American Association of Critical Care Transport (ACCT) Testimony

Full Committee Hearing: U.S. Government Response to the Ebola Outbreak

November 6, 2014

(Submitted for the Record)

The Association of Critical Care Transport (ACCT) appreciates the opportunity to submit the following testimony in response to the Senate Appropriations hearing entitled: US Government Response to the Ebola outbreak held on November 12, 2014.

ACCT is a non-profit grassroots patient advocacy organization committed to ensuring that critically ill and injured patients have access to the safest and highest quality critical care transport system possible. ACCT is comprised of air and ground critical care transport providers, business organizations, associations, and individuals all striving to provide our communities, hospitals and EMS partners in care, regulators, and policy makers with a path toward a safer and more trustworthy critical care transport system for patients.

Our member organizations provide the entire spectrum of out of hospital services from 911 emergency ambulance response and specialty care transport services, to the most complex intra and interstate critical care medical transport. Together our members operate 570 medical helicopters, 50 fixed wing air ambulances, and 80 ground critical care units across more than 45 states. Over 25 million patients are transported by emergency ambulances per year across the country. Over 400,000 of these patients are critically ill or injured, requiring specialist teams, medical technology and vehicles for advanced cardio pulmonary, neurological, burn, and trauma care during emergent transport. The majority of these patients are transported between hospitals, moving from community hospitals to trauma and specialist tertiary level critical care medical centers. This critically vulnerable population is the focus of ACCT.

ACCT appreciates the opportunity to highlight several key issues for the Committee. First, we need to ensure the 24 hours a day, 365 days a year ability of critical care transport (CCT) providers to deliver effective treatment while maintaining the highest levels of transport safety for all critically ill and injured patients. Second, we need federal support to improve our CCT system's readiness and operational capability to transport patients with highly infectious disease (HID) such as Ebola (EVD), as part of a regionalized system of patient treatment and transport. While the current focus is on managing EVD patients, this is but one potential HID. Third, we need federal support to sustain the substantial extended operational costs for transporting HID/EVD patients, which can add several thousand dollars of additional costs to safely and effectively transport patients.

Safe Transport for Critical Care Transport Physicians, Nurses and Paramedics:

As demonstrated in the recent transfers of EVD patients to specialized centers, CCT is essential in providing appropriate care to HID/ EVD patients. We must ensure the safety of our CCT physicians, nurses and paramedics as we move patients with HID/EVD to hospitals designated to treat them. Thus, we must use portable vehicle bio-containment systems that can be placed into fixed wing and ground ambulances, have a sufficient number of Personal Protective Equipment (PPE) currently in very short supply, a supported specialized disposal system for contaminated equipment, and the resources to maintain readiness training for all of our practitioners and support personnel. Our clinical personnel must be assured of the highest degree of safety and infection control in transporting HID/EVD patients -- failure is not an option.

Without an ongoing federal commitment to maintain readiness for personal protection, training activities and ambulance infrastructure investments, we cannot adequately ensure that our health system is ready for Ebola or any other HID emergency. There is currently no funding stream to help CCT providers develop equipment caches, and ramp up the substantial additional operational costs beyond standard critical care to treat and transport HID/EVD patients. Congress must provide resources for PPE, air and ground critical care transport infectious disease containment systems, disposal costs, and training for critical care transport practitioners and support personnel as they manage the front lines of this and other deadly diseases. Air and ground ambulances provide life-saving services to critically ill and injured patients who trust that such services are operated at the highest standards of patient safety and quality. Unfortunately, the public's trust cannot be assured in the absence of any readiness funding mechanism. The current adhoc approach to meet the high costs of potential HID/EVD CCT transport requests is not sufficient as providers have no means to make investments for additional potential and uncompensated operating transport costs.

Regionalizing CCT Preparedness and Response for Ebola:

The current experience in managing Ebola in the United States has also shined a spotlight on the long-standing need to move forward with the development of a coordinated and regionalized approach to emergency care. The Institute of Medicine (IOM) Report, "*Emergency Medical Services: At the Crossroads*, in 2006 called for the development of regionalized systems of emergency care including the need for well integrated ground and air critical care transport. Such a system will ensure patients immediate care and transport to to the medical center that is best suited to provide optimal care. It will also help ensure the trauma and medical centers and hospitals where patients are sent have the infrastructure, equipment, personnel, procedures and protocols in place to properly protect our frontline practitioners and the general public.

As the current HID/EVD experience demonstrates, we still have a long way to go to ensure that every American will receive the right care, in the right time, in the right place as part of a coordinated system of regionalized emergency care. Regionalization of resources is applicable

for trauma and specialized medical centers by concentrating critical trauma or HID/EVD patients to the hospitals best equipped and prepared to treat them. This is also true for critical care transport providers. We need to make appropriate investments in a concentrated number of ground and air vehicles configured to transport highly infectious patients. Regionalizing the response capability is a rational use of limited resources; however, even that targeted investment is beyond the current financial capability of CCT providers as there is no separate funding for the significant additional readiness and operational costs to manage these patients.

Federal Support for the Entire Emergency Medical Care System:

To illustrate the kinds of patients with acute critical conditions that we treat and transport every day: there are 53,000 deaths each year from the respiratory failure complications of influenza and pneumonia, 118,000 deaths from unintentional traumatic injury, and 35,000 deaths from multi-organ failure and septicemia. CCT providers struggle to maintain sufficient mobile intensive care resources and clinical capability to treat and transport people whose lives hang in the balance every day. As we work to improve our ability to respond to the development of HID/EVD in the U.S., we must not lose sight of the hundreds of thousands of patients the emergency care system treats and transport every day who depend upon us for life-saving care. More importantly, we need to maintain sufficient surge and redundancy capacity to meet other "black swan" unexpected environmental, infectious disease, or man or nature caused public health emergency or mass casualty events.

The Congress has enacted many needed programs on a bipartisan basis to build the key components of our emergency care system, but not all of them are fully funded, and some of them aren't funded at all. For example, Part H of Title XII of the Public Health Service Act is authorized at $100 million to improve trauma service availability including through improvement in air medical capability, infrastructure and coordinated response. Yet, this program remains unfunded. This is the type of infrastructure that prepares our systems to meet unanticipated events such as HID/EVD for or any patient with a life-threatening or critical illness or injury. The regional response system must also account for the transport of patients in all weather conditions requiring substantial improvements in healthcare aviation systems such as helipads, weather, and instrument landing systems. Air and critical care medicine must be better integrated into the EMS system as recommended by the IOM and that requires greater investments to ensure our ability to move all patients to definitive care. We urge the Congress to recognize the significant challenges highlighted by the current adhoc response to the HID/EVD crisis and fully fund <u>all</u> the trauma and emergency care programs authorized in Parts A-D and H of Title XII of Public Health Service Act.

The public assumes that should they need critical care transport, that we will be there for them -- that they will receive the highest quality of critical care and transport to the hospital best equipped to treat them. Working together, we can better ensure that public trust.

Thank you again for the opportunity to submit testimony. Please contact, Roxanne Shanks, RRT, MBA, FABC, ACCT Executive Director at rshanks@lifeflighteagle.org or (816) 858-6175 if you have any questions or need further information.