Testimony of the Northwest Healthcare Coalition
Before the Joint Informational Hearing of the Senate Veterans Affairs and Emergency Preparedness Committee and the Health and Human Services Committee

Submitted by

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Chairman Vulakovich, Chairwoman Baker, and Committee Members, thank you for the opportunity to provide comments regarding my hospital's experience and the Northwest Healthcare Coalition's experience with the Commonwealth's Hospital Preparedness Partnership Program between the Pennsylvania Department of Health (PADOH) and the Hospital and Healthsystem Association of Pennsylvania (HAP).

My name is Matthew Linse. I'm the Emergency Services Liaison for Saint Vincent Hospital in Erie, Pennsylvania. In some fashion, I've been involved with public safety and emergency preparedness for over 20 years. One of my duties with Saint Vincent Hospital is being an active committee member with our Emergency Preparedness Program. There are many spokes in the wheel of hospital preparedness—too many for one individual to handle—so duties at our facility are split up by committee members. Some committee members oversee internal processes, some handle security issues, and some oversee critical off-sight facilities. My duties include acting as a conduit between the hospital and external emergency response partners like EMS, fire, police, 911 Centers, and any other entities that have anything to do with preparedness and emergency responses.

I'm also the chairman of the Northwest Healthcare Coalition. The coalition is made up of 11 acute care facilities and roughly 40 extended care facilities throughout Crawford, Erie, Forest, Venango, and Warren Counties. Along with healthcare facilities, our coalition has a partnership with EMS, local emergency management agencies, local and state health departments, Bureau of Public Health and Preparedness (BPHP), HAP, and other regional coalitions throughout Pennsylvania. We meet regularly and share information.

Like all of the Healthcare Coalitions across the Commonwealth, we were created to be compliant with hospital preparedness funding that was transferred from funding individual facilities to funding a coalition of providers. This was mandated by the Office of the Assistant Secretary for Preparedness and Response (ASPR). In some aspects, the Northwest Healthcare Coalition mirrors the Health & Medical subcommittee of the Northwest Pennsylvania Task Force. The Coalition was built using the Task Force's existing foundation. Why recreate or reinvent something that's already established and functioning? Building off of that, we developed bylaws and elected committee leadership.

Today's coalition is miles ahead of our Task Force's Health & Medical Subcommittee. When I first became involved in the subcommittee, there was some structure and leadership, but nothing was formalized. Early on, few facilities participated and attendance was spotty; simple things like meeting minutes didn't exist. The addition of HAP management enhanced this early version of today's coalition. There was never any inclusion of extended care facilities, but regional HAP management organized and brought these key healthcare facilities to the table.

Our once simple coalition began to grow and take a more mature shape. Is there 100% participation with every facility within our region now? Certainly not. We do face challenges; we're not without flaws, but we chip away at these challenges, and much of this is done because of HAP's presence.

While some work was needed, and the time line to create the Northwest Healthcare Coalition was somewhat condensed, a fair amount of the groundwork had already been completed, so the undertaking was less daunting and this led to a product that was much more polished.

The Finish Line

When an incident or disaster occurs, there is the initial response by first responders. Media might flock to the scene. Maybe the local EMA gets involved and an incident command is established. Communication is established between all partners. Support agencies like the Red Cross may arrive. All this unfolds, and typically, what's the goal? Get the patients and victims to the hospital, right? Sure there's more to managing an incident or disaster than that, but, for the most part, the hospitals are viewed as the finish line—get the victims and patients to the ER doors so they can be treated. Prehospital providers are trained to get trauma victims to a hospital within the first hour, the "Golden Hour." When it comes to cardiac patients, the saying is "Time is Muscle!" Over and over, we train our first responders to treat and transport swiftly.

But, for the patient or victim, the arrival to the hospital is virtually the beginning to their treatment and recovery. Their healing process can last days and weeks and months. The wounds and injuries can be both physical and physiological. Often times, the families and loved ones need emotional support and treatment.

When these incidents and disasters occur, EMS and fire and police respond. But inside the walls of the hospital, a whole other response is unfolding. Preplans come to life. To make room for a surge of patients, Emergency Departments expedite admits and discharges. Inpatient departments do the same. Elective Surgeries and procedures are halted and ORs are made readily available for victims. Additional staff might be called in. A flurry of tasks and check lists pop up so that the surge of victims can be absorbed and lives can be saved. Everything from medical supplies and staff availability to water and food is assessed. Is there enough? What's needed? How can we get it?

When an emergency occurs, you know to call 911. When a hospital experiences an emergency, what number do we call? Who can help us?

In 2014, late one night, Saint Vincent Hospital experienced a crippling event that nearly resulted in an evacuation of the facility. Subzero temperatures caused a malfunction with the boilers that heated the facility. The temperatures in the hospital dropped rapidly. Pipes throughout the facility froze then ruptured. Nursing stations, patient rooms, ORs, and hallways began to flood with water. Pipes for fire suppression systems also froze. The hospital needed heat and help.

Our first step was to submit an unmet needs form to our local EMA. But, coinciding with this, two other phone calls were made. The first was to our regional HAP manager. And the second was to the EMS specialist from the regional EMS Council, a position that no longer exists. From there, all external help was facilitated through them. Most of what they did was invisible to hospital staff, and this allowed us to manage the incident. Both the HAP manager and EMS specialist were on scene within a matter of a few hours, and they remained on scene for a few days. Large external propane heaters were brought onsite and were used to warm vital areas.

It took hours to get the boilers repaired and back online. Because of the water damage, it took months to fully recover, but because of the regional support, we were able to avoid evacuating patients which would have put lives at risk. Our biggest fear was trying to relocate our most critical patients on ventilators. This is not an easy undertaking under the best of circumstances, and doing it in frigid temperatures could have had grave consequences. When we first initiated our internal disaster code and opened our command center, there was no clear finish line, but we knew who we could call to get the support and resources needed so we could eventually cross that line. All of this was done without any loss of life.

Leaning Forward

Whether it's a large or small hospital, it's impossible to be prepared for every single hazard. But, when an incident occurs, it is possible to mitigate and diminish the potential devastation it may have. This is done by being proactive, by *Leaning Forward* and getting to know who your community partners are and what support is available.

Much like other coalitions throughout Pennsylvania, The Northwest Region's has a solid partnership in place and it's only becoming more organized and more inclusive. We're leaning forward and looking for ways to continue to build upon the existing foundation the Task Force created years ago. With HAP's encouragement and support, we've looked past our geographical boundaries, and we're now partnering with the Northwest Central and Southwest Healthcare Coalitions. This partnership makes sense. There are two large healthcare providers that have facilities scattered throughout the western side of the state. Patients and families travel up and down the Interstate 79 corridor on a daily basis. There are large trauma centers, burn centers, and pediatric specialties in the southwest. Many physicians are educated, trained, and hired by these healthcare systems. In both the north and south regions, equipment and supplies sit minutes away from the interstate, ready to be deployed. If a large event were to occur, we would more than likely see a sharing a resources and assets between these regions.

We can't predict the future and we don't know what's on the horizon, but we lean forward, we prepare, and we continue to build relationships with partners. We do this in hopes of keeping hospitals and healthcare facilities open, in hopes of keeping that finish line accessible. We do this in hopes of saving lives.