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EMERGENCY PREPAREDNESS

States Are Planning for Medical Surge, but Could Benefit from Shared Guidance for Allocating Scarce Medical Resources

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Highlights

Highlights of GAO-08-668, a report to congressional requesters

Why GAO Did This Study

Potential terrorist attacks and the possibility of naturally occurring disease outbreaks have raised concerns about the "surge capacity" of the nation's health care systems to respond to mass casualty events. GAO identified four key components of preparing for medical surge: (1) increasing hospital capacity, (2) identifying alternate care sites, (3) registering medical volunteers, and (4) planning for altering established standards of care. The Department of Health and Human Services (HHS) is the primary agency for hospital preparedness, including medical surge. GAO was asked to examine (1) what assistance the federal government has provided to help states prepare for medical surge, (2) what states have done to prepare for medical surge, and (3) concerns states have identified related to medical surge. GAO reviewed documents from the 50 states and federal agencies. GAO also interviewed officials from a judgmental sample of 20 states and from federal agencies, as well as emergency preparedness experts.

What GAO Recommends

GAO recommends that the Secretary of HHS ensure that the department serve as a clearinghouse for sharing among the states altered standards of care guidelines developed by individual states or medical experts. HHS was silent on GAO's recommendation. HHS and the departments of Homeland Security, Defense, and Veterans Affairs concurred with GAO's findings.

To view the full product, including the scope and methodology, click on GAO-08-668. For more information, contact Cynthia A. Bascetta at (202) 512-7114 or bascettac@gao.gov.

What GAO Found

Following a mass casualty event that could involve thousands, or even tens of thousands, of injured or ill victims, health care systems would need the ability to "surge," that is, to adequately care for a large number of patients or patients with unusual medical needs. The federal government has provided funding, guidance, and other assistance to help states prepare for medical surge in a mass casualty event. From fiscal years 2002 to 2007, the federal government awarded the states about $2.2 billion through the Office of the Assistant Secretary for Preparedness and Response's Hospital Preparedness Program to support activities to meet their preparedness priorities and goals, including medical surge. Further, the federal government provided guidance for states to use when preparing for medical surge, including *Reopening Shuttered Hospitals to Expand Surge Capacity*, which contains a checklist that states can use to identify entities that could provide more resources during a medical surge.

Based on a review of state emergency preparedness documents and interviews with 20 state emergency preparedness officials, GAO found that many states had made efforts related to three of the key components of medical surge, but fewer have implemented the fourth. More than half of the 50 states had met or were close to meeting the criteria for the five medical-surge-related sentinel indicators for hospital capacity reported in the Hospital Preparedness Program's 2006 midyear progress reports. For example, 37 states reported that they could add 500 beds per million population within 24 hours of a mass casualty event. In a 20-state review, GAO found that

- all 20 were developing bed reporting systems and most were coordinating with military and veterans hospitals to expand hospital capacity,
- 18 were selecting various facilities for alternate care sites,
- 15 had begun electronic registering of medical volunteers, and
- fewer of the states—7 of the 20—were planning for altered standards of medical care to be used in response to a mass casualty event.

State officials in GAO's 20-state review reported that they faced challenges relating to all four key components in preparing for medical surge. For example, some states reported concerns related to maintaining adequate staffing levels to increase hospital capacity, and some reported concerns about reimbursement for medical services provided at alternate care sites. According to some state officials, volunteers were concerned that if state registries became part of a national database they might be required to provide services outside their own state. Some states reported that they had not begun work on or completed altered standards of care guidelines due to the difficulty of addressing the medical, ethical, and legal issues involved in making life-or-death decisions about which patients would get access to scarce resources. While most of the states that had adopted or were drafting altered standards of care guidelines reported using federal guidance as they developed these guidelines, some states also reported that they needed additional assistance.