



**CALIFORNIA
HEALTHCARE
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

**California Healthcare Association
Testimony on
The Little Hoover Commission
Study of The Public Health System**

*Presented by:
C. Duane Dauner, President
California Healthcare Association
State Capitol, Room 437
Sacramento, California
October 24, 2002*

Introduction

The California Healthcare Association (CHA) is pleased to address the Little Hoover Commission regarding the Commission's study of California's public health system. CHA represents approximately 500 California hospitals and health systems. California hospitals treat more than 3 million inpatients and more than 41 million outpatients annually. These hospitals employ more than 400,000 Californians.

California hospitals provide a wide range of patient services and programs that benefit the residents in their communities. As hospitals deliver more services in non-inpatient settings, outreach activities and community interaction, including coordination with public health programs, are increasingly becoming an integral part of their everyday activities. Improving quality and community health status are high priorities for both hospitals and public health programs.

The CHA vision for California is "an optimally healthy society." Our goal is for "every Californian to have equitable access to affordable, high-quality, medically necessary health care." To achieve these standards, strong public and private health care systems must exist and work together.

Important Role of Public Health

Public health must be viewed as a combination of federal, state and local programs. At the federal level, public health programs include the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration and the Federal Emergency Management Agency. Each has a specific role in the public health of our nation.

At the statewide level, public health is structured to interface with federal and local public health programs. Also at the state level, public health has an educational and regulatory focus to protect the public. Some state public health efforts focus on providing services to the medically indigent. Hospitals rely on state public health to be responsible for coordinated emergency communication systems, and disease surveillance utilizing information systems and laboratory services.

At the local level, some counties have become a major provider of services to the medically indigent in addition to their surveillance of water wells, food service establishments, etc., and related tracing, screening and prevention activities.

Prior to World War II, federal, state and local public health were responsible for all aspects of communicable disease prevention, identification and treatment. During the past 50 years, the development of vaccines, antibiotics and changes in lifestyle behaviors have changed the role of public health. These changes have resulted in the "benign neglect" of the traditional public health system and have placed the focus of public health on the care of the indigent. While many hospitals still work closely with local health departments, the relationship at the state level has changed considerably. The state Department of Health Services (DHS) performs many traditional state health department services and functions, including the licensing of hospitals.

In addition, hospitals in California now are regulated under the guise of public health by the Air Resources Board for pollution emissions; the Department of Toxic Substances Control for the disposal of hazardous wastes; Cal/OSHA for employee injuries; the State Fire Marshal for life/safety issues; the Office of Statewide Health Planning and Development (OSHPD) for building code requirements; and the Office of Emergency Services (OES) and the Emergency Medical Services Authority (EMSA) for disaster preparedness and response. The list of state agencies that ensure the health of the public is long but most are not part of the state's traditional public health department.

In recent years, the fire or police departments are the first responders to a disaster. Bioterrorism is creating unprecedented demands that must involve public health departments. Therefore, in preparing for and responding to terrorist incidents, the latest threat to the health of the public, it is not simple to determine the role of public health. The expansion of state and local entities, now responsible for protecting the health of the public, requires an overall coordination function at the state level. The state should also identify the role traditional public health should play.

Importance of Being Prepared For All Types of Disasters

Prior to World War II, disaster response was usually handled locally with the assistance of the Red Cross. Communicable diseases, such as tuberculosis, malaria and diphtheria, were handled by public health officers and nurses. In the case of an epidemic, federal public health service teams were brought in as needed. As these diseases came under control, the role of local health departments became one of chiefly data collection from hospitals and physicians for certain communicable diseases.

In disasters, such as earthquakes, floods, fires, explosions, etc., first responders such as fire and police take the lead. Hospitals treat the injured sent to them. The role of the traditional public health department in a disaster is to ensure that issues such as water contamination are addressed. In a terrorism incident, we may or may not rely on the traditional method of response. In an explosion, the traditional disaster response could be used. However, in a bioterrorism chemical or radiation terrorism incident the response would be very different. Hospitals and clinics may be the first responders. Just as hospitals backup fire and police, hospitals require backup when they are the first responders. Hospitals may not have the surge capacity to treat victims nor have the resources for decontamination, isolation or treatment. Further, hospitals may not be the best option for handling such cases.

While the State Strategic Committee on Terrorism, OES, EMSA, state and local public health, as well as hospitals, are working on terrorism preparedness and response through various venues, today we are not prepared to address most responses to terrorism incidents.

Special Challenges For Hospitals

In carrying out the role of first responder in a disaster or in assisting traditional first responders, hospitals face a number of special challenges. CHA has attached reports to this testimony which address these special challenges:

Attachment 1: "CHA Summary of California Hospitals' Financial Performance 1996-2001," October 2002 (1 page)

Attachment 2: "OSHPD Quarterly Report Annual Executive Summary Report for 2000 and 2001" (1 page)

Attachment 3: "CHA Health Care Scene in California and the Future," June 2002 (8 pages)

Attachment 4: CHA Special Report: "Financial Pressures Continue for California Hospitals," March 2002 (4 pages)

Attachment 5: CHA Special Report: "Rural Hospitals Contributions to Health Care and Local Economics," July 2002 (4 pages)

Attachment 6: CHA Special Report: "Nursing 2000: California Health Care Providers Face Critical Issues," October 2000 (4 pages)

Attachment 7: "Financial Health of California's Hospitals," Shattuck-Hammond Partners, San Francisco, June 8, 2001 (103 pages plus appendices)

The following is a summary of the special challenges facing California's hospitals.

Financial Stresses

In 2001, California hospitals collectively had a negative operating margin of -2.48 percent. Approximately two-thirds of California hospitals are losing money from operations and approximately one-third from all sources of income. In 2001, California hospitals had \$3.3 billion in uncompensated care costs. The 1997 federal Balanced Budget Act will result in a total reduction of \$5 billion in California Medicare payments by 2005. Medicare pays less than 90 percent of actual costs. Medi-Cal is a worse payer than Medicare. California ranks last among the 10 most populous states in Medi-Cal expenditures per eligible and 47th nationwide. Health plan payments from the private sector dropped or remained level between 1993 to present. Some private health plans have delayed payments, denied claims, requested extensive backup information and taken other actions to disadvantage hospitals. Some plans currently transfer more financial responsibility to patients. California also has 7 million uninsured many of whom use hospital emergency rooms as their point of entry into the health care system.

California's 70 rural hospitals are in worse financial shape than their urban counterparts because of diseconomies of scale and the fact that they have a greater percentage of indigent patients.

Hospitals face external stresses on an ongoing basis. Workforce disruptions, personnel shortages and restrictive legislation, such as nurse-staffing ratios, are examples. With the shortage of nurses, hospitals will be forced to close needed services in order to comply with the ratios.

Regulatory agencies, while a necessity, can also cause stress. Due to seismic-safety requirements for plan review and the area compliance process, it takes two to three years longer to construct a new hospital in California. Since hospitals use or generate small amounts of silver halide, mercury, dioxin, ethylene oxide, pharmaceuticals listed as hazardous materials, and low-level radioactive waste, California hospitals are required to meet stringent state laws aimed at refineries, mining operations and utilities.

Another stress, which is unique to California, is the initiative process. Some propositions use general fund monies that would have gone to health care for non-health activities when they are enacted. Examples on the November 5, 2002, ballot are Propositions 49 and 51.

Workforce Issues

Severe shortages exist in nursing, pharmacy, laboratory, radiology, social service, specialty and technical areas. By far, the largest vacancy is nursing. These shortages have developed over time and cannot be resolved overnight. CHA is sponsoring legislation to increase the number of registered nurse student positions; streamline the education processes and enhance vertical mobility; and provide scholarships and loans to qualified students. In departments with fewer employees, the loss of a pharmacist, laboratory technologist, etc., can be even more problematic than losing one nurse.

Costs will increase as a result of nurse-staffing ratios; financial pressures on hospitals will be exacerbated. The state DHS estimates that the ratios will cost hospitals \$480 million annually. Regardless of cost implications, a sufficient number of new nurses is not available. Consequently, hospital services will be curtailed and patients will not have access to needed health care. Hospitals already are forced to shut down units or services temporarily because nurses are not available to staff the services. Emergency and special services are the most vulnerable. The regulatory process is expected to be completed in 2003, with the ratios going into effect by January 2004.

According to the California Employment Development Department, estimates indicate that California will have a shortfall of approximately 109,600 nurses by 2010. Projections for the shortage are based on a ratio of 545 registered nurses (RNs) per 100,000 patients and an increase in population of 17.7 million. California is currently 49th in the number of nurses per 100,000 population.

The nurse shortage is further eroding California hospitals' financial position. Hospitals are paying registry and traveling nurses much more than staff nurses (approximately \$25 to \$50 per hour for staff nurses; \$60 to \$90 per hour for registry/traveling nurses). The same survey indicates an average urban California hospital is spending approximately \$1.5 million annually for registry/traveling nurses above the costs that would be incurred if the nurses were employed by the hospital.

The workforce shortage in the hospital setting must be addressed in preparation for a terrorist incident.

Technology and Pharmaceuticals

PriceWaterhouseCoopers in an April 2002 report on “The Factors Fueling Rising Healthcare Costs” estimates that the costs of medical advances, including drugs, devices and testing, increased 22 percent between 2001 and 2002 and is the biggest factor in rising health care costs. The American Hospital Association (AHA) reports that this 22 percent increase represents \$15 billion of the increase in health premiums. Today, 10 percent of health care costs are attributed to drug expenses.

Unfunded Mandates

California hospitals get hit with numerous unfunded mandates. These include the seismic-safety mandate which requires that all hospitals meet life/safety seismic standards by 2008, and are in substantial compliance with more strict standards by 2030. This unfunded mandate is projected to cost \$24 billion without financing costs. However, RAND recently completed a study stating the mandated costs could be as high as \$41 billion. The state estimates the nursing-staffing ratio mandate will cost California hospitals \$480 million per year.

As a result of California’s stringent environmental laws, California hospitals pay significantly more than hospitals in other states for the disposal of medical, hazardous, pharmaceutical and low-level radioactive waste. In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), also known as the Kennedy-Kassebaum Act. HIPAA provides protection for employees that change jobs and contains other requirements that ensure that individuals with health insurance are treated fairly. HIPAA also establishes significant transaction, privacy, security, confidentiality, reporting and compliance requirements. Many of these new standards require system changes for hospitals and physicians. To comply with HIPAA, California hospitals will spend up to \$3.5 billion by 2003. Yet, there is no increase in Medicare payments or in any other program to cover these dramatic new costs.

Quality/Patient Safety

Hospitals strive to provide quality care and the level of quality is monitored by numerous public agencies and private groups. PriceWaterhouseCoopers estimates that health care costs went up 7 percent between 2001 and 2002 due to litigation and risk management issues. Although not yet mandated, hospitals are being strongly encouraged by patient advocates and insurers to use computerized physician order entry systems to reduce errors. The estimated cost is more than \$1 million per hospital.

California was the first state to mandate the use of sharps safety devices. While safety devices reduce workers’ injuries, on average the price of the devices has tripled.

Surge Capacity

For years there was a surplus of hospital beds. That surplus no longer exists. Currently, according to OSHPD, California hospitals have a total of 104,758 licensed beds and 93,455 beds available to treat patients. However, only 82,362 beds are staffed. This figure includes all beds

including skilled nursing, rehabilitation and mental health. The licensed bed number is of no use for planning purposes because many of these beds no longer exist. The licensed number also includes beds that are currently in suspense. Due to staffing shortages many of the available beds cannot be used in a disaster. This was evident in the flu epidemics of 1998 and 1999. This will become a larger issue due to the seismic mandate. By 2008, 39 percent of California's 2,500 hospital buildings will have services diminished for an extended period of time due to major structural and nonstructural retrofits and replacements. An additional 50 percent will have diminished capacity for a shorter period of time to meet nonstructural retrofitting requirements. The majority of hospitals will downsize inpatient bed capacity in meeting the seismic-safety mandate. The vast majority of California hospitals do not have the surge capacity to meet the demands of a disaster.

To address surge capacity this year, CHA sponsored AB 2035 (Frommer, D-Los Angeles) which proposed three mobile disaster field hospitals in the state of 40 beds each that could be used as one, two or three separate units. The estimated purchase cost is \$10 million, complete with furnishings and supplies. The annual operating costs with replenishment of outdated supplies is \$1 million per year for all three disaster field hospitals. The bill was held in suspense during the 2002 session, due to its cost.

Susceptibility to Infection

Due to many hospital patients being in a weakened state and many other patients suffering from contagious diseases, it is relatively easy for contagious diseases to spread in a hospital. Hospitals are required to maintain infection-control programs that include surveillance, education, standard precautions, established practices and engineering components.

In a bioterrorism event, hospital patients would be susceptible to smallpox or to another contagious or contaminating agent. CHA is taking a number of steps to help hospitals prevent infections, including:

- Working with DHS Infection Control and Communicable disease programs to establish infection control standards and educate hospitals on their implementation.
- Working with the Hospital Building Safety Board and OSHPD on reviewing current hospital air exchange standards to determine whether current standards need to be changed.
- Keeping CHA members up to date on the most current CDC guidelines and providing other educational materials, including information on new products which reduce infection.
- Promoting the concept of the disaster field hospital to keep victims of a bioterrorism incident from spreading the disease to hospital patients and to ensure that there is more surge capacity.

ER/Trauma Care Crises

There are 45 trauma centers in California (see Attachment 8). Most of the other general acute-care hospitals operate an Emergency Department (ED). The three levels of EDs are comprehensive, basic and standby. Most trauma centers and EDs lose money. They must be open, staffed and available 24 hours every day. Facilities, equipment and hospital personnel shortages, and the lack of physician coverage make emergency services vulnerable. Personnel shortages and the lack of specialty on-call physician coverage make it difficult for hospital EDs to remain open. Statewide, hospitals are losing more than \$400 million annually operating trauma centers and EDs. Further, hospitals are paying physicians more than \$250 million each year to maintain on-call availability. As the financial, space and human resources vises close in hospitals will be forced to go on diversion with increasing frequency. In such instances, emergency patients must be treated at other hospitals. However, these problems are statewide and patients may be unable to obtain timely emergency care. The trauma center/ED issue must be an immediate priority. Funding, rules, personnel, equipment, facilities and coordination are high on the priority list. California hospital EDs do not always have the surge capacity needed to treat patients on a daily basis. EDs cannot be counted on for a terrorist response.

Consequences of September 11, 2001, Incident

Since September 11, 2001, all hospitals in California have increased their preparedness in the event of a terrorism incident. It is fortunate that EMSA had a terrorism preparedness education program scheduled in October 2001. The majority of hospitals attended these sessions. Hospitals have been working closely with the 26 local EMSAs (LEMSA) which cover the state and include one or more of the 58 counties. Many hospitals conducted terrorism drills. Some hospitals have purchased personal protective equipment and others are focusing on decontamination preparedness. To date, there has been no state effort coordinating these activities. Depending upon the county, there may or may not be coordination with traditional first responders. Some fire and police have no interest in conducting disaster drills with hospitals. None have been coordinated with the National Guard.

As part of the Health Resources Services Administration (HRSA) Grant Program managed through EMSA, a detailed terrorism preparedness and vulnerability assessment will be conducted of all California hospitals. CHA is working closely with EMSA to ensure that there is at least a 90 percent response to the survey. The survey is key to assessing and planning for the role of hospitals and public health in disaster preparedness and response, as well as establishing funding priorities.

The American College of Emergency Physicians (ACEP) reports that nationally only one out of every 30 hospitals had stockpiled medications for a bioterrorism incident prior to September 11, 2001. They also found that 87 percent of hospitals could handle no more than 15 casualties at any time. ACEP also reports that prior to September 11, 2001, no hospitals were prepared for a bioterrorism incident and 73 percent were unprepared for a chemical incident.

Based on AHA estimates, California hospitals require \$1.3 billion to be prepared to respond to a terrorism incident, exclusive of facility construction costs.

Community Preparation for a Response to a Disaster

Hospital employees and physicians on their medical staffs provide around-the-clock care as a routine matter. In times of disaster or emergency, they continuously make extraordinary sacrifices in their dedication to care for patients. From fires, earthquakes, riots, train wrecks, airplane crashes, vehicular accidents, floods and hurricanes, to personal assaults and terrorist attacks, hospital employees and physicians respond with untiring commitments to saving and caring for patients.

In President George W. Bush's Executive Order creating the Office of Homeland Security, the following sobering statement was included, "According to the Johns Hopkins Center for Civilian Biodefense Studies, no hospital or group of local hospitals in the United States could effectively manage even 500 patients demanding sophisticated medical care such as would be required in an outbreak of anthrax. In the event of a contagious disease outbreak, such as smallpox, fewer patients could be treated. There are not enough staff, beds, supplies or drugs to cope with a sudden, significant surge in patient demand." In a recent briefing AHA held on the World Trade Center (WTC) disaster, it was reported that the four hospitals closest to the WTC had enough problems caring for their existing patients let alone treating additional patients. Although the emergency departments in America's hospitals are the frontline of medical assistance to victims of terrorist attacks and their families, California's trauma centers and EDs confront a Code Blue crisis of inadequate payments and a shortage of space and facilities.

Surge capacity will be vital to Californians in the event of an attack. Yet, it may not be available and it is expensive to maintain. No amount of government drills, review of disaster plans or training of clinicians will solve the basic problems of inadequate medical capacity and under financing.

We must be honest and understand that a major mass casualty incident will overwhelm the resources of most communities and individual hospitals. This, in and of itself, should not be viewed as a "failure" of our emergency or health care systems. Rather, it should re-emphasize the importance of local and regional cooperation between hospitals and public health and others that play a vital role in responding to disasters.

If a disaster occurs in California, there are components in place to respond. LEMSAs take the lead in California's bottom-up approach to disaster response. However, due to size, budgets and location, all LEMSAs are not equal. There is not a state agency that establishes a minimum policy for LEMSAs nor are they evaluated. CHA, DHS and EMSA are working to ensure all California hospitals are utilizing the Hospital Emergency Incident Command System (HEICS) in time of disaster. HEICS is a management tool, which allows for a customized hospital response to the crisis at hand. It enables hospitals, medical transportation, law enforcement, fire and local governments to communicate more quickly and efficiently. HEICS was successfully used in a regional response to the 1994 Northridge earthquake.

The HEICS model helps hospitals interact with the Standardized Emergency Management System (SEMS) used by state and county agencies to facilitate mutual aid. The use of HEICS and SEMS assists in the integration of roles and the deployment of resources, including:

- Medical Supplies
- Medical Personnel
- Patient Transportation
- Needed Utilities
- Needed Mechanical Systems
- Food Service
- Facility Inspection
- Facility Evacuation

There are three key components for a response to a disaster that require immediate attention in California:

Communications

Communications need immediate attention. Numerous counties have their own systems through which hospitals can identify available beds and determine which ones are on diversion. Unfortunately these systems are not compatible across county boundaries. At this time, greater Los Angeles, San Diego, San Francisco and Santa Clara counties have systems that are not compatible. If California had a disaster that destroyed phone and e-mail communications, communication would only occur via the World War II technologies of HAM radios and walkie-talkies. At this time, there is also no common terminology or a data set that could be used in communications.

Fourteen state agencies are currently planning a radio communications system; however, neither counties nor hospitals are involved in the planning of this system.

There must to be a state-level entity that coordinates and oversees all disaster-related communications.

Surveillance

The state is developing the Rapid Health Emergency Alert Communication and Training System (RHEACTS) as California's health alert network. RHEACTS must be developed to interface with other communication and surveillance systems. The development of a surveillance program is a key criteria that must be met if money is forthcoming from CDC. The program must be developed to expand comprehensive statewide surveillance for priority threat agents and include hospitals and clinics.

Funding

Although the federal funds coming to California are inadequate to prepare for a terrorism incident, they are substantial and can assist in terrorism preparedness and response if used wisely. These include:

- CDC Grant (Public Health) - \$60.6 million

- Additional CDC L.A. share (Public Health) - \$25.0 million
- HRSA Grant (Hospitals) - \$10 million
- Additional HRSA L.A. share (Hospitals) - \$3.6 million
- Metropolitan Medical Response System (MMRS) Grants (18 largest California cities) - \$600,000 each
- FEMA Grants (Traditional First Responders) - \$400 million (\$300 million local and \$100 million state)

At this time there is no program to prevent duplication of effort among these programs nor is there any effort to coordinate the optimum use of these funds.

Recommendations

California entities involved with disaster preparedness and response activities have a long history of working with disasters, averaging more than one major disaster per year during the past 14 years. However, a biochemical, nuclear or radiation terrorist incident is different from a typical disaster and requires many more resources and much more coordination between the public and private systems involved with disaster preparedness and response. CHA recommends the following:

- Although California has a bottom-up planning response for disaster preparedness and response, there should be a single state entity that sets overall policy to ensure there is coordination of efforts and avoidance of duplication. CHA believes the state entity should:
 - Develop an overall plan for the expenditure of grant funds.
 - Ensure there is a coordinated surveillance system throughout the state.
 - Ensure there is adequate and coordinated laboratory and other testing capacity.
 - Ensure coordination between existing and new communication systems.
 - Ensure there is coordination of education and training programs, as well as coordinated disaster drills.
 - Ensure there are resources available to meet the needs of the worried well and friends and family of victims. This should be outside of the hospital setting in order to make better use of limited resources.

- Engage first responders and lay stakeholders in efforts that result in coordinated planning and deployment of hospital resources to treat victims.
- All existing disaster-related communication systems must be linked and new communication systems must be compatible with existing systems.
- California should give priority to the development of a surveillance system that includes direct access to hospitals and clinics.
- California should develop the use of disaster field hospitals to assist with needed surge capacity and to handle cases that should not be treated in existing community hospitals. Further, updating of arrangements to use military disaster field hospitals would broaden the base of support in the event of a bioterrorism incident.
- The current California Government Code and Health and Safety Code give broad powers to the Governor and local health care officers in responding to a state of emergency. There should be a state entity working with public and private entities in fleshing out some of these powers through regulations. Some key issues that need to be addressed include:
 - Quarantine, isolation and vaccination policies.
 - Role of government, if any, in directing the operation of non-governmental hospitals during a state of emergency.
 - Government reimbursement of costs to private entities assisting in a terrorism response.
 - Relief from certain regulations when a public health terrorism emergency is declared.

Summary

The public health system in California has been shortchanged for decades. Now, new threats to the health of Californian's bring new focus to the importance of public health services that are coordinated with other resources throughout the state.

Making the decisions to adequately fund public health, hospitals and other key players in the emergency services/health care delivery systems will be difficult. Many meritorious programs are competing for scarce financial resources. Nevertheless, innovative vision and strong leadership are needed to preserve the health of Californian's; to be as prepared as reasonably possible for unanticipated incidents; and to make California a safer place to live.

Thank you for the opportunity to present these views for your consideration.