

Financing Surge Capacity and Preparedness

A white paper prepared for the June 10-11, 2009 workshop on medical surge capacity hosted by the Institute of Medicine Forum on Medical and Public Health Preparedness for Catastrophic Events

*By William M. Smith
Senior Director Emergency Preparedness, UPMC*

Introduction

The fact that hospitals and health systems face numerous financial pressures relating to everyday operations is well documented. The dawn of less advantageous private third party payor agreements and reductions in federal reimbursements, along with increasing human resource, supply, and technology costs as well as an aging infrastructure have created significant hardships. In addition to this economic stress, hospital Emergency Departments and inpatient facilities are routinely operating at or near 100% of capacity on a daily basis. Given all of this, the unilateral investment in surge capacity has been minimal.

In the face of an emergent surge condition, whether occasioned by a sentinel incident such as hurricane Katrina or a slower-growing event such as pandemic influenza, hospitals' already stretched resources are stressed even further. (Even though actual evidence from Toronto in 2003 shows that hospital inpatient admissions may actually decrease during such an event¹).

Federal funding for hospitals and public health entities has been provided through the Hospital Preparedness Program (HPP) and the CDC to date. These have served to improve the position of hospitals and other health entities in relation to equipment and supplies. The restrictions in these programs, have, however, discouraged investments in other surge-sensitive areas such as infrastructure, alternative care site planning, or staffing.

Another facet of the surge dilemma is the need for care providers to be able to provide adequate documentation and support to third party payors. The requirement for fiscal responsibility extends to these entities so that they can continue their mission in the maintenance of the healthcare system.

The goal of the Institute of Medicine Forum on Medical and Public health Preparedness for Catastrophic Events Financing Surge Capacity and Preparedness section is to "identify funding mechanisms that could be utilized to ensure effective and efficient medical surge capacity preparedness and response".²

Projected Surge Impact Issues

The effects of an acute or extended surge event on hospitals include numerous factors. Staffing may be compromised for a variety of reasons: ill employees, transit impacts, staff reticence to "bring something home", or a feeling of need to remain home with their families. Supplies (including pharmaceuticals and durable medical equipment) could be negatively affected due to supply chain interruptions, competing demands from all other providers, international

transportation interruptions, or raw material shortages. Physical facilities may also be insufficient to support an influx of large numbers of injured or ill persons.

In the wake of Katrina the following access to service issues were identified:

- Closure of most acute care hospitals, including Charity Hospital (MCLNO)
 - Loss of Level 1 Trauma, mental health beds, other specialty care
 - Open hospitals operating at reduced capacity but almost full
- Open safety-net clinics decreased from 90 to 19
- Doctors and other health workforce relocated
- Pharmacies closed, including Charity's low-cost pharmacy
- Half of nursing homes closed
- 49% of New Orleans residents surveyed reported no usual place of care prior to storm – further impacted after
- 27% were uninsured
- 18% reported mental health challenges ³

An added detrimental effect on the profitability of the institutions, and hence, their ability to remain in operation as a support resource, is also projected. "HHS has advised hospitals in a pandemic to 'Defer elective admissions and procedures until local epidemic wanes,' freeing capacity for influenza patients"⁴ Deferring higher profit surgical cases for lower-margin flu cases will result in diminished revenues. In addition, issues relating to increased numbers of uninsured patients requiring care would surface. "Using US pandemic planning assumptions and national data on health care costs and revenues, a 1918-like pandemic would cause US hospitals to absorb a net loss of \$3.9 billion, or an average \$784,592 per hospital."⁵

Discussion

The discussion of what key elements must be considered in future funding initiatives should be multi-pronged.

1. Funding Use Restrictions

Current grant programs used by health care facilities to improve surge capacity include significant restrictions on the use of the funds. What is the process by which future grant guidelines should be evaluated in terms of the most efficacious use of these funds to promote true surge capacity enhancements?

2. *Partnerships on Reimbursement Strategies*

The need for collaborative planning relating to disaster condition workable reimbursement strategies is great. The success of a health plan or other insurer in timely restoration of normal business operations relies on collaboration with “employees, vendors, health care providers, government agencies, and other community organizations.”⁶ Should public and private stakeholders be able to readily identify the approved courses of action in designated emergencies so that the payor process continues in an uninterrupted manner?

3. *Regional Initiatives*

As available monies for preparedness become more restricted the need for cooperative regional uses of the funds becomes greater. To date, the bulk of preparedness support for hospitals to address surge capacity has primarily been managed at the local institutional or health system level. Should future grant guidelines mandate the development of coordinated regional projects?

4. *Regulatory Activity*

The United States House of Representatives Committee on Oversight and Government Reform conducted an analysis of US hospital surge capacity compared to the post bombing experience in Madrid in 2004. The report titled “Hospital Emergency Surge Capacity: Not Ready for the ‘Predictable Surprise’” stated:

“After conducting the “snapshot” survey on March 25 at 4:30 p.m., the Committee staff sent follow-up questionnaires to the hospitals surveyed. Twenty-three of the hospitals responded to the questionnaire. Their responses indicate that the level of emergency care they can provide is likely to be further compromised by three new Medicaid regulations, the first of which takes effect on May 26, 2008. According to these hospitals, the new Medicaid regulations will reduce federal payments to their facilities by \$623 million per year. If the states choose to withdraw their matching funds, the hospitals could face a reduction of about \$1.2 billion. The hospitals told the Committee that these funding cuts will force them “to significantly reduce services” in the future and that “loss of resources of this magnitude inevitably will lead to curtailing of critical health care safety net services such as emergency, trauma, burn, HIV/AIDS, neonatology, asthma care, diabetes care, and many others.”⁷

What are the regulatory efforts that could assist in improvement of institutions’ pre-incident preparation for catastrophic events as well as ensure viability post incident?

5. *Recovery Strategies*

A piece of the emergency surge continuum that has not been adequately addressed in funding strategies to date is the formalization of recovery efforts. Returning the healthcare system to “green” status is vital to the restoration of public health support. Should emphasis on investment in the recovery processes for hospitals and insurers be part of future funding considerations?

6. *Gap Analyses and Measurement*

The ability to conduct gap analyses of the current vs. desired states of surge capacity funding may dictate that some sort of “metrics of preparedness” be developed. What are the best metrics to assess surge success: regulatory compliance, exercise performance, other elements?

Conclusion

Today’s financial realities are clearly reflected in the healthcare sector. Investment in surge capacity as a “what if” hedge is increasingly weighed as a lesser priority in the face of other difficult decisions impinging on the day-to-day solvency of the institutions. The growing time lapse since the most recent September 11-like event has also promoted an “it can’t happen again” attitude. The work of groups like the IOM in formulating policy discussions on fiscally-responsible ways to address the issue of surge capacity in health care is vital to the ability of the health care system to face natural and man-made threats in the future.

References

¹ Schull et.al. “Surge Capacity associated with restrictions on nonurgent hospital utilization and expected admission during an influenza pandemic: lessons learned for the Toronto severe acute respiratory syndrome outbreak “Acad. Emerg. Med 2006 No; 12(11):1228-31 Epub 2006 Jun 28.

² IOM Forum on Medical and Public health Preparedness for Catastrophic Events Draft Agenda June 2009

³ Kaiser Commission on Medicaid and the Uninsured, “*Voices of the Storm: Health Experiences for Low-Income Katrina Survivors*,” (KCMU publication #7538), August 2006

⁴ Jason Matheny PhD, Eric Toner MD , Richard Waldhorn MD, “Financial Effects of an Influenza Pandemic on US Hospitals” *Healthcare Finance*, (Aspen 2007), 58

⁵ Ibid, 62

⁶ Scott Armstrong and Ben Cutler, “Preparing the Way- Disaster Readiness Planning for health Insurance Plans” (AHIP 2007), 12

⁷ United States House Of Representatives Committee On Oversight And Government Reform Majority Staff ,

“Hospital Emergency Surge Capacity: Not Ready For The ‘Predictable Surprise’” (Washington, GPO: May 2008),

iii