

Hearing on

*Assessing Public Health and the Delivery of  
Care in the Wake of Hurricane Katrina*

*Before the*

**Committee on Energy and Commerce  
Subcommittee on Health  
Subcommittee on Oversight and  
Investigations**

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*Testimony by*

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I am Joe Cappiello, Vice President of Accreditation Field Operations for the Joint Commission on Accreditation of Healthcare Organizations. I appreciate the opportunity to testify before the subcommittees on Health and Oversight and Investigations on the health care delivery situation in the wake of hurricane Katrina.

Founded in 1951, the Joint Commission is a private sector, not-for-profit entity dedicated to improving the safety and quality of health care provided to the public. Our member organizations are the American College of Surgeons; the American Medical Association; the American Hospital Association; the American College of Physicians; and the American Dental Association. In addition to these organizations, the 29-member Board of Commissioners includes representation from the field of nursing as well as public members whose expertise spans such diverse areas as ethics, public policy, insurance, and academia.

The Joint Commission currently accredits over 15,000 organizations in the United States. These include hospitals (both general acute care and specialty), critical access hospitals, laboratories, health care networks (including integrated delivery systems, HMOs and PPOs), ambulatory care, office-based surgery, assisted living, behavioral health care, home care, hospice, and long term care organizations. About one-third of accredited organizations are hospitals, comprising the nearly 85% of hospitals that contain 96% of U.S. hospital beds.

Emergency Management has been a priority for the Joint Commission for over 30 years. In 1999 with the help of emergency management experts and 2 years before the disaster of 9/11, our emergency management standards were revamped to reflect the most current thinking in the

field. At that time, the Joint Commission started the process of assessing and modifying our accreditation standards to better reflect the need for health care organizations to be involved in community-wide planning, as opposed to only focusing on their institution. Following the terrorist attacks on September 11, 2001 and the subsequent anthrax exposure, our efforts took on a new sense of urgency.

In 2003, the Joint Commission published *Health Care at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems*, a report that reflected the work of a roundtable of experts. These experts were assembled under the Joint Commission's Public Policy Initiative to frame the issues associated with (and to recommend strategies for) developing community-wide preparedness.

More recently, the Joint Commission partnered with the Illinois Department of Public Health, the Maryland Institute of Emergency Medical Services Systems, and the National Center for Emergency Preparedness at Columbia University to convene two expert roundtable meetings. In addition, over the past four years, Joint Commission has conducted site visits to communities impacted by a disaster, such as New York City and Washington, DC (following the terrorist attacks and anthrax exposure), Houston (massive flooding during 2001 Tropical Storm Allison), Southern California (wildfires), Florida (the 2004 Hurricanes) and the North East (power outage in August, 2003). Information gleaned from the roundtable meetings and site visits to communities impacted by a disaster was used to develop *Standing Together: An Emergency Planning Guide for America's Communities*.\*

In continuing effort to understand communities' response and recovery of their healthcare system following a large scale disaster, the Joint Commission sent a team of disaster experts to the region devastated by Hurricane Katrina. The charge of that team was to make initial observations and establish contacts for a more deliberate debriefing in the future. I was part of that team and I am here today to discuss our observations and to highlight for you efforts that are underway to restore the health care infrastructure in the Gulf Region.

### **What Our Team Saw Last Week**

In New Orleans, we witnessed a health care delivery system attempting to recover from a staggering blow. In recent history, a major city in the United States has never experienced the destruction wrought by Hurricane Katrina. Major parts of the infrastructure that support medical care—water supply, sewage system, and electricity—have been significantly damaged. At the time of our visit, only three of New Orleans' 16 acute care hospitals were fully operational. Other hospitals are trying to open their doors as quickly as possible. When we departed New Orleans on September 16, there was no 911 system (although a call center was being established), no ambulance transport system, no Level 1 trauma center, no burn center, no home health care, no long term care nor any dialysis centers. That is part of the challenge this city faces.

In New Orleans, we visited Ochsner Medical Center where we took part in the “virtual” daily briefing, which brought together a broad array of federal, state and local healthcare leaders to discuss daily status reports and coordinate their efforts. We also visited several other facilities

that were in the process of recovery. While New Orleans has been the focus of much of the press reports, we visited areas in Mississippi where the destruction was as severe and whose recovery will be just as difficult. For example, Hancock Medical Center in Bay St. Louis will face the same challenges to restore service to its community as any hospital in New Orleans. For a period of time, they were being supported by federal Disaster Medical Assistance Team (DMAT) teams in their parking lot and coping with extensive water damage.

In Mississippi, we had the opportunity to visit several deployable medical units designed to accommodate surge control for an existing functioning hospital. **Nevada 1** is an air transportable, expandable Federal Management Shelter capable of treating a wide range of health care conditions and a large number of patients. It has a capacity of 100 beds and can be set up for both primary and ICU care, as well as labor and delivery. **Carolina 1** is an air transportable facility that has at its core, an 8 bed fully equipped ICU and a fully functioning Operating Room. These deployable units are clearly life saving entities that can supplement existing medical infrastructure. These health care assets can bring much needed supplies and emergency systems with them, and can be helpful for staging, surge control, and providing special medical services.

Furthermore, we learned of many acts of heroism and caring that medical professionals rendered throughout this disaster and I can say with certainty that there were a thousand other acts of compassion that will go unrecorded and unnoticed. Such is the nature of health care professionals.

I would remind the members that the Joint Commission is interested in and accredits the full spectrum of care. My remarks are directed with equal importance to the care provided outside of the hospitals, as well as hospital-based care. Hospitals in every community rely on and need the support of community-based structures to effectively accomplish their mission. My comments are directed toward the restoration of the synergistic interplay of all health care resources that comprise the fabric of care.

### **Resuming the Delivery of Health Care Services in the Gulf States**

The following is a list of activities that are essential to restoring health care services to the affected states in the next few weeks to months. They are not listed in order of significance.

- Disseminate information at a national level to advise returning residents and workers of certain responsibilities, dangers, and available services. Incoming residents and workers should be apprised of—
  - the need for vaccinations, especially Tetanus and Hepatitis A;
  - locations of facilities providing free vaccinations;
  - specific hazards, such as water, mud, debris;
  - the ways to access emergency help; and
  - limitations of the health care system, e.g., what is open and closed, what services are available and not available, where services are located, and how to contact service providers.
- Provide the information noted above to people a second time as they enter the city in order to reinforce and update the information as needed.

- Resume the traditional 911 services as soon as possible because alternative call centers are not as effective—i.e., people will not remember the number or find it quickly during a crisis.
- Begin Level 1 trauma services in the New Orleans area.
- Restore supportive medical services as quickly as possible and commensurate with the re-population plan. These services include, but are not limited to pharmacies, laboratories, diagnostic imaging centers, ambulance services, and dialysis centers.
- Develop a plan for the delivery of healthcare to the chronically ill, but ambulatory low-income and uninsured populations, whose normal health care providers are not operable. The affected states had high rates of both low income and uninsured people. In New Orleans, for example, the majority of those uninsured or in poverty relied upon Charity Hospital for primary care and other services, but it is unlikely that this hospital will reopen any time soon.
- Establish services for disabled and special needs populations, such as medical transport and rehab facilities, as soon as possible.
- Re-establish the post-acute care infrastructure, such as home health, rehabilitation, and nursing home care, quickly to ensure that hospital beds--which will be at a premium--are not unnecessarily tied up with those who could be helped at lower levels of care.
- Ensure that providers have broad scale access to the Department of Health and Human Services (DHHS) network of pharmaceutical records in order that the pharmaceutical history of residents can be known by those providing treatment.
- Institute a process that ensures that patients receiving services in temporary care sites are provided with their medical information so that it is portable to other sites of care and to primary care providers who may treat them in the future.

- Focus on ensuring that a number of critical physical plant and environment of care concerns are addressed, especially mold abatement. Engineers with mold abatement training should be identified and brought in as soon as possible. Environment of care issues are paramount to resuming patient care. Other concerns involve air quality, sanitation, and contamination.
- Monitor on a daily basis the number and geographic location of individuals with rashes, fevers, and diarrhea to ensure that any trends indicating a public health concern are identified early. Disseminate this information to all relevant health care and public health entities.
- Establish mechanisms to communicate across health care facilities so that care delivery can be coordinated and made efficient and effective. A common communication system will help to leverage health care assets and disseminate essential information that is necessary for recovery.
- Implement and expand upon the Department of Health and Human Services' Critical Infrastructure Data System (CIDS) to capture real time, accessible data needed for recovery purposes.
- Make available safe water and restore sewage capabilities, so that health care organizations can resume operations.
- Ensure that returning health care workers have adequate access to housing, food, and other supportive services (including payroll) because without such services, they will be less likely to return to affected areas.
- Assist health care facilities to establish laundry services and sterilization capabilities.
- Establish telemedicine services, to provide access to specialists from unaffected areas.
- Integrate mental health and clinical care services. There needs to be a strong focus on appropriate mental health care in order to deal with increased risks of behavioral health

issues, such as suicide, lack of access to psychotropic medications, and post traumatic stress disorder.

### **Efforts Underway**

The Joint Commission is commonly recognized as an entity with the unique capability of bringing disparate groups together to focus on a common goal. We are engaged in that activity today. The Joint Commission is working collaboratively with federal, state and local officials to ensure that health care organizations in the affected areas can obtain a sufficient level of functioning to provide safe health care services. There has been significant study on the graceful degradation of care but few studies or experiences with the reestablishment of care. The Joint Commission will participate and collaborate with these officials in developing a strategy for ramping up hospitals and other health care organizations to full service institutions

For example, we are working with a wide spectrum of organizations to help get systems back up and running by establishing a minimal, consensus-driven checklist that will provide organizations with guidance on what they must do to meet state and federal requirements for reopening their facilities. That checklist will add increasing granularity as levels of care increase. For example, there will be a basic set of criteria for re-opening the doors of closed facilities so that they are safe for occupancy by staff and patients. The criteria will become more specific as particular types of services are brought on line, such as surgery.

The Joint Commission is also an active participant the “Emergency System for Advanced Registration of Voluntary Health Personnel (ESAR VHP).” This Health Resources and Services Administration (DHHS) project brings public and private sector groups together to identify and address issues and formulate responses associated with credentialing and privileging volunteer health care personnel. Hurricane Katrina was the first real test of those states who have been funded to put this system into practice. We were pleased that this system could be activated to help.

### **Concluding Remarks**

In conclusion, there remains much work to be done in the Gulf states, but there is also an opportunity so rare and unusual that it cannot be overlooked. The opportunity presents itself to be innovative in the reconstruction of the healthcare infrastructure of a major city, to make New Orleans a model health delivery city that will do more than just bring back the professionals and citizens that fled the city but a model that will attract the best and the brightest of every profession. God willing, we will never have this opportunity again.

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\* A copy of *Standing Together: An Emergency Planning Guide for America's Communities* is attached.