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when minutes count

HHS Pandemic Preparedness Plan to Be Released This Fall

The Department of Health and Human Services (HHS) expects to release its Pandemic Influenza Preparedness and Response Plan sometime this fall. While the release is still weeks away, HHS Secretary Michael O. Leavitt has made clear in recent comments that critical components of the plan will include faster detection of viral threats and speedier delivery of drugs and vaccines. The solutions he has outlined include the following measures:

- Improve disease surveillance to cope with viral threats;
- Increase medication distribution points;
- Use postal workers to deliver medicines to individual homes;
- Increase the number of "community caches" of emergency medications, such as hospitals; and,
- Explore the idea of giving individual households "pre-event" emergency drug kits.

As a pandemic threat, scientists are closely watching the H5N1 avian flu virus. Health officials are concerned about the short supplies of vaccines and the medication Tamiflu to counter the virus. If an easily transmitted form of the virus were spotted quickly, however, drugs and vaccines in relatively small quantities could be used in conjunction with quarantine to keep H5N1 from spreading to large numbers of people. a new study published in the journal ***Nature*** said an outbreak in Thailand of an easily transmitted form of H5N1 could be stopped using an international stockpile of three million doses of antiviral drugs. In an earlier speech on HHS's preparations for viral threats, Leavitt said the federal government is increasing its stockpile of Tamiflu and a vaccine against H5N1 to 20 million doses of each. Yet, such doses are still far below the quantities that would be needed if the virus were not quickly detected and contained.

To better cope with viral threats, Leavitt said disease surveillance must be improved. "We already collect information from pharmacies about over-the-counter medications and from nurse call lines about reported illnesses and symptoms," he said. "We can and will do more. We intend to link reporting data from emergency rooms in select cities so we can improve our near real-time surveillance of potential disease outbreaks." But he added, "we have to get better" at distribution after that point. "Our experience so far makes it clear that we don't have enough points of distribution . . . Imagine the traffic congestion if there were a handful of distribution points within a metropolitan area during a period of widespread panic." In line with HHS's goal to have medicines delivered to individual Americans within 12 hours of a federal decision to deploy medications to a community, Leavitt said the department is considering the use of firehouses as distribution points. (Cont'd page 3)

CMS Relaxes Rules to Aid Katrina Stricken Areas

In a release dated September 2, 2005, the Centers for Medicare & Medicaid Services (CMS) stated its intention to assure that the Medicare, Medicaid, and State Children's Health Insurance Programs (SCHIP) will flex to accommodate the emergency health care needs of beneficiaries and medical providers in the states devastated by Hurricane Katrina. Many of the programs' normal operating procedures will be relaxed to speed provision of health care services to the elderly, children, and persons with disabilities who depend upon them. (Cont'd page 2)

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Many beneficiaries have been evacuated to neighboring states where receiving hospitals and nursing homes have no health care records, information on current health status or even verification of the person's status as a Medicare or Medicaid beneficiary. CMS is assuring those facilities that in this circumstance the normal burden of documentation will be waived and that a presumption of eligibility should be made.

CMS offers the following relief immediately:

- Hospital emergency rooms will not be held liable under EMTALA for transferring patients to other facilities for assessment, if the original facility is in the area where a public health emergency has been declared.
- Health care providers who furnish medical services in good faith, but who cannot comply with normal program requirements, will be paid for services provided and will be exempt from sanctions for noncompliance, unless it is discovered that fraud or abuse occurred.
- Normal licensing requirements for doctors, nurses and other health care professionals who cross state lines to provide emergency care in stricken areas will be waived as long as the provider is licensed in their home state.
- Certain HIPAA privacy requirements will be waived so that health care providers can talk to family members about a patient's condition even if that patient is unable to grant that permission to the provider.
- Medicare contractors may pay the costs of ambulance transfers of patients being evacuated from one health care facility to another.
- Crisis services provided to Medicare and Medicaid patients who have been transferred to facilities not certified to participate in the programs will be paid.
- Programs will reimburse facilities for providing dialysis to patients with kidney failure in alternative settings.
- Normal prior authorization and out-of-network requirements will also be waived for enrollees of Medicare, Medicaid or SCHIP managed care plans.
- Hospitals and other facilities can be flexible in billing for beds that have been dedicated to other uses, for example, if a psychiatric unit bed is used for an acute care patient admitted during the crisis.

More information about CMS emergency relief activities, including phone numbers for the state medical assistance offices can be found can be found at **www.cms.hhs.gov**.

State Agencies Respond Slowly to Major U.S. Health Threats

According to a study report recently released by RAND Corp., many of the nation's public health agencies were dangerously slow to respond to reports of botulism, anthrax, smallpox and bubonic plague in a government-funded test of U.S. readiness to battle bioterrorism and other major health threats. The health agencies, on the front lines of the nation's defense against contagious diseases, often performed poorly and occasionally gave bad advice to researchers posing as doctors. The study – published in the journal ***Health Affairs*** – tested the agencies' ability to respond quickly to reports of contagious symptoms.

Of 19 public health agencies in 18 states, only two consistently met federal guidelines to return calls from physicians within 30 minutes. Three agencies didn't respond at all to the first five calls they received. In one case, a caller posing as a doctor was told to "go back to sleep" and not to worry after he'd reported classic symptoms of bubonic plague. Another caller reporting symptoms of botulism was told, "You're right, it does sound like botulism. I wouldn't worry too much if I were you." According to the report, in a real crisis the bad advice and delays in responding to calls could cause countless deaths. (Cont'd page 3)

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The agencies' identities were kept secret after they agreed to participate in the study, which was paid for by the U.S. Department of Health and Human Services. Agency directors did not inform their staffs that researchers would be calling. The calls were made from February to November 2004. Only 19 of the approximately 2,800 agencies nationwide were tested in the unusual study because of the sensitivity of having researchers misidentify themselves.

Some health workers contacted asked the right questions about patients' symptoms and location. But when presented with a report of a patient with "pustules on the face, arms and legs with lesions in the same stage of development," none "suggested isolation of the patient," the authors wrote. In response, Alison Johnson of the Centers for Disease Control and Prevention said agencies are responding to calls faster than in the past, but "there's always room for improvement."

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With respect to using postal workers to deliver needed medicines, Leavitt noted that several issues must be worked out, including training workers to handle the supplies and ensuring their safety in the event of panic over shortages. As for HHS's exploring the idea of giving individual households "pre-event" emergency medications, such action would be in anticipation of a viral threat and for use only when directed by public health authorities. Leavitt reasoned, "Examining how we could move medications to the ultimate front line has to be part of our thinking. We need to think outside the box. I can assure you the terrorists will."

The States: Medical Malpractice Update

Caps Signed into Law in Illinois

On August 25, 2005, **Illinois** Governor Rod Blagojevich (D) signed into law a bill that caps noneconomic damages in medical malpractice cases at $500,000 for cases against doctors and at $1 million in cases against hospitals. Blagojevich, himself a lawyer, said he set aside his own concerns about limiting malpractice damage awards for victims because physicians and hospital administrators said it would reduce the insurance costs they contend are driving doctors out of the state. Under the new law, the state Division of Insurance will have more authority to review medical malpractice insurance rates and reject those considered unreasonably high. The agency also will create a Web site to inform doctors about their malpractice insurance options. The law mandates that insurers disclose the information and formulas used to set their rates. In addition, the state Department of Professional Regulation will double the number of malpractice investigators on staff and construct a malpractice Web site that will include information about doctors.

The law also aims to curb costly lawsuits through the "Sorry Works" pilot program, which encourages doctors to offer apologies and financial settlements in malpractice cases, rather than go to court. The law is expected to be challenged in court, where the state Supreme Court twice has thrown out state laws limiting damages in the last three decades.

T SC Legislature Considering More Reforms

South Carolina lawmakers are considering new malpractice reform legislation only months after the enactment of a bill that capped noneconomic damages in malpractice lawsuits at $350,000 for an individual defendant and $1.05 million for multiple defendants. Being discussed is "I'm sorry" legislation, which would allow physicians to apologize for medical errors without concern that patients could use the apologies as evidence in malpractice lawsuits. About 17 other states have already enacted such laws. Also under consideration is the use of alternative methods to resolve lawsuits and the removal of barriers that prevent the discussion of patient care among health care providers.