Testimony
Subcommittee on State, Local, and Private Sector Preparedness and Integration
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The Key Role of NDMS in Disaster Response

Statement of

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Good morning Chairman Pryor, Ranking Member Ensign, and Members of the Subcommittee. Thank you for the opportunity to discuss the National Disaster Medical System (NDMS) and the key role it plays in our nation's response to disasters. I have been a part of NDMS since 1987, as a team physician and Team Commander. I have also served as the Chief Medical Officer for NDMS and have deployed to numerous incidents as part of NDMS.

NDMS remains one of the most significant federal medical response resources and has a long history of responding to natural and man-made disasters in this country. Most recently, NDMS responders were deployed to Haiti to provide care for victims there. Additionally, NDMS patient movement and definitive care functions were activated to evacuate and care for victims brought to the U.S. NDMS is also an organization that continues to evolve and improve as it learns from previous responses through a robust corrective action program instituted at HHS.

HHS may activate the NDMS to provide aid to victims of a public health emergency or to be present at locations at risk of a public health emergency. Under the National Response Framework (NRF), HHS is the lead federal agency for Emergency Support Function #8 (ESF#8): Public Health and Medical Services. NDMS is an integral part of our response capability that can be activated by HHS to provide assistance through ESF#8 of the NRF for incidents in which the Department of Homeland Security assumes overall Federal incident

management coordination responsibilities in accordance with the NRF and HSPD-5. HHS may also activate the NDMS to provide assistance in accordance with our own authorities if necessary. Further, through interagency agreements under the Economy Act or other applicable authorities, HHS may activate the NDMS for incidents where other Departments, such as the Department of State, have the lead responsibility for providing assistance. Teams from NDMS provide health care, deceased victim identification, patient movement, and veterinary care.

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NDMS was conceived in 1981 as an evolution of the Civilian–Military Contingency Hospital System developed by the Departments of Defense (DOD) and Veterans Affairs (VA) to care for casualties exceeding the capacity of DOD and VA hospitals. NDMS is an interagency cooperative effort among HHS, DOD, VA, and DHS. Through the partnership of these federal agencies, in conjunction with States, private sector institutions and medical professionals appointed to federal service, NDMS developed the capabilities for medical response, patient evacuation, and hospitalization in times of disasters. NDMS has been managed by HHS since its inception, except for a four-year period (2003-2006) when it was transferred to DHS. In 2007, it was returned to HHS as a result of the Department of Homeland Security Appropriations Act, 2007, and the Pandemic and All Hazards Preparedness Act. It is now part of in the Office of the Assistant Secretary for Preparedness and Response (ASPR), Office of Preparedness and

Emergency Operations. The ASPR, under section 2811 of the Public Health Service Act, has the authority to activate NDMS.

Currently, NDMS has 7,856 employees who are intermittent federal employees and are used intermittently for federal deployments, authorized training, and day-to-day activities required to manage the 95 response teams within the system. NDMS also has approximately 1,700 participating hospitals that agree to receive patients during disasters and upon activation of the NDMS. When HHS requires patient evacuation, the DOD moves patients to one or more pre-designated locations. These locations are called Federal Coordination Centers (FCC).

There are 72 FCC locations nation-wide. The FCCs work with local and state emergency management and health departments to coordinate the distribution of patients to non-federal NDMS-participating hospitals. Participating hospitals are recruited by the FCCs and all of them sign a memorandum of understanding with NDMS that outlines the duration of treatment and the payment schedule for NDMS patients. Hospitals agree to seek reimbursement from NDMS only after seeking reimbursement from all other payors, such as health insurers or TRICARE, except another Federally recognized payer of last resort, such as Medicaid. For Medicaid patients and patients who do not have health insurance coverage the NDMS reimbursement rate is equal to the Medicare payment amount for definitive care plus 10 percent. For patients with health insurance who are not Medicare or TRICARE beneficiaries, NDMS will pay the difference

between the amount paid by the health insurance coverage and the amount payable at 110% of the Medicare payment amount. In other words, currently NDMS reimburses after private insurance and before Medicaid, up to 110 percent of the Medicare payment amount. NDMS does not reimburse hospitals for Medicare beneficiaries.

NDMS has three components: medical care, patient movement, and definitive care. Medical care is provided by Disaster Medical Assistance Teams (DMATs), which are staffed by federal intermittent employees with an indefinite appointment. These employees are activated as needed and are paid when deployed during times of response. In addition to the DMATs, NDMS has other more specialized teams, including the Disaster Mortuary Operational Response Teams (DMORTs) and National Veterinary Response Teams (NVRTs), which perform deceased victim identification and animal health care, respectively. Our International Medical Surgical Response Team (IMSURT) provides critical care and life-saving surgery for victims. NDMS teams provide both acute and primary care in field facilities and also can augment local hospitals.

NDMS is structured to respond quickly. In response to the Haiti earthquake, NDMS deployed over 1,200 personnel beginning within 24 hours of the request for assistance, and remained engaged for over six weeks. DMATs are placed on a rotating call schedule that enables us to maintain a ready roster of teams and equipment available for deployment on short notice.

The second component of NDMS is patient movement, for which collaboration with DOD and VA is essential. DOD has the lead for providing air assets for movement out of the affected area. DOD staff establish points of embarkation, provide medical care at the airhead, and provide aircraft and medical staff for the transport of patients to be evacuated. In addition to the DOD resources, FEMA has established a national ambulance contract. This contract provides ground ambulances, air ambulances, and para-transit buses for short distance patient evacuation. The ambulance contract was developed to address a gap analysis conducted jointly by FEMA and HHS in preparation for the 2006 hurricane season. The ambulances provided through this contract are incorporated into states' emergency response to support local evacuation efforts. Following evacuation and hospitalization, HHS is responsible for returning patients to their home state and utilizes private contractors to perform that function.

The final component of NDMS, definitive care, is defined as the provision of inpatient hospital services in NDMS-participating hospitals to patients affected by a disaster. Bed availability is assessed via bi-monthly bed counts conducted by VA and DOD. Civilian hospitals participate on a voluntary basis and agree to provide available beds when requested by NDMS. Patient distribution is coordinated by the local FCC in conjunction with the state and local emergency management departments.

Recent Improvements to NDMS

Since NDMS has returned to HHS, it has been called upon to respond to hurricanes, earthquakes, floods, ice storms, and a variety of National Special Security Events (NSSEs), including the 2009 Presidential Inauguration. NSSEs provide an important way for teams to train and practice while providing service during real events, an important efficiency measure. In 2010 alone, NDMS has deployed over 1,700 personnel. In addition, NDMS activated two Federal Coordination Centers to accept evacuated patients from Haiti. NDMS implemented a corrective action program that reviews every response and exercise to identify ways to improve the capability to respond to future disasters as well as operational efficiency and cost-effectiveness. We learn from every event.

Logistics changes

HHS has taken several actions to enable responding teams to deploy faster when activated and to reduce costs. A major action has been the consolidation and restructuring of our team and regional warehouses. This has resulted in increased standardization of equipment caches, has improved maintenance of the equipment and supplies and has decreased waste. HHS has established two regional warehouses and has consolidated nine smaller warehouses into other existing warehouses which have resulted in an annual savings of over $900,000. Over the next two years, additional warehouses will be consolidated to maximize

standardization and enhance our readiness and efficiency. The additional consolidation will result in an annual savings of $1.8M.

Medical equipment and supply caches are also being modularized so they can be deployed in more scalable and mission appropriate configurations. Caches for pediatric care and critical care are already under development.

Team Changes

NDMS team structure is undergoing substantial changes that will enable NDMS to respond more effectively. The DMAT structure has been modularized to enable greater flexibility for response. Sixteen new teams have been created to expand the depth of response capability. We have also been working with various professional organizations to roster specialists in pediatrics, surgery, and critical care. These medical and surgical specialists will be deployed when their specific skills are required.

NDMS has also supported HHS Service Access Teams (SAT), which serve as patient case managers for patients evacuated to NDMS hospitals. The SATs track patients from the point of debarkation through hospital discharge. They arrange post-hospital medical follow-up care and coordinate the disposition of patients after discharge, including transportation back to their originating medical care facility, long-term care, home of record or a temporary location until they can

be received in their home state. The SATs were successfully deployed to Atlanta and Tampa for NDMS patient reception during the Haiti response.

Patient Movement

HHS has convened the Senior Leaders Council on Patient Movement, which consists of senior-level personnel from the VA, DOD, and DHS. This group provides a mechanism to coordinate activities across the NDMS partnership regarding the evacuation of victims, their tracking through the system, and their return.

NDMS has developed the Joint Patient Assessment and Tracking System (JPATS) as a means of tracking patients as they move through the NDMS. JPATS complements our electronic medical record (EMR), which has been used for several years in NDMS. The JPATS and the EMR represent a more effective way to manage clinical information and to more effectively transfer patient information through the echelons of medical care in a disaster. We have also used data obtained from the EMR to perform near "real time" surveillance of specific diseases and to assist in determining the demobilization of our teams. JPATS enables NDMS to better track patients as they are evacuated and to convey that information to hospitals and families. The NDMS FCCs have been trained in JPATS and used the system in the Haiti response. NDMS has plans to train hospitals on JPATS so they, too, can use it when they receive NDMS patients.

Twice in the past, HHS has put in place contracts for returning patients and is in the final stages of contract negotiations to put in place a longer term mechanism to return patients to their home/hospital once the affected area is safe and the patient is medically able to return. It is our intent to have a contractor on retainer that can be engaged when its services are needed.

The 2008 Hurricane Season – Gustav and Ike

HHS greatly appreciates the contributions made by Little Rock, Arkansas to victims of Hurricane Gustav. We also have great respect for the Arkansas Hospital Association for raising concerns about our performance during the 2008 hurricane season. They have challenged us to do better and have been collaborative in helping us achieve a higher standard of response. NDMS recognizes that there were difficulties with the return of patients from Arkansas to Louisiana after Hurricane Gustav. Little Rock hospitals maintained responsibility for patients long after their medical needs were addressed. The mitigating circumstances of Hurricane Ike were partially responsible for delays in returning patients to Louisiana. However, not all problems were a result of Ike's impending impact. In our corrective action process, several issues were identified and changes have been implemented that should all but eliminate those problems from recurring.

To date, ASPR leadership has met with the Arkansas Hospital Association three times, most recently in May 2010. Regional ASPR staff have communicated with them and the Arkansas Department of Health, as well.

We are working with the Department of Veterans Affairs and local offices to determine a suitable place for an HHS-staffed Federal Medical Station in Little Rock, Arkansas, which would serve as a temporary medical facility for patients who were ready for discharge but unable to return home. HHS has also worked with Louisiana to establish a 250-bed Federal Medical Station in northern Louisiana, which will serve as a temporary receiving location for patients discharged from Arkansas hospitals if the patients are not able to return to their home of record or starting location. We will deploy our SATs early to assist in the case management of evacuated NDMS patients. As mentioned previously, we are awarding a standing contract that will make non-emergent medical transport available to return evacuated patients to their homes or other receiving facility.

We are confident that the improvements made to NDMS and the newly implemented efforts dedicated to improving patient return will minimize recurrence of delays experienced by Arkansas hospitals in the 2008 hurricane season. NDMS has been a responsive and valuable national resource for over 25 years. We are committed to a continuous improvement process that will enable NDMS to remain flexible and responsive to current and new threats.

Thank you for allowing us the opportunity to participate in this hearing. I am happy to answer any questions you may have.

Patient Movement & Return
Hurricanes Gustav & Ike 2008