Written Testimony of

L. Anthony Cirillo, M.D., F.A.C.E.P.

Chief, Center for Emergency Preparedness & Response
State of Rhode Island
Department of Health

Emergency Department Attending Physician
Director of Health Policy & Legislative Advocacy
Emergency Medicine Physicians, LLC

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Mr. Chairman and members of the committee, my name is L. Anthony Cirillo, M.D., F.A.C.E.P. I serve as the Chief of the Center for Emergency Preparedness and Response (CEPR) for the State of Rhode Island Department of Health and as a practicing emergency department physician employed by Emergency Medicine Physicians (EMP), a single specialty medical group practice.

I would like to thank you for allowing me to testify today to discuss the current successes and ongoing challenges in planning and preparing for a pandemic influenza event. I would like to share with you my dual perspective as both the coordinator of public health emergency preparedness for our nation's smallest state and as a practicing emergency physician in an urban community hospital. As of today, I can share with you that although progress has been made in preparing the public health and healthcare sectors for response to a pandemic influenza event, there is still considerable work that needs to be done, and there are challenges both of scope and depth of preparation that will need to be addressed in order for our country to meet the challenge of a pandemic influenza event.

The Rhode Island Experience

The Rhode Island Department of Health serves as the sole public health agency within the state as there is no other city / county based public health infrastructure. As such, the department is responsible for the administration of all traditional public health promotional and protection programs, including Healthy People 2010, food and water protection, laboratory, epidemiology and disease control. Beginning in early 2006, the Center for Emergency Preparedness and Response (CEPR) was established by Dr. David Gifford, the Director of Health. CEPR was established to coordinate all public health emergency preparedness activities on behalf of the department. CEPR serves as the liaison entity, on behalf of HEALTH, for all other emergency preparedness efforts within the state and is the designated lead agency for Emergency Support Function #8 (ESF-8), Health & Medical, within the state's Emergency Operations Plan.

In my role as the Chief of CEPR, I serve as the Principal Investigator, on behalf of the department, for both the CDC Public Health Emergency Preparedness (PHEP) and the Hospital Preparedness Program grant administered through the office of the Assistant Secretary for Preparedness and Response (ASPR) within the Department of Health & Human Services. In addition, CEPR serves as the representative entity in participation in the development of investment justifications under the Department of Homeland Security grant funded programs.

The successes in pandemic preparedness in Rhode Island have come, to a great extent, due to the strength of our partnerships and working relationships within the state and the New England region. I would like to acknowledge here today, two other Rhode Islanders who represent key partners within the state with whom the Department of Health has worked closely with in these efforts. Mr. Thomas Kilday, who currently serves as the Homeland Security Grant Manager at the Rhode Island Emergency Management Agency, is a paramedic and previously served as the Program Manager for the Hospital Preparedness Program at the Department of Health. Mr. Peter Ginaitt, who currently serves as the Director of Emergency Preparedness for Lifespan, the state's largest healthcare system, is a former state representative and retired Captain of Emergency Medical Services for the City of Warwick.

In Rhode Island, we have strived to develop an integrated and coordinated system for the public health and healthcare systems to respond to a pandemic influenza event or other public health emergency. Ongoing coordination with our hospitals through the Hospital Preparedness Program facilitated the establishment of ten healthcare coordinating service regions in the state for pandemic influenza. In this model, each of the ten acute care hospitals within the state would serve as the coordinating entity for a geographic area. Utilizing the Hospital Incident Command System for management of healthcare in that area, each hospital will report to the Department of Health as the coordinating entity for all ESF-8 activities within the state.

Volunteers during a pandemic event will be coordinated through Volunteer Reception Centers (VCRs) which will be managed by the Volunteer Center of Rhode Island (VCRI), a non-profit organization with expertise in volunteer coordination. VCRI has been provided funding through the Pandemic Flu grants and has established a single, unified statewide volunteer management system. VCRI will be able to open ten volunteer reception centers simultaneously to manage volunteers throughout the state. Volunteers will be pre- credentialed utilizing the Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), another program funded under the Hospital Preparedness Program grant.

Stockpiling of critical supplies including patient care equipment, personal protective equipment, ventilators, and other support materials at the state level has begun in order to provide an initial cache of materials to equip Alternate Care Sites (ACS) in each of the hospital coordinated healthcare regions.

Outreach and risk communication messaging to the senior community, other special populations, and the general public through brochures, newspaper inserts, classroom materials, and public service announcements has already occurred.

Regional interstate cooperation in pandemic preparedness planning has also occurred among the six New England states and the State of New York. Early in 2006, after US Secretary of Health and Human Services Michael Leavitt's visits to the states to discuss pandemic preparedness, coordinated planning and response to a pandemic event, representatives from each of the Departments of Health in seven states participated in workgroups on the following topics:

1. Community Containment
2. Personal Protective Equipment
3. Antiviral Medication / Vaccine Utilization
4. Laboratory Testing / Disease Surveillance
5. Fatality Management
6. Surge Capacity

These workgroups met in person or by teleconference for ~ 3 months culminating in a two-day summit held in Boston in late June 2006. These workgroups identified common best practices among all the states, as well as the areas of differing response strategies. A key lesson from the summit meeting was that in order for there to be effective public health response to a pandemic, this response needed to be coordinated with state governmental leadership and emergency

management agencies as well. Therefore a tabletop exercise was held at the Naval War College in Newport, RI in August 2006. Participating in this exercise was the seven states noted above as well as representatives from the FEMA Region I and HHS Region I offices.

Despite the progress referenced above, there is still considerable work to be done. Ongoing challenges include:

1. Inadequate funding to purchase enough materiel to ensure care of anticipated numbers of patients during a pandemic influenza event, as federal funding for preparedness continues to decrease.

2. Shifting and inconsistent federal grant priorities related to pandemic flu and overall public health emergency preparedness efforts which create inefficiencies in program management.

3. Disincentives to the purchase of antivirals due to exclusion of state held cache from Shelf Life Extension Program (SLEP).

4. Continued need to coordinate planning across state borders, especially in those states with multiple and close state borders.

The Emergency Department Experience

As a practicing emergency physician, I have personally witnessed and shared with my colleagues across the country, the increasing demand for clinical services being placed on emergency departments. With an increase in the number of uninsured Americans now in excess of 47 million, more and more individuals do not have appropriate access to medical care. In the absence of a medical home, people who experience injury or illness of themselves or loved ones will seek care in the one environment where they know they will never be turned away, the Emergency Department. Emergency departments are the health care safety net for everyone in this country – the uninsured and the insured.

Emergency departments are overcrowded, surge capacity is diminished or being eliminated altogether, ambulances are diverted to other hospitals, patients admitted to the hospital are waiting longer for transfer to inpatient beds, and the shortage of medical specialists is worsening. These are the findings of the Institute of Medicine (IOM) report "Hospital-Based Emergency Care: At the Breaking Point," released in June 2006.

On June 29, the Centers for Disease Control and Prevention (CDC) released its results from its 2005 National Hospital Ambulatory Medical Care Survey (NHAMCS), the longest continuously running, nationally representative survey of hospital emergency department and hospital outpatient department use.

According to the CDC data:

- Emergency visits are at an all-time high of 115 million in 2005 — an increase of 5 million visits in one year.
- From 1995 through 2005, the number of emergency department visits increased by 20%, from 96.5 million to 115.3 million visits annually. This represents an average increase of more than 1.7 million visits per year.
- During this same period, the number of hospital emergency departments decreased by 9%, from 4,176 to 3,795.

Hospitals and Emergency Departments in this country are being challenged to meet the everyday demand for healthcare services. As the population grows and ages there will be more people requiring healthcare services. As the number of uninsured Americans increases, more and more of this care is provided without reimbursement. The overall effect of this increase in demand for healthcare services at the emergency department and hospital level is to significantly reduce, and in many facilities eliminate, any surge capacity for response to a public health emergency, whether it is a pandemic event or a mass casualty incident.

Every day emergency physicians save lives across America. Emergency departments provide an essential community service and are the safety net of medical care in this country. However, emergency departments are at the breaking point and additional resources and long-term solutions must be provided before systemic failure eliminates the ability of emergency physicians to provide care when and where it is needed.

There is a secondary concerning effect of the increase in the demand being placed on hospitals and emergency departments that is a reluctance to invest in preparedness activities. As the healthcare delivery system has become more stressed, both in terms of volume of services and uncertainty in levels of reimbursement, there is an increased reluctance to expend financial resources on preparedness activities, both in support of training and exercises. Although regulatory demands on hospitals and other healthcare facilities to prepare for public health emergencies continue to increase, there is no reimbursement for such activities from private insurers. This puts a greater demand on funding for preparedness activities to come from federal or state sources.

Hospitals today operate utilizing just-in-time inventory management systems, making the delivery of healthcare more cost-effective, but significantly reducing the on-hand availability of additional materiel needed to respond to large scale public health emergencies. Again, this places a greater demand on funding from federal or state sources to meet this critical need.

Engaging and educating the largest part of the response pyramid.

Given that it is unlikely that there will be adequate stockpiles of supplies and equipment for an entire pandemic event, it is imperative that we are able to engage the general public and encourage them to assume responsibility for their own preparedness. Just as the saying goes that "all disasters are local", so is the response to a disaster. In the truest sense for a pandemic, this means that preparedness must begin with individuals, families, neighborhoods, and communities.

It is this last challenge that is the most difficult, and likely the most important in ensuring that society at large will remain intact during a prolonged pandemic event. As the perception of risk of a pandemic event wanes in the media and general public, the receptiveness of the public to risk communication related to preparedness also wanes.

It is critical to the successful response to a pandemic event that we develop a "culture of preparedness" in this country, in order to ensure that those who have the means to prepare for themselves do so. If we can accomplish this through risk communication and broad-reaching educational programs, then the burden of response on government will be reduced so that scarce resources can be shifted to those who are most at risk.

However, reaching and educating the base of the pyramid takes time. While those of us directly involved in preparedness activities can devote the necessary time to incorporate new information and plans regarding a pandemic or other public health emergency into our working knowledge, it is not the primary focus of the general public or other healthcare professionals.

Conclusion

States and our local healthcare partners are willing participants in the development of systems to respond to a pandemic event or other public health emergency. While the resources and support of the federal government is essential to the creating and sustaining the capability and capacity required to sustain a response to a large scale ongoing incident like a pandemic event, the coordination of all large scale public health emergencies will be at the state and local level.

It is important to understand that increased requirements to deliver training and undertake exercises and drills related to pandemic event or other public health emergencies require considerable planning time and utilization of resources in order to be effective. In many cases, these resources are being stretched very thinly, both at the state and healthcare facility level. As the requirements for delivery of more training, drills and exercises increase under federal grant programs it is critical that all federal preparedness grant programs related to pandemic influenza or other public health emergency be more closely aligned and coordinated so that we at the state level can more effectively develop an appropriate response to whatever public health emergency may occur.

Mr. Chairman and members of the committee, I thank you for the opportunity to discuss these important issues with you this morning and would be happy to answer any questions at this time.