.
Jurisdictions were required to improve their ability to provide mental health services, strengthen trauma and burn care, and increase their supplies of personal protective equipment and pharmaceuticals. Money could also be used to support training, education, and drills and exercises.

This year the program's focus turns to efforts to improve the capability (ability to manage unusual or very specialized medical needs of patients) of local and regional health care systems to manage mass casualty events and integrate preparedness activities across disciplines and agencies. The goal is to ensure that each jurisdiction has a system in place that will result in fewer deaths, long-term disabilities and required hospitalizations.

Progress has been made in getting the NBHPP funds to the local healthcare system. In the early stages of this program, awardees had some difficulty in quickly expending the large infusion of funds because State health departments were not set up to quickly establish large grant programs. States cited three main reasons for initial delays: (1) some State governments were reluctant to quickly hire the necessary staff to operate these programs; (2) due to procurement processes at the State level, some delays were encountered in trying to award contracts to hospitals and (3) before disseminating funds to hospitals, States were first required to conduct a State-wide Needs Assessment of their ability to respond to a bioterrorist event, infectious disease outbreak, or other public health emergency. These three barriers have

diminished with time and States are now reporting greater success at getting bioterrorism preparedness funds to their local healthcare system.

The NBHPP program has built upon the needs assessments and implementation plans developed by grantees during previous years and the updates of these assessments and plans during FY 2003 through FY 2005. Proposals are approved and funded in accordance with preparedness priorities developed by the States and other jurisdictions. Information on the improvements in hospitals' capacity to respond to public health emergencies in general, and to bioterrorism in particular, is part of the progress reports submitted by the States and other jurisdictions.

The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program is a component of the NBHPP. This program, focused on developing the personnel component of medical surge, has provided grant funds to States for purposes of establishing a standardized, volunteer registration system that includes verified information on volunteer health professional identity, license status, certification, and privileges in hospitals or other facilities. The establishment of these standardized State systems will give each State the ability to quickly identify and better utilize health professional volunteers in emergencies and disasters and will lead to a virtual national system that will allow the easy exchange of volunteers across States and through the Federal government as necessary. The value of these State based registries was demonstrated in the aftermath of hurricanes Katrina and Rita when 21 State registries deployed over 8,300 health professionals to the affected areas.

The NBHPP focus this year and moving forward is to continue to enhance medical surge capacity and capability as well as to develop a response structure that allows the

conceptualization and ultimate implementation of complex health and medical response through a single system.

Since the inception of the program in FY 2002, the NBHPP has established and awarded cooperative agreements to 62 States, Territories and select cities. These cooperative agreements have been essential for developing and coordinating healthcare emergency response plans at the State, regional and local level for the management of mass casualty events that might otherwise overwhelm the healthcare system.

Significant progress has been made by awardees in establishing plans, developing partnerships and collaborations, and assessing crucial needs and how to address them. The majority of jurisdictions have in place, or are finalizing, a system to receive and distribute pharmaceuticals made available from Federal sources, such as antibiotics and smallpox vaccines.

States are putting mechanisms in place to address the gaps in communications systems among hospital emergency departments, outpatient facilities, emergency medical services (EMS) systems, and State and local emergency management, public health and law enforcement agencies. States are also developing strategies to implement memorandums of understanding (MOU) and mutual aid agreements to foster intrastate and interstate collaboration in meeting medical surge needs. These include personnel, equipment and supplies, training and exercises.

A Program Assessment Rating Tool (PART) review of the program was conducted for the FY 2004 budget. The program received a rating of "Results Not Demonstrated". The assessment indicated that the program had not yet demonstrated results due to its relative newness and the inherent difficulty in measuring preparedness for events that do not regularly occur. New performance measures focused on developing medical surge capacity were developed. However, these measures were developed during the PART review and early in the

life of the program and the overall evolution of preparedness response. They are not the best measures as we go beyond developing capacity and work to develop medical surge capability. We are in the process of developing new medical surge capability measures. In January of this year, the program convened an expert panel of awardees, hospitals, State hospital associations, the American Hospital Association, academia and others to develop measures. The draft measures were cross checked against other measures and standards including CDC's performance measures, the Targeted Capabilities List, and JCAHO standards. We underwent a national vetting of the draft measures and just this week we reconvened the expert panel and expect these measures to be in final in the next month.

Health and Human Services Secretary Mike Leavitt recently announced this year's funding for bioterrorism preparedness. On June 7th, Secretary Leavitt said in the award announcement: "Improving our nation's response to public health emergencies is an important part of securing America. All emergency incidents -- whether naturally occurring, accidental, or terrorist-induced --begin as local matters and with this program, States and communities will build on the preparedness gains they've made over the past four years."

This concludes my statement and I would be happy to respond to any questions.