



TEXAS HOSPITAL ASSOCIATION

**Presentation to the
Senate Health and Human Services Committee
Regarding H1N1 Issues**

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On behalf of the
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On behalf of its 490-member hospitals and health systems, the Texas Hospital Association is pleased to provide its perspective on how hospitals responded to the recent H1N1 pandemic. The world is fortunate that the H1N1 virus was not as virulent as originally anticipated. H1N1 was a good test, and hopefully we will learn from our experiences and be better prepared when the next pandemic occurs for it may be more threatening.

As I told the House Public Health Committee two years ago this when we were studying the state's response to Hurricanes Katrina and Rita, **hospitals never will meet preparedness expectations unless the state's underlying health care infrastructure is sound.** Two years later, our state's health care delivery system is under even more duress.

Recommendation #1: Texas needs a strong health care delivery system.

Hospitals across the state are struggling to maintain adequate emergency room and intensive care unit capacity to respond to normal demands for services. Trauma diversion at hospitals is a warning that hospitals can be overwhelmed in a disaster. Texas faces serious growth-related challenges; the state's population has been growing almost twice as fast as the nation's, so there are more people who need health care services. And, the population is aging, which is increasing the demand for services. Bed supply must keep pace with population growth. Today, patients use hospital emergency departments for primary care because they do not have primary care physicians, often due to lack of health insurance coverage.

Funding for government programs – such as Medicare and Medicaid – must keep pace with demand for services. Medicaid caseloads and utilization estimates need to be realistic rather than budget-driven. At times – such as during flu season – the demands on the health care system exceed capacity. A catastrophic medical event – similar to an H1N1 outbreak – or a natural disaster could overwhelm existing resources.

Texas must deal with the following issues to make sure our current health care delivery system is strong:

- The large uninsured population;
- Inadequate access to affordable health insurance;
- Inadequate incentives for businesses to provide employees with health insurance coverage;
- Inadequate funding of Medicaid and the Children's Health Insurance Program; and
- Barriers to achieving clinical integration and reducing physician shortages.

To address these issues and strengthen the state's health care delivery system, Texas hospitals recommend the following:

- Adequately funding Medicaid will help eliminate the cost shift to paying patients, which will reduce premiums;
- Appropriating all of the money collected to offset a portion of uncompensated trauma care which would give hospital emergency departments more resources to prepare for and respond to crisis situations;
- Making health insurance more affordable will make it more accessible; more insured Texans means less cost shifting, which will reduce premiums;
- Driving adoption of evidence-based medicine through reimbursement policies and pilot programs will reduce costs for all payers;
- Repealing the arcane prohibition on the corporate practice of medicine would help hospitals – particularly those in rural areas – recruit physicians and improve access to care; and
- Encouraging transparency and accountability for *all* providers would improve patient outcomes and likely lower costs.

A stronger health care delivery system throughout Texas will enable the state to respond more efficiently and effectively to whatever disaster may strike.

Recommendation #2: Resolve vaccine-related issues.

There are a number of lessons to be learned from the H1N1 pandemic. First, vaccine issues were part of the problem.

Production of Vaccine/Essential Products

Thousands of Texans die or are hospitalized each year because they don't get influenza vaccinations. While public education encourages people to get vaccinated, in the case of H1N1, the vaccine was not available initially. In my 2008 testimony, I discussed the need for increased domestic vaccine production. The concern about vaccine production has not been resolved. Had the H1N1 pandemic been more life threatening, early delays in production and distribution would have had dire consequences.

Concerns about vaccine production capacity also apply to other essential products. In the case of the H1N1 pandemic, manufacturers were unable to provide an adequate supply of face masks, despite federal standards of care that required their use. In addition to having the capacity to produce vaccines and other essential products quickly, manufacturers also must have contingencies to expand production quickly as the pandemic or mass casualty hazard grows.

Vaccine Distribution

Another vaccine-related issue involves ordering and distribution. TDSHS is to be commended for putting together an order/distribution system on such short notice. However, most hospitals agree that the ordering /distribution process can be refined. Initial confusion regarding the anticipated requirements for use of IMMTRAC for vaccine data collection/entry discouraged private physicians from participating which resulted in increased burden for health care facilities. Participation in vaccination efforts by private physicians is critical, and the state must create a data collection system that does not impede their involvement.

Confusion about vaccine delivery also created problems. Once ordered, vaccine was slow to arrive. Hospitals did not know when vaccine would arrive. Sometimes vaccine and supplies came separately and at other times together. Some hospitals have suggested that vaccine should be delivered directly to pharmacies to ensure prompt, appropriate storage. THA suggests that TDSHS interview hospital pharmacies directly to get their input about refining the distribution processes. THA would be pleased to facilitate this effort.

Some hospitals experienced problems related to vaccine expiration dates. Inadequate information and poor communications created confusion and unnecessary problems. Again, specifics on how to resolve these problems would best be offered by hospital pharmacists.

Vaccine Distribution Priorities

Hospitals also have expressed concern about distribution priorities. In general, health care workers must receive vaccine before the general population. However, there currently is no mechanism to enforce vaccination priority once vaccine is released into the commercial network. THA understands that some clinics ordered vaccine and marketed it with little attention to priority populations. Government should ensure that priorities are followed.

To prioritize vaccination of health care/hospital workers, hospitals must be given sufficient supplies of vaccine to enable them to vaccinate not only health care workers *but also* all members of the worker's household. Household members should be designated at the same high priority for vaccination as the health care workers themselves. The ability of any hospital to respond to rapid increases in demand for health care services is crucially dependent upon sufficient personnel able to report for work. Unless

family members are vaccinated, some health care workers will need to stay home to care for sick children or spouses rather than come to work.

Mandatory Vaccination of Health Care Workers Issues

Vaccination of health care workers protects not only the health care worker, but also the patients they treat. The decision to serve as a health care worker is a personal choice, and inherent in that decision is a willingness to treat and protect patients using the best practices available. Those practices often include vaccination. Federal law provides liability protection for adverse reactions to manufacturers and those administering the vaccines.

Without doing a survey of hospitals, it is impossible to give specifics about hospital policies related to vaccination of health care workers. However, based on anecdotal evidence, THA can report that policies seem to vary among hospitals. While science has proven that the benefits of vaccination for influenza outweigh the risks, some hospitals experienced a few health care workers who refused to take the vaccine when it became available. Some hospitals allowed employees who refused vaccination to continue to work but required them to take other precautions, such as wearing masks. In a few cases, non-compliance with hospital-specific policies led to dismissal.

An inherent problem in mandating health care employee vaccination is the problem of liability. If an employer mandates vaccination as a condition of employment, will the employee sue for discrimination? Should a mandatory policy apply to all health care employees, or just those with direct patient contact? What is the hospital's liability if a mandatory vaccine is not available for administration? A mandate from the state requiring vaccination – along with rapid distribution of vaccine for health care workers – potentially could improve compliance, as well as address employer liability issues.

Recommendation #3: H1N1 treatment guidelines and protocols should be clear and evidence-based; Texas should communicate problems to the appropriate federal officials.

Some hospitals and physicians reported issues with federal guidelines for treating H1N1 patients. Disputed science led to confusion over the use of N95 masks. The recommendations of national professional groups (Society for Healthcare Epidemiology of America, Infectious Disease Society of America, and Association for Professionals in Infection Control and Epidemiology) were ignored. This created problems for hospitals, and N95 masks were used to follow national guidelines when infection control practitioners thought they were not needed. Despite acknowledgement of flaws in the science on which the use of N95 masks was recommended, the guideline remains in place. Government should listen to those with expertise in infection control and follow their recommendations.

Physicians have reported inadequate guidance on the use of Tamiflu. Some of the initial recommendations for treating H1N1 were not fully vetted before they were issued. More concerning is that these issues were not resolved between the first wave of H1N1 in April, and the follow-up wave in the fall.

States expect the Centers for Disease Control and Prevention and the Occupational Safety and Health Administration to provide leadership and direction. While the state follows federal public health guidance, it is important for Texas to share its concerns and problems. Dr. Lakey is raising Texas concerns with federal public health officials, and Texas hospitals support his efforts.

Recommendation #4: Provide some liability protection for physicians and other health professionals who provide care in emergency situations, such as a pandemic or natural disaster with mass casualties.

When a large scale disaster occurs – from a hurricane to a pandemic – having an adequate number of health care professionals available is critical. Some licensed professionals may be reluctant to provide services due to concerns about their liability.

In a crisis, doctors see patients without the benefit of the complete medical history, or diagnostic tests may not be available.

Especially in life-threatening situations, quick action is required, often under less than optimum situations. Health care professionals doing their best should not be subject to the same medical standards as they are under normal circumstances. Changing the standard that constitutes malpractice to “gross negligence” in emergency situations would help ensure an adequate supply of medical professionals in these times of great need.

Recommendation #5: Better public education about self-care and better communication with the news media are needed to reduce over- and inappropriate reaction to the outbreak of an infectious disease, like H1N1.

THA knows that inappropriate use of hospitals during the H1N1 pandemic diminished their effectiveness and led to some mild chaos. The media and government must learn to refine their messages. The data on H1N1 did not support the elevated level of public anxiety, much of which was created by government and media pronouncements. The politics of fear and 24/7 news have created a response addiction. Actions always must be measured in response to the threat.

Perhaps because of that fear – and misinformation – some hospitals were overwhelmed with patients seeking vaccinations as well as diagnosis/treatment. For example, Dell Children’s Medical Center of Central Texas here in Austin had to erect tents to accommodate all of the parents/children seeking vaccination as well as treatment for potential H1N1 infection. Had other avenues been available – private physicians’ offices or more public health clinics – this response would not have been necessary. Triageing patients at the hospital is an expensive, inefficient way to provide vaccination or diagnosis for what often turned out to be a simple cold or flu.

Having to set up a large triage area to assess whether individuals have been exposed to H1N1 potentially compromises the availability of staff to treat true emergencies or an increased inpatient load. While the hospital emergency department is the only access to care for uninsured patients, those with insurance also sought help at hospitals, partly because their doctor was not available after-hours or on weekends, or had a long wait time for an appointment.

Uninsured patients who presented at hospitals seeking help with H1N1 issues were treated the same as any other uninsured patient. By state and federal laws, hospitals are required to assess and stabilize any patient who presents in the emergency department, regardless of ability to pay. Some hospitals established separate areas for people who potentially had H1N1 to limit its spread. As is the case with any other non-life threatening condition, use of the emergency department is the most expensive place to obtain treatment. Alternatives to ED care – such as private physician offices or clinics – would be a more efficient use of resources.

State officials should examine how public health priorities are communicated to physicians. THA is aware of one clinic that would not accept Medicaid patients even though it received free vaccine and supplies. When commercial providers receive free vaccine and supplies, they must respect priorities set by state and federal governments or face penalties. Government did not enforce its policies.

Summary

The H1N1 pandemic should teach us that we must move to the next level of preparedness. THA recommends the following actions to accomplish that:

- Work with stakeholders to create a strong health care delivery system for Texas, including adequate state funding.
- Help the Texas Department of State Health Services resolve vaccine-related issues.
- H1N1 treatment guidelines and protocols should be clear and evidence-based; Texas should communicate problems to the appropriate federal officials.
- Provide some liability protection for physicians and other health professionals who provide care in emergency situations.
- Improve public education about self-care and communicate more effectively with the news media to reduce over- and inappropriate reaction to a crisis, from the outbreak of an infectious disease like H1N1 to a natural disaster like Hurricanes Katrina, Rita and Ike.

The Texas Hospital Association is pleased to have partnered with TDSHS and the State Office of Emergency Management on several disaster situations. THA's primary role is facilitating communication among hospitals and state agencies. The state's response has improved steadily, and THA will continue to work with the Legislature, appropriate agencies and other stakeholders to achieve better emergency readiness.

Thank you.