

Hospital Preparedness for Bioterrorism

JAMES D. BENTLEY, PHD^a

I have been asked to address what happens when, despite the best detection, the best prevention, and the best information, people get sick in a bioterrorism attack and end up in the hospital. The hospital is the likely source of care because it is accessible 24 hours a day, 365 days a year. It's where you and I, our friends, and our neighbors assume we're going to get care in an emergency.

The question before us is, what are the challenges facing hospitals as they confront the potential for bioterrorism? I'd like to share thoughts in three areas with you.

THE HOSPITAL'S KNOWN ENVIRONMENT

Let's address three elements of today's known hospital environment. The first is the financial crisis that our hospitals face in terms of what they may think of as "the perfect storm." Like the book and movie, which portrayed the convergence of three storms, hospitals currently face unprecedented change in the three major payment systems that support hospitals.

1. The Balanced Budget Act passed in 1997 has extracted significantly more money from the Medicare payment stream than Congress intended.
2. Most states have moved from a fee-for-service Medicaid payment system for the low-income citizens to a system of using managed care plans. In making that change, the states generally said they would spend no more on a per capita basis than they did under fee-for-service, even though the administrative costs of managed care add 15% to 20% to the cost of the program. That 15% to 20% has come at the expense of quality of care.
3. Private payers, concerned about their cost and competitiveness, have been extremely diligent in holding back on their payments.

In this environment, if the hospital now says, "I want to spend significant sums of money preparing for bioterrorism or a similar event," it is sending a red flag

^aAmerican Hospital Association, Washington, DC 20004-282

Address correspondence to: James D. Bentley, Senior Vice President, Strategic Policy Planning, AHA, Liberty Place, Suite 700, 325 Seventh Street NW, Washington, DC 20004-2802; tel. 202-626-4631; fax 202-626-4630; e-mail <bentley@aha.org>.

© 2001 Association of Schools of Public Health

to the payer community, who hears, “We overpaid you. There’s room to negotiate downward.” This is because no one pays for planning and preparation.

Second, we are in the midst of a major and significant work force shortage throughout the hospital community. Every 10 to 15 years for the past 40 years, someone from the American Hospital Association (AHA) or the American Nurses Association could have described how we had a shortage of nurses. That case exists today, but it’s no longer the core problem. We have a shortage, but it’s not just a shortage of nurses. It’s pharmacists, technologists, technicians, housekeepers, and food service workers. It’s throughout the entire establishment. The shortage is the real constraint on hospital capacity and surge capability. Also, the shortage is not only short term, to be eliminated if the economy softens. It is long term because we face a demographic shift in which the “baby boom” generation had more people going into health careers proportionately than the smaller, subsequent generations coming along. Finally, as we listen to young people, we find that interest in health care careers has moved from favorable 30 years ago to unfavorable today.

The third problem is the regulatory burden facing hospitals. This is a partial list of the regulations currently requiring attention by the executives in the nation’s hospitals:

- Billing system accuracy and compliance;
- Safer needles;
- Limitations on medical device reuse;
- Medical error reduction;
- Medication error reduction;
- Privacy and security of personal medical information;
- Filtering of blood products;
- New requirements for restraint and seclusion;
- Ergonomic standards for employees;
- Reduce solid wastes, especially of heavy metals;
- Heightened productivity to meet BBA payment targets;
- Uniform billing procedures and processes for all payers.

Every item is something that a federal agency believes is appropriate to require the health care system to do. The difficulty for the health care system is that the sum of those regulatory initiatives exceeds—both in cost and management capacity—the ability of the institution to adapt to change and manage.

As the hospital moves forward and looks at

bioterrorism preparedness, their known environment is one in which funds are tight, staffing is short, and regulatory burden for other areas is high.

THE UNKNOWNNS

When the chief executive officer (CEO) and his or her team begin to address preparedness of bioterrorism, one of the first questions is, “What’s known?” Here’s a partial list of the questions they need answered:

- What’s the substance or agent?
- When and where might it strike?
- On what scale will it spread in our community?
- What personal protective gear will the Occupational Safety and Health Administration require?
- What will the Environmental Protection Agency require in the way of disposal of contaminants?
- What will be the impact on the still-coming stream of current patients? After all, if you are a mother about to give birth to a child, you may not find going to a hospital that has a large number of infected patients very tolerable.
- What do we know about the science and procedures for addressing this? In most cases, when the hospital team asks those questions, the outcome is more questions and very few answers.

RECOMMENDATIONS ON PREPAREDNESS

In the face of the unknowns, the Office of Emergency Preparedness awarded the AHA a small grant to bring together people from the federal government and hospitals throughout the country last March to discuss hospital preparedness. Attendees ranged from CEOs to people responsible for equipment and materiel in the institutions. They discussed hospital preparedness for mass casualty incidents and made recommendations. Their general conclusion was that mass casualties by definition will overwhelm the capacity of hospitals and the health care system in this country. For 20 years we have striven to reduce capacity and flexibility to respond to the nation’s interest in cost containment. A mass casualty incident with great numbers of new patients will take us beyond hospital capabilities in any normal sense. In a mass casualty environment, the hospital needs to react in three levels: as an organization in its own right, using its own disaster plan; as a part of the community’s health care system (physicians, public health agencies, laboratories, school health nurses, visiting health nurses, nursing homes); and, perhaps most difficult, as a part of a community-

wide effort that extends far beyond the health care system and includes police and fire in terms of public safety roles and schools in terms of perhaps feeding and housing.

Altogether, the group made about 60 recommendations for hospital preparedness in four areas: the need to prepare for a community-wide response; staffing; communications, including the need for a single voice for the community; and public policy. The report is available on the Internet at www.ahapolicyforum.org/policyresources under "Reports and Publications." Some key recommendations follow.

Staffing:

- Unduplicated count of capacity.
- "Reserve staff" identifying physicians, nurses, and hospital workers who are retired, have changed careers, or now work in areas other than direct patient care.
- Allow physicians and nurses to practice in another jurisdiction in emergencies.
- Develop hospital temporary privileges.
- Plan for support of staff families.

Public Policy:

- Need for a means to pay for the planning, education, standby supplies, and training costs of preparedness.
- The Emergency Medical Treatment and Labor Act needs to be refined.
- Need Congressional commitment to assist in caring for disaster victims and in disaster recovery.

I'd like to emphasize two recommendations: one on staffing and another on public policy. In the past two years, hospital associations have brought their members together to talk about mass casualty or mass disaster incidents. We have asked them what was the most important and most unexpected bottleneck. Consistently, it is care for family members of the hospital staff. From 70% to 85% of the hospital work force is female. Most are heads of household or are responsible for the care of family members in a household. Many disasters—such as an airplane crash, a truck explosion, a bus going off a highway—are very short incidents. They're gone in 24 hours, except for a couple of patients who are hospitalized. Hurricanes, floods, and bioterrorism incidents are long-duration events requiring the staff to stay long hours, remain at their posts, and return to the hospital early. The staff's ability to remain consistently depends on the ability of their family to be protected and cared for. Hospitals have tried

two patterns that haven't worked. One pattern has been to say, "You may bring your family to the institution. Then you'll know they're safe." That's probably not a welcome strategy in a bioterrorism incident. Similarly, saying to the staff, "Go home and take care of your family and return" may not be a successful strategy. The staff member who goes home, turns on television, and sees whatever the media are presenting on the incident may be reluctant to return. At this time, hospitals cannot even tell their staff that a national decision has been made that the staff members and their families will have priority in terms of immunizations or antibiotics. As a result, it's very likely that at least some hospital staff will question whether they want to put themselves in harm's way by returning to the hospital. The ability to sustain the hospital staff at work, in our members' judgment, becomes one of the critical factors as to whether the hospital can function effectively.

There are areas of public policy that appear to be quite detached from bioterrorism or biomedical warfare but are very important. One of them is the Emergency Medical Treatment and Labor Act (EMTALA). Under that law, the hospital must screen and stabilize every patient who presents, even if the emergency department is closed or full. It doesn't allow the community to separate hospitals into those that are clean and those that are exposed. It doesn't allow the community to tell the clean hospitals not to admit exposed patients. All hospitals simply have to see, stabilize, and screen any patient who makes it on the property. EMTALA includes no exception provisions under which a mayor, governor, or other official could waive the general rules in the public health interest of the community.

The act was passed for very good purposes. It was designed to prevent a hospital or physicians in a hospital from refusing to see a patient who did not have insurance by simply sending that patient on to another hospital. However, in the context of a bioterrorism incident, EMTALA gets in the way of the ability to differentiate hospitals and make community-wide or community-level decisions.

CONCLUSION

So, the bottom line on hospital preparedness has three cornerstones.

1. Hospitals already face severe challenges, and they're really not looking for more unfunded mandates.
2. Issues such as care of families and federal statutes like EMTALA obstruct hospital preparedness.

3. As the hospital's leadership team sits down with the trustees to balance today's requirements for care and needs with tomorrow's possibilities, the words "weapons of mass destruction" get in the way. There is no more harmful term to interest the hospital community in preparedness than "weapons of mass destruction." It

holds out no hope. It's a very politically charged term. It is a very negative term. The words being used are important. The words currently being used, particularly "weapons of mass destruction," are reducing interest in hospital preparedness.