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# RESPONSIBLE RESOURCE MANAGEMENT AT THE NATION'S HEALTH ACCESS AGENCY

## HEARING

BEFORE THE

FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, AND INTERNATIONAL SECURITY SUBCOMMITTEE

OF THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

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WITNESSES

THURSDAY, JULY 27, 2006



ALPHABETICAL LIST OF WITNESSES

# RESPONSIBLE RESOURCE MANAGEMENT AT THE NATION'S HEALTH ACCESS AGENCY

**THURSDAY, JULY 27, 2006**

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION, AND INTERNATIONAL SECURITY,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 2:32 p.m., in room SD–342, Dirksen Senate Office Building, Hon. Tom Coburn, Chairman of the Subcommittee, presiding.

Present: Senators Coburn and Carper.

## OPENING STATEMENT OF CHAIRMAN COBURN

Senator COBURN. The Subcommittee on Federal Financial Management, Government Information, and International Security will come to order.

I want to first thank all of our guests for being here and the time they spent. I also want to tell you, regardless of what comes through this Subcommittee hearing, we do appreciate your service and your dedication to carrying out the charges that you have been tasked with.

The title of our hearing is "Responsible Resource Management at the Nation's Health Access Agency." I will apologize in advance. I do not think Senator Carper is going to be able to make it. The Senate is not in formal session with votes, but I will try to cover his areas of concern, as well, in the hearing.

This, I believe, is our 43rd hearing on oversight since April 12 of last year. I have a prepared statement that I will place into the record, but I want to make a couple of points.

Six billion dollars goes through the Health Resources and Services Administration (HRSA) a year and they have a vision statement that is very broad. One of the things that we have tried to do is to raise the awareness of metrics, measurement of goals, and then evaluation of the metrics as to the goals of whether or not we are accomplishing what we want and also using that as a tool to help us decide where to direct monies in a better way, where do we get the best dollar return in terms of accomplishments at HRSA.

I am a big believer in the Performance Assessment Rating Tool (PART) system. I know it has tremendous flaws, but it is better than no system. One of the things that is quite evident at HRSA

is that the failure rate is about one in three programs inside HRSA to either identify the goal or perform up to the goal.

So the purpose of this hearing really is to talk about two areas, but also just to raise the awareness that we are going to be continuing to have hearings in areas in which I do not think you would disagree is how do we get the best dollar return for what our goals are, and also to give maybe some more direction. We recognize we are not the Executive Branch, but we do have the power of the purse and the authorization power to try to redirect those.

This is all part of a larger goal, is how do we handle health care in America? How do we make it affordable and accessible, which you all are keyed into in terms of the accessibility, and how do we do that to a degree where people can afford it? Part of that problem is the bigger problem of prevention, which HRSA is supposed to be associated with, as well, and how do we change the format in America from treating of disease to investing in health.

I know that you are both dedicated in those areas. The question is do we have the performance measures and the guidelines with which to assess the success or failure and the objective measurements of whether or not we are successful or failing in all the agencies, all the programs run by HRSA.

Just as an example, we had a hearing 4 months ago on the Ryan White and it has taken 4 months to get the answer to questions from HRSA. To me, 4 months to answer two or three simple questions either means it is not a priority or you do not have the capability or organizational skill to answer those questions.

Also, we had a report from GAO, I believe it was, in terms of the 340(b) program and what we know is we are wasting at least $4 million a month because we are not getting the best prices, which was some of the questions we asked, and that is a recent GAO report.

So the point is not to be critical of individuals. Nobody doubts your dedication or your desire to do what is in the best interests of our country, but rather to have a real frank discussion about what we can do better, how do we do it more efficiently, and how do we measure what we are doing to see if we are accomplishing the goals that were set out to us.

So I will put my full statement into the record.

[The prepared statement of Chairman Coburn follows:]

PREPARED STATEMENT OF SENATOR COBURN

We're here to talk about Responsible Resource Management at the Nation's Health Access Agency—otherwise known as the Health Resources and Services Administration (HRSA). In essence, we're here today for nothing more than a routine health checkup.

As a practicing physician, I have often learned that sometimes you treat symptoms in patients because they're a real problem. Other times, those symptoms are really alerting you to a much bigger problem in the patient. Today we're going to look closely at some programs that aren't performing well. And while we expect these programs to make improvements, they are only symptoms of a bigger problem at HRSA—a universal lack of performance measures and therefore, a lack of accountability to the taxpayers for how public funds are being used.

I recently held a hearing on President Bush's efforts to take a multi-trillion dollar government and apply some sort of standardized outcome evaluation on it—even if it's a crude instrument—known as the Performance Assessment Rating Tool (or (PART). The PART is a tool to review the strengths and weaknesses of government programs as agencies go through the annual budget process. PART findings, as the

agency before us today knows, do influence funding and programmatic decisions. As we found at that hearing, the Office of Management and Budget has reviewed 793 programs, accounting for $1.47 trillion in taxpayer money. Almost a third of these programs came up either totally ineffective or are "not demonstrating results." One-third of $1.5 trillion is $500 billion.

So, how do you manage a multi-trillion dollar Federal Government with literally hundreds of agencies and departments? First, you ask each agency: "what are we trying to accomplish?" You set measurable goals that can be tied directly to the outcome you're trying to achieve. And then you work diligently to achieve those benchmarks, keeping good track of your money and your data along the way.

An agency's success will in large part depend on its mission being realistic, measurable, and whether it has a role appropriate for the Federal Government. HRSA is a $6 billion-a-year agency with the stated goal to "provide national leadership, program resources and services needed to improve access to high quality, culturally competent health care." What do you get when you have an unrealistic and unmeasurable goal like this? You get seven out of 21 programs that have been measured so far failing when it comes to rating program performance—that's a third of the programs—and those are only the ones that have been measured so far.

When you're talking about healthcare, the results of inadequate performance can mean the difference between life and death. We had a hearing a few months ago on another HRSA program—the Ryan White CARE Act—the Nation's safety net for people infected with HIV/AIDS. Due in part to HRSA decisions, some patients are stuck indefinitely on waitlists for drugs that could save their lives—some have even died on the waitlists. GAO reported that the government is being overcharged for those same life-saving drugs by unacceptable amounts. Backing up this finding, the HHS Office of the Inspector General released a report last week on HRSA's "340B" affordable drug pricing program. The report found that 14 percent of purchases were made at prices that were higher than they should have been—resulting in $3.9 million in projected overpayments during just one month last year. HRSA has known about the weaknesses in the 340B program but has never corrected the problems. In this and other areas, HRSA has not been accountable.

Let's take another example. HRSA spends $6.2 million on its "Stop Bullying Now" campaign, an initiative launched in early 2005 that occupies quite a bit of "real estate" on HRSA's internet home page. The recently updated web page includes a "stop bullying now" jingle, 12 games, 12 "webisodes" of short animated stories featuring characters that "just might remind you of people you know" (and a promise for new episodes every couple of weeks) as well as quirky cartoon "experts" that answer questions about bullying. I don't doubt that there are good intentions behind this program, that HRSA wants to deter violence and stress in schools. But how does this program fit into HRSA's goal of "ensuring access to culturally competent health care for all?" HRSA's own website lists nearly 30 private groups addressing the problem, and a host of other programs at HHS, including violence prevention at the Centers for Disease Control and Prevention, and mental health programs at the Substance Abuse and Mental Health Administration, as well as the Departments of Justice and Education are working towards the same goal. I wonder why this campaign even belongs at HHS. Duplication and priorities that are out of whack are the natural results of poorly conceived mission statements and a lack of measurable objectives.

We could go on. But today we'll be examining two programs in particular. First, Healthy Start—a program originally conceived to reduce infant mortality. The program is currently going through the PART process. Healthy Start was first intended in 1991 as a 5-year pilot funded at $345.5 million, and today continues to receive large sums of money—about $90 million—$100 million a year since 2000. Healthy Start was designed to reduce infant mortality, but has floundered in achieving results. It is a great shame for our Nation that the United States ranks second worst among developed nations in infant mortality rates.

The second program in the spotlight today is HRSA's National Bioterrorism Hospital Preparedness program. The program received low PART scores, and the Federal Government has poured over $2 billion into this program since it was created in 2002 in the Public Health Security and Bioterrorism Preparedness and Response Act in answer to the anthrax attacks of the fall of 2001. It's also expected to receive another $474 million in 2007. The primary purpose of the program is to assist communities to develop adequate surge capacity to handle a moderate bioterrorism or natural health disaster. Building surge capacity is hard, and expensive. In the case of a massive epidemic or a disaster with catastrophic casualties, it's likely that no community would have "adequate" capacity, but there's a lot that can be done today to make us as prepared as possible. However, with poor oversight, the taxpayers have poured in billions of dollars to the program, but there remain well-documented

wide-spread deficiencies in the capacity, communication, coordination, and training elements required for preparedness and response in the efforts made so far. This is simply unacceptable.

In addition, the Emergency System for Advance Registration of Volunteer Healthcare Personnel (ESAR-VHP), as authorized in law in 2002, is a critical portion of the Hospital Preparedness program. The law required the Secretary to directly develop and implement a coordinated national database for the advance registration of health professionals for Federal use in case of a nationally declared emergency. Without this program, in a disaster situation, when volunteer doctors and nurses show up and want to volunteer their desperately needed services, they will not be able to do so. Despite clear need, with the program authorized after 9/11 and addressed by the 2002 law, the Department has done stunningly little. Finally, even as a program which does not match the requirements of the law, is still in the design stage. Officials are simply passively sending funds to States to develop their own systems—an approach rife with problems that we'll address later today with our witnesses.

I want to thank our witnesses for being here today and for the time they spent preparing testimony. I'd like to quote a man whose work I admire—Hank McKinnell, Chairman and CEO of Pfizer Inc., who rightly points out in his new book that "the hopes and dreams of grandchildren everywhere depend on us today—since the future they will inherit is ours to create."

Senator COBURN. I want to thank our guests for being here. I would like to recognize Dr. Peter Van Dyck, who is both a physician and has a master's in public health. He was appointed Associate Administrator for Maternal and Child Health Bureau in the U.S. Department of Health and Human Services, Health Resources and Services Administration, in 1999. As Associate Administrator for HRSA's Maternal and Child Health Bureau, Dr. Van Dyck is responsible for a $836 million budget this year. The Bureau is charged with promoting and improving the health of mothers, children, and families, particularly those that are poor who lack access to care. It administers the Maternal and Child Health Services Block Grants Programs for the State, the Healthy Start Initiative, and the Abstinence Education Program, among other programs. Prior to that, he was Senior Medical Advisor for 4 years to the Maternal and Child Health and HRSA Directors. He is currently Executive Secretary of the Secretary's Committee on Infant Mortality.

Joyce Somsak was appointed Associate Administrator of the Healthcare Systems Bureau in the U.S. Department of Health and Human Services, Health Resources and Services Administration on February 28, 2005. My, that is a long title. As head of HRSA's Health Care Systems Bureau, Ms. Somsak oversees $500 million in programs and services under the National Bioterrorism and Hospital Preparedness Program. The Bureau administers $471 million in fiscal year 2006 awards to the States to strengthen the ability of hospitals and other health care facilities to respond to bioterror attacks, infectious disease outbreaks, and natural disasters that may cause mass casualties. The Bureau also directs programs that oversees the procurement, allocation, and transplantation of human organs, tissue and bone marrow, manages the Vaccine Injury Compensation Program, and administers grants to the States to improve health insurance coverage for the uninsured. She served as Acting Director for the Vaccine Injury Compensation Program, is Director of HRSA's State Planning Grants Program, Acting Director of the Division of Transplantation, and is a member of the Department of Health and Human Services task force to implement the new Medicare Part D drug benefit Medicare Advantage legislation.

I would like to recognize you both in the order in which your bios were read. You have no time limit on the amount of time. It is just me and you, and so feel free to take off, Dr. Van Dyck.

**TESTIMONY OF PETER VAN DYCK, M.D., M.P.H.,[1] ASSOCIATE ADMINISTRATOR, MATERNAL AND CHILD HEALTH BUREAU, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Dr. VAN DYCK. Thank you, Mr. Chairman, and Members of the Subcommittee. I am Dr. Peter Van Dyck from the Health Resources and Services Administration, the Director for the Maternal and Child Health Bureau in the Department of Health and Human Services. I want to thank you for the opportunity to testify today concerning responsible resource management at HRSA, the Nation's health access agency.

Today, I will concentrate my remarks on the Healthy Start Program, one of the programs in the Maternal and Child Health Bureau and one about which I am very proud to represent.

In the late 1980s, a national concern about persistently high levels of infant mortality led to a number of efforts to address this problem. Although infant mortality rates have declined over time, the rate of decline had slowed by the middle 1980s, and relative to other developed nations, the United States' ranking had slipped. Even more alarming was the racial disparity in infant mortality rates. Black infants in the 1980s were more than twice as likely to die their first year of life than white infants.

A White House study then recommended the development of a major initiative to mobilize and coordinate the resources available in selected communities and to demonstrate effective approaches to reduce infant mortality. Concerned about this persistent high rate of infant mortality, President George H.W. Bush created the Healthy Start Initiative to fund 15 projects in areas both urban and rural where the infant mortality rates were 1.5 to 2.5 times the national average, and so the Healthy Start Demonstration Program began as a demonstration program in 1991.

Each year in the United States, about four million women give birth. Most have safe pregnancies and deliver healthy infants, but some women give birth too early, they see their babies die soon or after birth, or die themselves in pregnancy-related deaths. These difficulties continue to occur in greater numbers among women who are members of racial and ethnic minority.

According to the most recent available data from CDC's National Center for Health Statistics, the national infant mortality rate in 2003 was 6.9 deaths per 1,000 live births and the racial and ethnic breakdown was 14 deaths per 1,000 live births for black infants, 5.9 per 1,000 for Hispanics, and 5.7 per 1,000 for whites.

Healthy Start began with a 5-year demonstration phase to identify and develop community-based system approaches to reducing infant mortality and improve the health and well-being of women, infants, children, and their families. Since its inception, Healthy Start has been located in HRSA. It was originally funded under the

[1] The prepared statement of Dr. Van Dyck appears in the Appendix on page 29.

authority of Section 301 of the Public Health Services Act and most recently authorized as part of the Children's Health Act of 2000.

Healthy Start was founded on the premise that communities can best develop and implement the strategies necessary to eliminate the factors contributing to infant mortality, low birthweight, and other adverse perinatal outcomes among their own residents, especially among populations at high risk. Healthy Start communities form local coalitions of women, their families, health care providers, businesses, various public and private organizations, all working together to address disparities in perinatal health. Every Healthy Start site is guided by its consortium. Local residents are recruited, they are trained and employed as case managers and outreach providers.

HRSA provides the Healthy Start communities with national leadership in planning, directing, coordinating, monitoring, and evaluating the implementation of the various Healthy Start programs throughout the country. Specifically, the national program collects and analyzes information regarding the Healthy Start projects, provides program policy direction, technical assistance, and professional consultation on Healthy Start activities. It obviously administers the grants and contracts and serves as a focal point within the Department for Healthy Start.

The program now reaches 96 communities in 37 States, the District of Columbia, and Puerto Rico, and each of these vulnerable communities receives funds but has suffered from poor perinatal outcomes or an infant mortality rate in one or more racial, ethnic, or geographically disparate populations that is at least 1.5 times the national average.

While each Healthy Start project is unique as its community setting, there are certain hallmarks of all Healthy Start projects. Healthy Start was one of the pioneers in the use of women living in the community as outreach workers and home visitors. The approach achieves several things. It saves money, pregnant women respond better to other community-based women who have walked in their shoes, so to speak, and it has provided real and meaningful jobs to hundreds of unemployed or under-employed women in vulnerable communities.

Healthy Start communities do not stop helping to build healthy families when a healthy baby is born. They stay with the mother, the baby, the whole family for 2 years, monitoring the baby's growth and development, ensuring the mother's health and safety so that each new family is assured a Healthy Start.

These projects have been forward-thinking in their recognition that there can be both physical and psychological threats to a mother's health before, during, and after pregnancy, and they are particularly focused on identifying and treating perinatal depression. Part of what all Healthy Start projects are funded to do is to help their communities build and strengthen the medical, social, and psycho-social resources available to the women and their families. These projects are actively engaging mothers, babies, and families through these crucially important first 2 years of the child's life. These years are critical, as we know, because any difficulty in a child's development can be uncovered and addressed early, and the child's parents can be most readily engaged in positive par-

enting techniques that will result in optimal development and adjustment.

Just as important, Healthy Start programs begin with a fundamental precept that it is important to make sure that the mother has a medical home and that she is followed along with her infant to improve her health through risk reduction and health education. Good interconceptional care for women can make a subsequent pregnancy less risky for both mothers and babies.

Throughout the history of this program, it has been monitored by an independent council known as the Secretary's Advisory Committee on Infant Mortality, and the initial program design included a rigorous national evaluation. This evaluation, the first one for Healthy Start, was released in 2000. It used matched comparison communities, Healthy Start communities to non-Healthy Start communities, and to the original 15 Healthy Start program communities. The evaluation revealed several statistically significant differences.

More than half of the Healthy Start communities had improved adequacy of prenatal care. Four Healthy Start communities had declines in the pre-term birth rate. Three had reductions in the low birthweight rate. And two had declines in the infant mortality rate in the first 5 years of greater than 50 percent. The evaluation also found that Healthy Start projects were more effective in enrolling high-risk women into prenatal care and that the community-based interventions which Healthy Start uses may have longer-term impacts on future health and well-being of women and their families that have not yet been measured in the first years just surrounding that individual birth.

A major result of the first national evaluation was that using its findings, coupled with recommendations from the Secretary's Advisory Committee, HRSA was able to reshape the Healthy Start program to reflect what had been found to be most effective in that first rigorous evaluation.

Committed to implementing evidence-based practices and innovative community-driven interventions, Healthy Start works with individual communities to build upon their own local assets to improve the quality of health care for women and infants at all service levels. At the service level, beginning with direct outreach from community health workers to women at high risk, Healthy Start projects ensure that the mothers and infants have ongoing sources of primary and preventive health care and that basic needs—housing needs, nutritional needs, psycho-social needs, educational needs, and job skill building—are met. Following risk assessments and screening for perinatal depression, case management provides linkages with needed services and health education for risk reduction and prevention.

Getting women into prenatal care in the first trimester of pregnancy, or as early as possible, is critical since we know that prenatal care is critical to improving birth outcomes. Healthy Start has made proven impacts on participants' access to prenatal care. In 1998, participants' first trimester entry into prenatal care was only at 42 percent. By 2003, 5 years later, this number had risen to 71.4 percent, an increase of 73 percent across all Healthy Start sites in 5 years.

One of the first 15 sites, Washington, DC, reported for the year 2000 its lowest infant mortality rate ever, and in that same year, no babies born to Healthy Start clients died. Central Harlem is another example of a Healthy Start success story. The infant mortality rate there has dropped significantly since its project began in 1991, when in 1991 there were 27.7 infant deaths per 1,000 live births. By 2003, 10 or 11 years later, the rate had dropped to 7.3, from 27.7 to 7.3 per 1,000 births, a 273 percent decline.

Other locations have had real success in reducing low birthweight. In Baltimore, for example, the percentage of very low birthweight babies is 2 percent among participants with single births enrolled in Healthy Start. Ninety-nine percent of those clients are African American. That 2 percent compares to a 3.7 percent rate, almost twice, of very low birthweights among African American women throughout the rest of the city who are not in a Healthy Start site.

President Bush has asked for $101.5 million for Healthy Start in his fiscal year 2007 budget, an amount equal to the 2006 appropriation.

I am proud to represent the Healthy Start program. Thank you for this opportunity and I will be happy to respond to your questions.

Senator COBURN. Thank you, Dr. Van Dyck. Ms. Somsak.

**TESTIMONY OF JOYCE SOMSAK, M.A.,[1] ASSOCIATE ADMINISTRATOR, HEALTHCARE SYSTEMS BUREAU, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Ms. SOMSAK. Good afternoon, Dr. Coburn.

Senator COBURN. Good afternoon.

Ms. SOMSAK. Mr. Chairman, I am Joyce Somsak and I am the Associate Administrator of the Healthcare Systems Bureau in the Health Resources and Services Administration in the Department of Health and Human Services.

Senator COBURN. Like I said, it is a long title.

Ms. SOMSAK. It is a long title. At least I was able to drop "acting" off of one of those.

Senator COBURN. That helps.

Ms. SOMSAK. Thank you for the opportunity to testify today concerning responsible resource management at HRSA, which is our Nation's health access agency. The specific program that I have been asked to talk about today is the Bioterrorism Hospital Preparedness Program.

HRSA recently announced the latest round of grants for this program. This is the fifth consecutive year that we provided funding for the program, which was created after the terrorist attack of September 11.

Since then, the program has delivered over $2 billion to hospitals and health care systems in all 50 States as well as five territories, three freely associated States, and four large metropolitan areas, New York City, Chicago, L.A. County, and Washington, DC. This year, HRSA will be awarding $460 million to all these jurisdictions

[1] The prepared statement of Ms. Somsak appears in the Appendix on page 36.

to strengthen the ability of hospitals and other health care facilities to respond to bioterror attacks and other public health emergencies. Hospitals play a critical role in both identifying and responding to any potential terror attack or infectious disease outbreak.

During the first 4 years of the program, States used grant funds to develop surge capacity to deal with mass casualty events, such as expanding the number of hospital beds and developing isolation capacity at hospitals. Other priorities included identifying additional health care personnel who could be called into action in the event of an emergency as well as establishing hospital-based pharmaceutical caches for hospital personnel and associated EMS.

Recipients also used the funds to increase coordination of disease reporting among hospitals, local and State health departments, and to improve coordination and communication between public health laboratories and hospital-based laboratories.

Jurisdictions were required to improve their ability to provide mental health services, to strengthen trauma and burn care, and to increase their supplies of personal protective equipment and pharmaceuticals. Money could also be used to support training, education, drills, and exercises.

This year, the program's focus is turning to efforts to improve the capability of the local and regional health care systems to manage mass casualty events and to integrate preparedness activities across disciplines and agencies. The goal is to ensure that each jurisdiction has a system in place that will result in fewer deaths, long-term disabilities, and required hospitalizations.

Progress has been made in getting the funds to local health care systems. In the early stages of this program, there were some difficulties in quickly expending the large infusion of funds because State health departments were not set up quickly to establish such large grant programs, and also the capacity for the States to pass money on to the hospital systems did not exist because this was a new activity.

States have cited three main reasons for initial delays. Some State Governments were either reluctant or found it difficult to quickly hire the necessary staff to operate the programs. Due to procurement processes at the State level, delays were encountered in trying to award contracts to hospitals. And before disseminating funds to hospitals, they were required to conduct a state-wide needs assessment of their ability to respond to a bioterrorist event, infectious disease outbreak, or other public health emergency. These three barriers have diminished with time and States are now reporting greater success at getting funds to their local health care systems.

This program has built upon the needs assessments and implementation plans developed by the State grantees during the previous years and the updates of these plans from fiscal year 2003 to fiscal year 2005. Proposals are approved and funded in accordance with preparedness priorities developed by the States. Information on the improvements in the hospitals' capacity to respond to public health emergencies in general and to bioterrorism in particular is part of the progress reports that are submitted by the States and other grantees.

Part of this program is the Emergency System for Advance Registration of Volunteer Health Professionals, or as that wonderful acronym we call ESAR–VHP——

Senator CARPER. Can you say that one again?

Ms. SOMSAK. ESAR–VHP. That is one of our more interesting acronyms. This program focuses on developing the personnel component of medical surge and has provided grant funds to States for the purpose of establishing a standardized volunteer advance registration system that includes verified information on volunteer health professional identity, license status, certification, and privileges in hospitals and other health care facilities. The establishment of these standardized State systems will give each State the ability to quickly identify and better utilize health professional volunteers in emergencies and disasters and will lead to a virtual national system that will allow the easy exchange of volunteers across States and through the Federal Government, as necessary. The value of these state-based registries was demonstrated in the aftermath of Hurricanes Katrina and Rita, when 21 State registries deployed over 8,300 health professionals to the affected areas.

The National Bioterrorism Hospital Preparedness Program focus this year will be to continue to enhance medical surge capacity and capability as well as to develop a response structure that allows the implementation of a complex health and medical response through a single system. Since the inception of the program in fiscal year 2002, the program has established and awarded cooperative agreements to 62 States, territories, and select cities. These agreements have been essential for developing and coordinating health care emergency response plans at the State, regional, and local level for the management of mass casualty events that might otherwise overwhelm the system.

Significant progress has been made by State awardees in establishing the plans, developing partnerships, and assessing crucial needs and how to address them. The majority of the jurisdictions have in place or are finalizing a system to receive and distribute pharmaceuticals made available from Federal sources, such as antibiotics and smallpox vaccines.

States are putting mechanisms in place to address the gaps in communications systems among hospital emergency departments and outpatient facilities, emergency medical systems, and State and local emergency management, public health, and law enforcement agencies. They are also developing strategies to implement MOUs and mutual aid agreements to foster intrastate and interstate collaboration in meeting medical needs. These include personnel, equipment, supplies, training, and exercising.

You mentioned the PART program before. A PART review was done very early in this program, in fiscal year 2004, and we received a rating of "results not demonstrated." The assessment did indicate that the program had not demonstrated results due to its relative newness and the difficulty in measuring preparedness for events that do not regularly occur. We developed some new measures that focus on medical surge capacity. However, these again were developed early in the program and the program has evolved since that time.

We are currently looking to go beyond capacity and work toward capability. We believe the best measures of effectiveness of the program will be in capability, not just capacity. So we are in the process of developing new medical surge capability measures. In January of this year, we had an expert panel of awardees, hospitals, State hospital associations, and the American Hospital Association, academia, and others to develop the measures. We have measures now that were cross-checked against others, such as CDC's performance measures, our targeted national capabilities list, and JCAHO standards. We have a national vetting process that is almost complete and we expect these new measures to be final in the next month. We think these new measures will be better in terms of determining that our Nation's hospitals are prepared to handle emergencies.

Health and Human Services Secretary Mike Leavitt recently announced the funding for the preparedness program. His statement in the announcement was, "Improving our Nation's response to health care emergencies is an important part of securing America. All emergency incidents—whether naturally occurring, accidental, or terrorist-induced—begin as local matters, and with this program, States and communities will build on the preparedness gains they have made over the past 4 years."

Thank you for this opportunity to testify.

Senator COBURN. Thank you very much. Welcome, Senator Carper.

**OPENING STATEMENT OF SENATOR CARPER**

Senator CARPER. I have no opening statement. I am just delighted that our witnesses are here. I am glad I can stop by and join you for a while, and thank you for coming. I would like to have a chance in a minute or two to ask a—well, not in a minute or two, but later on, I will ask a couple of questions. [Laughter.]

Senator COBURN. Thanks. We are just going to go through some things.

Dr. Van Dyck, how many total women per year are impacted by Healthy Start?

Dr. VAN DYCK. Depending on the year, it is in the range of 16,000 to 18,000 to 20,000 babies born a year in the Healthy Start program. There would be a few more women than that because it takes 9 months to have a baby and you follow the women whether or not they are successful at their pregnancy and you follow them for a while after, so the number of pregnant women would be somewhat more than the number of births.

Senator COBURN. So around 20,000 lives impacted plus children, so you really have 40,000 lives, is that right?

Dr. VAN DYCK. At least.

Senator COBURN. Yes.

Dr. VAN DYCK. Correct, and again, we cannot forget if there is a sibling that is 1 year old——

Senator COBURN. That is getting some impact.

Dr. VAN DYCK [continuing]. And when that baby gets care and immunizations.

Senator COBURN. Thank you.

Dr. VAN DYCK. There may be another family member that gets care. So we serve more than that.

Senator COBURN. Just some old housekeeping. I sent you a letter—and you probably do not even recall this letter, I never got an answer to it—in 2000 on the Ryan White and Healthy Start on testing for HIV. What is Healthy Start and Maternal Child's position now for neonatal testing of newborns whose mother's status is not known?

Dr. VAN DYCK. Healthy Start women, if appropriate, get tested for HIV.

Senator COBURN. What about their children?

Dr. VAN DYCK. The children will also, depending on the local sites. It is recommended, but depending on the local sites' particular policies.

Senator COBURN. So we do not condition any grants on a totally curable and preventable disease at birth to test infants whose mother's status is not known?

Dr. VAN DYCK. The grants are not conditioned on that. There are recommendations that are done.

Senator COBURN. And what percentage of this 20,000 are there infants tested or their mother's status known?

Dr. VAN DYCK. I do not know the answer to that.

Senator COBURN. You do agree with the medical practice. The fact is if a child is treated early or treated during the intrauterine——

Dr. VAN DYCK. Absolutely.

Senator COBURN [continuing]. We can eliminate 90 percent of it.

Dr. VAN DYCK. Absolutely.

Senator COBURN. And a mother's status being known, even though the child might not test positive, if they are positive, breast feeding can lead—which is encouraged in Healthy Start—can lead to infection in the infant.

Dr. VAN DYCK. Absolutely, and we also know that a negative test at the beginning of pregnancy does not mean a negative test——

Senator COBURN. That is right.

Dr. VAN DYCK [continuing]. Later on in pregnancy, either, and these are highly recommended——

Senator COBURN. Interpartum testing is an important aspect of pregnancy and delivery, and I was just wondering why we would not require that as a part of these grants.

Dr. VAN DYCK. That is a policy we would have to review.

Senator COBURN. Knowing that one out of every three people who is infected with HIV in our country do not know it.

HRSA has had a PART evaluation, that is true, correct?

Dr. VAN DYCK. Healthy Start?

Senator COBURN. Yes, Healthy Start and Maternal Child, is that correct?

Dr. VAN DYCK. The Maternal and Child Health Block Grant had a PART review the first year, 5 years ago. Healthy Start just has had a PART review and it is not posted or finished yet.

Senator COBURN. OK.

Dr. VAN DYCK. We have completed the review.

Senator COBURN. I am fully supportive of the goals of Healthy Start and Maternal Child, so as I question you, it is not that I do

not support the goals of the program and I want you to bear that in mind. What are the metrics that you use in Healthy Start for grants? In other words, what are the controls and measurements and outcomes to know in the grants that we are, in fact, for the amount of money, $5,000 per individual, that is the best way to spend the money, and what percentage of that $5,000 per individual actually gets to care, to treatment?

Dr. VAN DYCK. First, the $5,000 per individual, that might be per birth, but not per individual, if you will allow me——

Senator COBURN. But the per woman treatment. Let us use it as per woman treatment.

Dr. VAN DYCK. Per family unit.

Senator COBURN. OK.

Dr. VAN DYCK. Just to not understate it. We have a number of performance measures that have been used for a number of years. The first is to reduce the infant mortality rate among the Healthy Start program participants, and our long-term goal for 2013 is to reduce it to 4.28 infant deaths. To give you an idea, and we have been following this since the beginning of the program, in 1991 to 1993 when the program first began in those 15 communities, the rate averaged around 20. In 2000, it was 13.9. In 2003, it was 11. In 2004, it was 7.65.

Senator COBURN. So each one of these grantees have to return all this data to you?

Dr. VAN DYCK. Yes, sir.

Senator COBURN. It is a component of the grant?

Dr. VAN DYCK. That is a requirement, and that is infant mortality. So not only do they have to return it, but we aggregate—we review each Healthy Start project against these performance measures——

Senator COBURN. So what——

Dr. VAN DYCK [continuing]. So aggregate it, as well.

Senator COBURN. So what happens if somebody is not performing right now?

Dr. VAN DYCK. Well, we work with them and we will send out technical assistance and we will review the grant again and we will review what they are doing.

Senator COBURN. And so who has lost a grant?

Dr. VAN DYCK. No one has lost a grant that I can remember, and I can check on this, from poor performance.

Senator COBURN. But that does not mean there has not been poor performance.

Dr. VAN DYCK. It does not mean there has not been performance that needs improvement. But the Healthy Start sites have improved.

Senator COBURN. A key finding from the 2000 mathematical review of Healthy Start found that even after the program had been around for several years and "despite considerable investment, programs were unsuccessful in developing a management information system that would allow for the ongoing tracking of service receipt by clients. Client-level data were of poor quality and were of limited use for program monitoring and for evaluation purposes." What has changed since then? That is the first part of my question.

And the second is the independent review that is ongoing now, and I understand the close-knitness of holding this close to the vest because of a history of people who let things out to hurt you in the past that were not necessarily in a balanced perspective, but since the early one, there have been two reports released in 2000 that came out of the early report. I understand there is currently another full independent review being conducted by Apt Associates at a cost of around $4 million for a full 3-year phased study that is in the final clearance at HRSA. You all denied us the ability to see that, which will necessitate us after we see it having another hearing. Can you update us on this particular review? Why was a report needed? When is it expected to be released, and what is it expected to contain?

Dr. VAN DYCK. This Healthy Start evaluation by Apt Associates is a 4-year study. The first 2 years are to get a better idea about what are the features of the Healthy Start projects across communities, what results have the projects achieved, and are there intermediate outcomes that would be helpful. Is there an association, then, between what elements the Healthy Start programs include in their programs and outcomes, and then how does that all fit together in improved outcomes.

There are two phases to the program. The first phase is what has just been completed and the document is in clearance, and that is an analysis of all 90-plus Healthy Start sites, how they serve people, what the elements are in their service package. That is in clearance currently as we speak and should be, I would hope, cleared within the next several weeks.

The second phase of the project is on the outcomes, and that is a smaller project designed to look at eight to ten particular Healthy Start sites against the findings in the first half of the evaluation to really tie together the practices, features, and elements that the Healthy Start site has implemented against the outcomes to see if there is a relationship between those elements and the outcomes, but in addition, to see if there is any evidence that particular elements have a greater impact on the outcome than others, and we suspect that may be the case. So this would allow us to tailor the programs much more succinctly.

Some preliminary results, just to give you an idea of the type of results that are in this first piece of the outcome, or the evaluation, are that 100 percent of the Healthy Start projects have elements that include health education and training to their participants. Ninety-nine percent of the Healthy Start projects have identified strategies for addressing the disparities in their particular population. Again, these are features of the program, and 97 percent of them have implemented these strategies. That gives you a flavor for the types of findings, the description of the elements and the number of Healthy Start sites that have those elements within them.

Senator COBURN. What about the earlier review where they were talking about the data being of poor quality and limited use to do any program analysis?

Dr. VAN DYCK. The Healthy Start program began in 1991 and there was a real attempt made in the first 15 projects and in those early years to develop a data system for those projects which was

uniform across the projects and would collect information such as I described that would allow you to measure outcomes. It was not very successful and it was changed to rather let us tell the Healthy Start sites what data we want to reach which outcomes and let them develop the system that best meets those needs for them, because many of them tie into universities——

Senator COBURN. I cannot be critical of that. That is a good approach to doing it.

Dr. VAN DYCK. And so now we do have good data and almost all Healthy Start sites have a data system that can allow us access to individual data.

Senator COBURN. If you were just divorcing yourself away from the importance of what Healthy Start is about and the maternal-child function and you sit and say, the $5,000, that does not count prenatal care. That does not count delivery costs. That is the cost. The question I have for you is how do we get more benefit? Instead of having 96 sites, how do we have 180 sites with the same amount of money accomplishing the same thing? In other words, how much money is spent on administering Healthy Start versus actually making the difference and how do we lessen that so we get this greater coverage with the same amount of money?

Dr. VAN DYCK. The Healthy Start legislation has limits on both evaluation and administration. Healthy Start law says we may spend up to 1 percent of the budget on evaluation. We spend a little less than that, but these are important national independent evaluations which are the elements that get us a decent PART score. I think I can assure you that our PART score will be quite positive.

Senator COBURN. Right. That is what we want.

Dr. VAN DYCK. But OMB requires an independent evaluation and that is what this pays for. So up to 1 percent of the money each year can be used for an independent evaluation. No more than 5 percent can be used for technical assistance, administrative kinds of costs, and so we stay under that 5 percent. So we have somewhere between 94 and 95 percent being spent on programs.

Senator COBURN. OK. Per family unit that you are impacting, we are spending $5,000 to impact in terms of postnatal care, pediatric care, parental training, diet, prenatal nutrition——

Dr. VAN DYCK. Right.

Senator COBURN [continuing]. All those things. We are spending $5,000 per unit. The question I would ask is, how do we get that cost lower so we cover more people?

Dr. VAN DYCK. Well, there are probably several ways. One is to look at the results of the evaluations to see which of these elements make a difference and which are nice but may not make as big a difference and focus more on those.

Senator COBURN. Let me tell you some personal experience.

Dr. VAN DYCK. Yes.

Senator COBURN. As you know, I am still delivering children on weekends, and routinely when I am in my office, I will get a call from somebody from Oklahoma State University and some Medicaid patient that I am caring for, they are in their home visiting them. They have driven to their home to visit them and they are telling me something that I have already told the patient that I al-

ready know the patient is compliant with, but to meet their marker they have to call the physician. That makes no sense to me. Now, I do not know if that is in the rigors of that particular grant program that is a requirement for them to do, but, in fact, if you are given really good prenatal care, which I like to think that the group that I was formerly associated with did, nutrition is a lot of the teaching—what medicines to avoid, what you can take without talking to us first. Parenting skills is a part of what you talk about. Signs of illness in newborn children, teaching that not just to the mother but to other family members that might be there.

I guess my question is I am somewhat amazed that we are not treating more with the same amount of money, that it is costing $5,000, or 94 percent of $5,000 to do this. And my question to you is in terms of having metrics to measure, can we design a metric system where you can take this program and instead of approaching 20,000 family units, you can approach 40,000?

There are a couple of reasons why I am asking it, and it is not to be critical of what you are doing. It is hard what you are trying to do. If somebody said you were king tomorrow and you could make everybody do it, you could do it a lot cheaper, I understand that, and you would not have to go through different universities and all these other different things. But this program is not going to get increased in terms of dollars. We are on the downward trend of shrinking every program we have just to be able to pay for the major programs that are out there and pay the interest.

So my question really goes and my charge to you is set up the metrics in a way where we can become much more efficient with the program, so we get two families for $5,000. And in terms of infant mortality, what will that mean? If you are lowering it 30 or 40 percent in these areas, then you are going to lower it 30 or 40 percent in other areas if we do that, and so the overall accomplishment of the goal will be that—I will stop now because I know Senator Carper has some other time constraints and I will come back.

Dr. VAN DYCK. May I respond, please?

Senator COBURN. You bet.

Dr. VAN DYCK. Yes. So I agree. The evaluation is one way to determine which elements are most efficient and effective. But we also do other things. We have community well baby clinics, where there may be 10 mothers together with their newborn babies getting a well baby visit or a well baby educational session, making that much more efficient. We use community workers or doulas extensively to bring women in to keep their appointments, to make sure that they come when they are scheduled and the time is not wasted and that they do everything that is necessary at that visit—seeing the dietician or the nutritionist or the social worker or the psychologist and physician or the nurse, so they do not have to come back on the interim, or get their lab work at the same time.

So there are many elements like this that I think we really do, and as far as the metric, we do have an efficiency measure which has been in effect since 2002 which is the number of persons served with constant funding. In 2002, it was 289,000. In 2004, the baseline was 367,000. And our target for 2008 is 410,000.

Senator COBURN. So you are growing the number of population.

Dr. VAN DYCK. So this is a metric for Healthy Start of efficiency that we worked out with OMB to try to show that we can serve progressively more people to a point with the same number of dollars.

Senator COBURN. One final comment before I turn it over. There is the case management technique that is being used in North Carolina on Medicaid parents. There is case management for the severely disabled, where they have an advisor that helps them manage it and it is not through the program, it is independent. Have you all looked at that to say, maybe we could do this better by just assigning case managers and Medicaid to accomplish the same goal?

Dr. VAN DYCK. All these women have case managers or care coordinators and they work in making the plan for that woman and making sure her visits are efficient and timely and go get her if she is not there. And so we do use case managers, and in fact, some of them might be modeled after the Baby Love Program in North Carolina, which is the EPSDT program for case managers through EPSDT.

Senator COBURN. All right, thank you. Senator Carper.

Senator CARPER. Thanks, Mr. Chairman. I want to just follow up, if I could. Ms., is it Somsak?

Senator COBURN. It is a Delaware name. I wanted you to know that. [Laughter.]

Senator CARPER. I wanted to ask Dr. Van Dyck a couple more questions, if I could, and if time allows it, I would like to come back to you for a question.

Dr. Van Dyck, you were just giving some responses to our Chairman with respect to the number of folks served. Would you just repeat those again?

Dr. VAN DYCK. In 2002, it was 289,000, rounded. In 2004, 367,000. So when I said earlier that the number of babies born does not truly reflect the number of clients seen in the program, this gives an indication of that. There are family members, other siblings, fathers who are all involved in this process, and there are many women that may come and end up not pregnant who still have been seen and evaluated. So, it is a significant impact.

Senator CARPER. And the level of funding between 2002 and 2004, how does one compare it with the other?

Dr. VAN DYCK. Funding in 2002 was $99 million, and the funding in 2006 is $101.5 million.

Senator CARPER. So it is basically flat?

Dr. VAN DYCK. So it is basically flat.

Senator CARPER. The quality of the service—you are providing service for more people. Are you providing comparable service? How do you evaluate the success of the care that you are giving, the service you are providing, the quality of the service that you are providing for all those people?

Dr. VAN DYCK. Quality is extremely important to us and we think if we lower the infant mortality rate, we decrease the low birthweight rate, and I might add that Healthy Start has decreased the low birthweight percent in Healthy Start clients really significantly.

Senator CARPER. How so?

Dr. VAN DYCK. In 1998, it was 12.1 percent of all babies born in Healthy Start were low birthweight, and in 2004, it was 9.3 percent.

Senator CARPER. Say those numbers and dates again.

Dr. VAN DYCK. In 1998, the low birthweight was 12.1 percent. And in 2004, it was 9.3 percent.

Senator COBURN. Would you care if I interject?

Senator CARPER. No, go ahead.

Dr. VAN DYCK. In the Nation, the low birthweight percent has increased for the last 15 years. We are not being successful in the Nation of reducing it, yet in Healthy Start, we are.

Senator COBURN. Those statistics are only important if you ferret out pre-term delivery, because the only way you measure low birthweight infants is to look at term infants who are low birthweight versus pre-term infants, and what are the numbers on those?

Dr. VAN DYCK. These are——

Senator COBURN. That is where you know whether you are making a difference.

Dr. VAN DYCK. I do not have that in front of me.

Senator COBURN. But you will admit, it is important. Pre-term delivery——

Dr. VAN DYCK. It is important for pre-term birth and low birthweight——

Senator COBURN. You bet, and I understand all the ramifications, but if you——

Dr. VAN DYCK. And they run together——

Senator COBURN [continuing]. Combine the statistics together, you cannot measure what you are really doing. We want to eliminate pre-term deliveries, which are much greater risk for children than a term infant that is low birthweight.

Dr. VAN DYCK. Correct.

Senator COBURN. And so what we want to try to do is if we had to pick which one do we want to excel in, it is pre-term deliveries.

Dr. VAN DYCK. Right.

Senator COBURN. I will not go into all the reasons for that, but there are a lot of reasons in our society today why we have that.

Dr. VAN DYCK. And that is true, and we have also decreased the pre-term delivery rate, and that has also gone up nationally.

Senator CARPER. In the State of Delaware, 15 or so years ago, there was a time that Mike Castle was our Governor—the fellow who served with our Chairman in the House for a while—but Delaware had maybe the highest rate of infant mortality in the country. In his administration, he went to work on it. I succeeded him as governor. We worked on it again. We have a new Governor who is mindful of this, but we are seeing our infant mortality numbers, which had dropped, beginning to rise again and they are now at levels that are alarming in our little State.

If you look at, and you mentioned the incidence of low birthweight babies being born, we have a lot of those for our State, and in a State with a fairly high level of income. We are not a poor State by any stretch of the imagination.

We used to have a Healthy Start program in Delaware and I think it went away, I want to say maybe in 2004. Is that correct?

Dr. VAN DYCK. Two-thousand-and-one.

Senator CARPER. Two-thousand-and-one. I know the State has been interested, and especially as we have seen our incidence of low birthweight babies rise and as we have seen infant mortality again having dropped to turn around and head back up, there is a significant interest in the State of Delaware having a Healthy Start program again. Could you give us some guidance as to how we ought to proceed to get a program again in our State?

Dr. VAN DYCK. Healthy Start has a competitive grant cycle. That cycle was competitive this last year, and so these grants are awarded for a period of, I believe, 4 years. So there will be another competition coming up in about 3 to 4 years, unless we get more money. Then we can have a new competition. Otherwise, these are the grants that will be in effect for the next several years.

Senator CARPER. All right. Can you give us some guidance? I do not know how often it is that States or programs are in existence and they are not funded or States reapply and they are not approved. What are the common reasons why States that might have a program do not continue to have a program, why they go away?

Dr. VAN DYCK. There is a lot of competition for the Healthy Start grants, as you might imagine.

Senator CARPER. You said there is a lot of competition. Give me some idea of what——

Dr. VAN DYCK. There may be two to three times as many applications as can be funded with the money.

Senator CARPER. OK.

Dr. VAN DYCK. One reason might be that the site has improved enough, lowered their infant death rate enough that they become ineligible for the grant and allow us to put somebody else into the competition or award a grant in an area that has worse, or less good, numbers.

Another might be—and again, these are reviewed by an independent review process—may be that the consortium that is built with the community folks does not meet the requirements. It could be that the partners that have been assembled to deliver the care and to provide this seamless network of care for the pregnant woman and her baby does not provide enough of that network. It could be that the grant just is not written well enough for the grants committee to get the essence of local communities' needs. It can be any of those or all of them.

Senator CARPER. In our State, it sounds like in order for us to get back into the game, we have to be ready 3 years from now?

Dr. VAN DYCK. Yes.

Senator CARPER. OK.

Dr. VAN DYCK. And we can offer technical assistance to make sure that there is an understanding about the guidance and all the rest.

Senator COBURN. Is there a reason that this was not a staggered grant process?

Dr. VAN DYCK. Well, the money became available at one time——

Senator COBURN. So you started on——

Dr. VAN DYCK [continuing]. And in order to spend the money, you have to start to spend the money——

Senator COBURN. I have got you.

Dr. VAN DYCK [continuing]. Because the money becomes available.

Senator CARPER. The last question I have, if I could, I missed your testimony and let me just ask for just one or two points you really want us to take away from here in terms of what you think are important. Then I am going to ask the same question of Ms. Somsak.

Dr. VAN DYCK. Well, there is a real need with an infant death rate in the Nation that is twice in African Americans what it is in whites—actually, more than twice—a Hispanic rate that is higher, and pockets of people who have significantly higher infant mortality and low birthweight or pre-term birth rates and lack of prenatal care, there are those significant areas that Healthy Start seems to be able to make an improvement in when they get a grant and they can stay with it for 4 or 5 years.

We just need to make that need known, because there are other areas that do not get funding, as you have suggested, where we could make a difference in the infant mortality rate. Healthy Start has proven successful. We are getting more efficient. We are decreasing numbers and we are doing independent evaluations and making them public. We could always move faster, but we think we are on the right track.

Senator CARPER. Good. Thanks very much.

Ms. Somsak, just briefly, if you could just summarize one or two major points that you want us to take away.

Ms. SOMSAK. Sure. I think the goal of the program, of the Healthcare Preparedness Program, is to improve the health care deliver at the hospital level, at the primary, the health care level where patients are likely to be seen. We need to do that, to be able to have them respond in emergency situations where there is a terrorist attack or an influenza outbreak. That capacity has to exist at the hospital level. That is where our funds go for the preparation.

The first few years of the program, we have worked on increasing the medical surge capability, the infrastructure, creating the equipment, creating the capacity to increase beds on short notice, training the personnel to be able to respond. Now we are moving towards, in the next few years, moving from just a focus on increasing capacity to making sure there is demonstrated capability. So that is the thing we have to be able to really assure, not just that you have the capacity, but when there is an emergency, can you activate the personnel you need? Can you demonstrate this in emergencies?

And we have seen it, not in drills, but we have seen it in a situation where there has been a chlorine tanker overturned, in South Carolina, and we have seen it in some workers who were crop dusted. They were really concerned. They were decontaminated in a facility. We have seen it with Hurricane Katrina, where we were able to mobilize personnel from across States in an emergency situation. So this is the kind of thing that this program really does, and it does it at a hospital level. It works in coordination with State and local health departments, but it is unique in terms of the hospital-level capacity that it works on.

Senator CARPER. Good. Thanks, and thank you both.

Senator COBURN. And we will leave the record open so you can ask additional questions if you want.

Senator CARPER. Thank you.

Dr. VAN DYCK. The number of pregnancies remained about the same.

Senator COBURN. So the expansion has not been in pregnant women, but in their family members, in those numbers?

Dr. VAN DYCK. It has been in the people surrounding the pregnant woman. And we think that is an important element in improving the care of that particular pregnant woman.

Senator COBURN. Well, I would not disagree. Is it more important than enrolling more pregnant women, though? That is the question to ask, not the other one.

I also note in the President's budget justification, which I assume you were involved in, that your targets are static, both in terms of first trimester prenatal care and low birthweight, and my question is why? I mean, you are making some progress. You have gone from 10.5 to 9.3 percent, but you keep a target that is 10.5 percent. Why wouldn't we want to go to 8 percent as a target? Why wouldn't we want 95 percent of all the women getting first trimester prenatal care? It is page 370 of the President's justification, and you can answer that later, if you would rather.

Dr. VAN DYCK. I do not have the same pages you have. We do have additional performance measures other than the infant mortality, one being entrance into prenatal care, and our target for 2007 is 70 percent. Our target for 2008 is 75 percent. And so in our performance measurement system, we do have an increase in target. The actual number in 2002 was 69. In 2003, it was 71.

Senator COBURN. And in 2004, 73. In 2005, 75. In 2006, 75. In 2007, 75. That is what you submitted in the budget justifications to Congress.

Dr. VAN DYCK. Right. So in 2008——

Senator COBURN. Next, on low birthweight babies, it is 10.5 percent from 2002 to 2007, and you are below that again. The question is, why is the target not lower? If we are going to use metrics and the input we have just had, your testimony that says, in fact, this is one of the things that really changes outcomes, and we know it changes perinatal death rates, why would we not up the target?

Dr. VAN DYCK. Well, there may be an overlap between when that was written and when the data came in for the performance measure——

Senator COBURN. Fair enough.

Dr. VAN DYCK [continuing]. And you point out something we will review, because our metric for the performance measures, which are our real measurement, are increasing, or decreasing.

Senator COBURN. OK. Fair enough. The one thing that has bothered me, this last year, you gave out three new grants and we had something like 233 applications. The only thing that bothered me in what you said is your PART score is going to be good now. It was not in the past, and yet——

Dr. VAN DYCK. No, I did not say it was not in the past. We have not been PART-ed before. This is the first——

Senator COBURN. Well, your independent reviews from 2000—let us put it that way, the fact is nobody has lost a grant for poor per-

formance, and if that is the case, then somebody has to question the evaluation of grants. If somebody who already has a grant and they are not performing well and you have 233 applications of which you are only going to be able to give three or four new grants to, there has got to be somebody in that group, after this has been going since 1988, ramped up in 1991 to 1995, is that correct?

Dr. VAN DYCK. Correct.

Senator COBURN. You really did not get ramped up until 1995, correct?

Dr. VAN DYCK. During that——

Senator COBURN. We cannot really judge you before 1995.

Dr. VAN DYCK. That would probably be a fair statement——

Senator COBURN. OK.

Dr. VAN DYCK [continuing]. Although we have tried to judge that period.

Senator COBURN. I understand. I am not critical of that. I am just saying from 1995 to 2006, not one of those grantees had such poor performance and not one of those applications showed a better need that one of the grantees lost their grant and somebody new got it.

Dr. VAN DYCK. No, I did not say that. I said I did not remember for sure if anybody lost for poor performance. There are—and I can check that. The other thing is whether somebody did not get a grant who previously had a grant because they could not successfully compete or the numbers in the grant did not show enough success. There have been grantees who have not been successful subsequently. You heard that case happening in Delaware.

Senator COBURN. Yes.

Dr. VAN DYCK. So there are instances where people——

Senator COBURN. Have lost their grant?

Dr. VAN DYCK [continuing]. Where they have lost their grant, yes.

Senator COBURN. All right, fair enough.

Dr. VAN DYCK. So there are two ways to look at that. One is for poor performance. The other is in a grant competition, they may not compete as well as somebody else, then, and we can give you those numbers.

Senator COBURN. You are in good shape.

Dr. VAN DYCK. Thank you for the opportunity, Dr. Coburn.

Senator COBURN. Thank you, and thanks for your pleasantness. And as I told you, if there is any area that you want to qualify when we get through that you think our assumptions are wrong or inappropriate or inaccurate, please bring them up.

Ms. Somsak, you have a tough job. We will never have the surge capacity we need, right? I mean, there is no way we can afford to put surge capacity, if we were to have a major catastrophic event, that we could have enough ICU beds and ventilators. So where do you draw the line? How do you do that, and how do you give us the best for the limited amount of money that we can go in this direction?

Ms. SOMSAK. I think there are two ways that States are approaching it that gives us a way to deal with capacity. The individual States are working to establish, with the State associations and State plans, to come up with ways to handle the surge capac-

ity. So within a State, we have a lot of, say, how you would do it. Like in New York City, they are working with not just hospital by hospital plans, but multiple hospitals working together, and I think that is the first way you are going to get it, is within a State that the hospitals work together so that every hospital is not getting every capacity, that you work together to establish and respond.

The other way you are getting it is across State lines, and this is really key. Particularly, for example, in the New England region, that whole series of States have come together to develop their surge capacity because they do not believe individually in their own States they would be able to deal with it, particularly if there is one major incident in one State and not another. So that is the second way we are seeing it, is that regional plans are being worked on to do it, and we are really encouraging that and we are seeing that across the country, particularly where you have a low population of adjacent States and things like that, that you are really going to have to have other people come to their help.

The third way is just in terms of the regional compacts, where you could have States that have compacts with other States to respond to their needs. So even though they do not plan regionally necessarily, they have compacts so they can respond to another State's needs. It is a lot easier, obviously, in terms of personnel, medical personnel, to be able to respond to another State in terms of capacity, but that is going on now and we saw it in Katrina, with many of the States stepping forward to help Louisiana and Texas.

Senator COBURN. So there has been $2 billion spent in grants on surge capacity.

Ms. SOMSAK. Yes.

Senator COBURN. Where was it spent?

Ms. SOMSAK. A lot of it has been on equipment.

Senator COBURN. How much of the $2 billion was spent on equipment and capacity?

Ms. SOMSAK. Well, overall, the requirement is that 85 percent of the money has to go to the hospitals to be spent on the requirements of the grant itself.

Senator COBURN. Has it?

Ms. SOMSAK. Of the 85 percent, I would have to find out the figures on how much actually was spent on the medical equipment component versus pharmaceuticals and storage.

Senator COBURN. Pharmaceuticals, stockpiling, and things like that. But my question is do you have at your fingertips the measurement tools to know, out of the $2 billion, the 85 percent of that—how much of that has actually gone to capacity, pharmaceutical stockpiles, ventilators, and beds versus how much went for those creating the program to get those? What is the percentage? Do you have that at your fingertips as a manager, and do you have the ability to measure that through the grant process, and if so, what are the results, and is every grant recipient spending that money appropriately and do you know that?

Ms. SOMSAK. The States are required to give us yearly reports on their progress in meeting their plans and the State plans go to what capacity they are going to be building at the hospital level. So the State is required to report on where they are building the capacity for hospital beds or decontamination units. We have tar-

gets in their grants that they are supposed to meet and then they have to report against those grant targets and tell us where they are in meeting the goals in terms of surge capacity, in terms of decontamination units and things like that.

Senator COBURN. But you do not have a metric yourself, other than self-reporting, that says you know where the money is spent? In other words, have you audited one of the grants?

Ms. SOMSAK. They are financially accountable for what they spend.

Senator COBURN. I know, but have you all audited the grants? Have you audited Oklahoma's money that they have gotten under this grant program to see that what they are saying is actually where the money went?

Ms. SOMSAK. I do not know about Oklahoma's.

Senator COBURN. Has anybody been audited to see that the money that has actually been spent, the $2 billion, actually went for what they said it went for?

Ms. SOMSAK. Even if they have not been audited to date, they will be audited under the financial because all the grants, any long-term grant has to be audited. There is an audit process that they have to go to. But I cannot tell you at this point whether that has occurred because a lot of the grants are only 3 years.

Senator COBURN. OK. Is there any requirement in the grant process that X-percentage of the money has to be spent on actual capacity, actual ventilators, actual pharmaceutical storage, actual units? In other words, if they have 85 percent of $200,000——

Ms. SOMSAK. Yes.

Senator COBURN [continuing]. Is there a requirement that you cannot consume it in consultants, planning, and conferences, but you have got to consume it in actually buying the goods?

Ms. SOMSAK. I do not know at this point, and I will get that information for you, as to what the restrictions are about the money that actually goes to the hospitals. I will tell you that the hospitals are spending more money, far beyond what we give them through the State, because hospital needs are great. So the hospitals are actually investing beyond in terms of preparing themselves for emergencies, and particularly major hospitals.

Senator COBURN. Let me tell you why I asked this question.

Ms. SOMSAK. OK.

Senator COBURN. HHS's own website, a report responding to the IG identified challenges. It established the bioterrorism preparedness as management challenge number three. It describes issues with both CDC and also surge capacity. One major issue that they outlined in that, the grantees failing to comply with financial accounting and reporting requirements in HRSA and CDC grant programs. Now, you have testified that they are required to do that, and here is the IG of your own agency saying they are not doing it.

Ms. SOMSAK. Yes.

Senator COBURN. So are they doing it or are they not doing it?

Ms. SOMSAK. I am not familiar with the IG report, but what year was the IG report? Which one are we talking about?

Senator COBURN. It is the one they filed this year on their challenge number three for HHS.

Ms. SOMSAK. OK.

Senator COBURN. OIG has issued 15 audit reports in 2003 on State and city monitoring of grantees receiving these, citing some States and major cities lacked any appropriate monitoring mechanism.

Ms. SOMSAK. OK.

Senator COBURN. So again, my job is not to beat you up on this. I am telling you what I am looking for.

Ms. SOMSAK. OK.

Senator COBURN. I am looking for, if they are supposed to report and they are not reporting, why are they getting the money? That is the question I have for you, and your own IG says they are not. So if they are not, then they either immediately have to start or they should not be getting additional money.

Ms. SOMSAK. OK.

Senator COBURN. And again, the whole purpose of that is for you, as an administrator, to make sure the money is going where you say it is going, and that is what we want it to do. This is a big deal for us. Senator Richard Burr is so concerned about are we going to be able to respond, and we are 5 years out and we are $2 billion down the road, and if you have grantees that are not responding and not reporting according to the requirements of the grant, my question for you is why are they still getting the money?

Ms. SOMSAK. Well, we have reduced—we have put holds on a number of grants to States where the State has failed to make progress towards it. We have also reduced funding for a number of States that have failed to make progress. There are a number of other States beyond those that we have worked with to increase the performance level. But there are problems with some of the States, but we have actually withheld funds or put holds on their funds where they have not made adequate progress until they have demonstrated additional progress.

Senator COBURN. But you would agree, as a management technique, as a director of this program, that if there are requirements in the grant and they do not think you are going to hold them to the grant requirements, then not just in terms of financial accounting, they may not respond in other areas. So the reason I asked you about metrics first is do you have that at your fingertips so that you know, and what I would like to see is you all to bring that up to date. That is our whole problem. It is not just HHS. We have not given you all the management tools you need to make measurements to evaluate whether or not you are having the performance that you want. There are things in the legislation, there are things in the management, but to actually say, how do I know this money is getting the best deal?

The other thing—just to clarify, that was challenge number three, HHS strategic challenge number three in their audit report for 2005. That is where that came from.

The other thing is all States, every State got some of these grant monies, right?

Ms. SOMSAK. Last year——

Senator COBURN. All hospitals got a small amount of money instead of a few designated surge centers?

Ms. SOMSAK. Not all hospitals in the State received money, but a large number of hospitals received money depending on the State's plan, working with the hospital association and the other hospitals.

Senator COBURN. But are there hospitals that have received this money that will not be strategic surge centers?

Ms. SOMSAK. Well, in terms of what the State's plan is, the problem is that no one can indicate where the event is going to occur and what is going to happen. I think the other issue is that it is not just bioterrorism. It is also other activities.

Senator COBURN. Sure.

Ms. SOMSAK. So, for example, with the flu, there is no real indication that you may have the capacity across a large number of geographic areas to be able to handle that issue. Just being in a large metropolitan area may not help you. And so when the States are looking in terms of planning for where the capacity should be, the feeling is that just concentrating in a few areas is not adequate.

And, for example, with the hurricane, what was the impact of the hurricane? As people moved out of the metropolitan area into what they called the ring area, and that is one of the strategies, too, is that what would happen in an emergency is people would not stay in the area. They would move out. So when people put together a plan, it is one plan—if you just say, well, we should just concentrate the money in one area, then if that area is attacked, then where is the capacity for the people that move out of that area? So I think that what the States are trying to do is come up with multiple scenarios in terms of planning for multiple, not just bioterrorism or a natural event.

Senator COBURN. OK. I admitted to you at first that you have a tough job, and I think it is a true statement, we do not have the amount of money to have the preparedness that we would like to have. There is no way we are ever going to have surge capacity everywhere. So the question then becomes, how do we prioritize this? I would question allowing the hospital associations to make that determination rather than strategic thinkers here looking at the numbers from CDC's health statistics and centers.

Is it strategic if every hospital, let us say in Oklahoma, gets a small amount of money, but much more to the bigger ones when, in fact, a hospital that is in Salisaw, Oklahoma, is 60 miles from a 300-bed hospital in Muskogee, in other words, in terms of surge capacity, and they have two ventilators at most now. Are we going to put 10 ventilators there in excess or are we going to put 50 in excess in a larger regional center that has a larger population to draw on?

So I guess the point I am making is I am not critical of what you are doing. I just want to make sure the word "strategic" is there and that we are not trying to please States on a political basis of everybody getting some money. It is kind of the rest of the grants at Homeland Security. If you give it to every State—we ought to do it based on risk, and your job is to try to figure out what that risk is. I know that is not easy. As a matter of fact, you will be criticized no matter what you do in this if we have an event. Everybody will say, no matter which way you would have gone, you are

going to get criticism because you have an unattainable goal of truly creating surge capacity.

Then when we have the PART score that is coming out for you, what I would do is ask that you all come back. Maybe we can just have a meeting in my office and go through what the results are on that so that we do not have to do it so formally.

Our goal is to hold you accountable, to make you better. There is no question on your motivation. Please understand that. But the biggest problem we have in the Federal Government is how do we squeeze more benefit out of the same amount of money, because we are in a pinch. In 2016, 81 percent of the dollars of this budget of this country, no matter whether we raise taxes or not, are going to be consumed by Medicare, Medicaid, Social Security, and interest. That means 18, 19 percent is left for defense, HHS, and everything else. So we need to have the metrics with which you can make the best decisions to take care of the most people and to supply the greatest amount.

I want to thank you for being here. Do either of you want to say anything in closing, a change of opinion or critical of the attitude or whatever? I want to give you an opportunity to do that. Ms. Somsak, you have got a smile. There is a question on whether or not you want to say it or not.

Ms. SOMSAK. No. I think when Senator Carper was here, I kind of summarized what I would like to point out, is that it is critical that we do prepare the hospitals and the primary health care. In other words, when the incident occurs, that is the people at the ground level that are going to be dealing with this situation. But it is important to make sure that we have the capacity, strategic capacity to say, and that people have the capability to be able to respond to an actual thing. We can plan all we want, but it is really important for the States to be able to demonstrate that they can actually respond to an incident.

Senator COBURN. You bet. All right. Thank you all very much. The hearing is adjourned.

[Whereupon, at 3:51 p.m., the Subcommittee was adjourned.]

# APPENDIX

*Testimony*
**Before the Committee on Homeland Security and Governmental Affairs**
**Subcommittee on Federal Financial Management, Government Information and International Security**
**United States Senate**

## Responsible Resource Management at the Nation's Health Access Agency: The Healthy Start Program

*Statement of*
**Peter Van Dyck, M.D., M.P.H.**
*Associate Administrator*
*Maternal and Child Health Bureau*
*Health Resources and Services Administration*
*U.S. Department of Health and Human Services*

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

**For Release on Delivery**
**Expected at 2:30 pm**

**Thursday, July 27, 2006**

Good afternoon, Mr. Chairman and members of the Committee. I am Dr. Peter Van Dyck, the Health Resources and Services Administration's Associate Administrator for the Maternal and Child Health Bureau in the Department of Health and Human Services. Thank you for the opportunity to testify today concerning responsible resource management at HRSA, the nation's health access agency. Today I will concentrate my remarks on the Healthy Start program, one of the programs within the Maternal and Child Health Bureau and one about which we have a good story to tell.

In the late 1980's, national concerns about persistently high levels of infant mortality lead to a number of efforts to address this problem. Although infant mortality rates had declined over time, the rate of decline had slowed by the mid-1980's, and relative to other developed nations, the United States' ranking had slipped. Even more alarming was the racial disparity in infant mortality rates; black infants in the 1980's were more than twice as likely to die in their first year of life as white infants. A White House study recommended the development of a major initiative to mobilize and coordinate the resources available in selected communities and demonstrate effective approaches to reduce infant mortality. Concerned about the persisting high rates of infant mortality among both urban and rural populations, President George H.W. Bush's administration created the Healthy Start Initiative to fund 15 projects in areas both urban and rural where the infant mortality rates were 1.5-2.5 times the national average. Healthy Start began as a demonstration program in 1991.

Each year in the United States, about 4 million women give birth. Most have safe pregnancies and deliver healthy infants, but some women give birth too early, see their babies die during or soon after birth, or die themselves in pregnancy-related deaths. These difficulties

continue to occur in greater numbers among women who are members of racial and ethnic minorities.

According to the most recent available data released by the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics, the national infant mortality rate in 2003 was 6.9 deaths per 1,000 live births. The racial and ethnic breakdown was 14 deaths per 1,000 live births for African-Americans, 5.9 per 1,000 for Hispanics, and 5.7 per 1,000 for whites.

Healthy Start began with a five-year demonstration phase to identify and develop community based system approaches to reducing infant mortality and to improve the health and well being of women, infants, children and their families. Since its inception, Healthy Start has been located in HRSA. Originally funded under the authority of Section 301 of the Public Health Services Act, Healthy Start was most recently authorized as part of the Children's Health Act of 2000.

Healthy Start was founded on the premise that communities can best develop and implement the strategies necessary to eliminate the factors contributing to infant mortality, low birth weight, and other adverse perinatal outcomes among their own residents, especially among populations at high risk. Healthy Start communities form local coalitions of women, their families, health care providers, businesses, and various public and private organizations that work together to address disparities in perinatal health. Every Healthy Start site is guided by its consortium. Local residents are recruited, trained, and employed as case managers and outreach providers.

HRSA provides the Healthy Start communities with national leadership in planning, directing, coordinating, monitoring, and evaluating the implementation of the various Healthy

Start programs throughout the country. Specifically, the national program collects and analyzes information regarding the Healthy Start projects; provides program policy direction, technical assistance, and professional consultation on Healthy Start activities; administers the Healthy Start grants and contracts; and serves as the Healthy Start focal point for the Department. The program now reaches into 96 communities in 37 states, the District of Columbia and Puerto Rico. Each of the vulnerable communities receiving funds has suffered from poor perinatal outcomes and/or an infant mortality rate in one or more racial, ethnic or geographically disparate population that is at least one and a half times the national average.

While each Healthy Start project is as unique as its community setting, there are certain hallmarks of all Healthy Start projects.

Healthy Start was one of the pioneers in the use of women living in the community as outreach workers and home visitors. This approach achieves several things: It saves money (extending services of professionals through the use of lower cost paraprofessionals or lay workers), pregnant women respond better to other community based women who have "walked in their shoes", and it has provided real and meaningful jobs to hundreds of unemployed or underemployed women in vulnerable communities.

As mentioned earlier, every Healthy Start project has developed a consortium, composed of neighborhood residents, clients, medical providers, social service agencies, faith representatives and the business community. This ensures that not just Healthy Start but the whole community is committed to the fight to reduce infant mortality and low birthweight.

Healthy Start communities don't stop helping to build healthy families when a healthy baby is born. They stay with the mother, the baby, the whole family, for two years, monitoring the baby's growth and development, ensuring the mother's safety and health, so that each new

family is assured a "healthy start". These projects have been forward thinking in their recognition that there can be both physical and psychological threats to a mother's health before, during, and after pregnancy, and they are particularly focused on identifying and treating perinatal depression. Part of what all Healthy Start projects are funded to do is help their communities build and strengthen the medical, social, and psychosocial resources available to women and their families. These projects are actively engaging mothers, babies, and families through these crucially important first two years of the child's life. These years are critical because any difficulties in a child's development can be uncovered and addressed early, and the child's parents can be most readily engaged in positive parenting techniques that will result in the child's optimum development and adjustment. Just as important, Healthy Start programs begin with the fundamental precept that it is important to make sure the mother has a medical home, and that she is followed along with her infant to improve her health, through risk reduction and health education. Good interconceptional care for women can make a subsequent pregnancy less risky for both mother and baby.

Throughout the history of the program, it has been monitored by an independent council, known as the Secretary's Advisory Committee on Infant Mortality, and the initial program design included a rigorous national evaluation. This evaluation, released in 2000, used matched comparison communities (that did not have a Healthy Start site) to the original 15 Healthy Start program communities. The evaluation revealed several statistically significant differences: more than half (eight) of the Healthy Start communities had improved adequacy of prenatal care utilization; four Healthy Start communities had declines in the preterm birth rate; three project areas had reductions in the low birthweight rate; and two Healthy Start communities had declines in the infant mortality rate of greater than 50 percent. The evaluation also found that Healthy

Start projects were more effective in enrolling high risk women into prenatal care, and that the community-based interventions which Healthy Start uses, may have longer term impacts on future health and well being of women and their families, that have not yet been measured.

A major result of the first national evaluation was that using its findings, coupled with recommendations from the Secretary's Advisory Committee, HRSA was able to reshape the Healthy Start program to reflect what had been found to be most effective.

Committed to implementing evidence-based practices and innovative community-driven interventions, Healthy Start works with individual communities to build upon their own local assets to improve the quality of health care for women and infants at both service and system levels. At the service level, beginning with direct outreach from community health workers to women at high risk, Healthy Start projects ensure that the mothers and infants have ongoing sources of primary and preventive health care and that basic needs (housing, psychosocial, nutritional, educational, and job skill building) are met. Following risk assessments and screening for perinatal depression, case management provides linkages with needed services and health education for risk reduction and prevention.

It is significant that the Healthy Start program was forward thinking in the recognition of the profound negative effects of perinatal depression, not only on birth outcomes, but also in the neonatal and post neonatal period. Beginning in 2001, 38 grants were awarded to provide screening for perinatal depression, and to enhance linkages to community-based intervention services for depression that are culturally and age appropriate. At the same time 35 grants were awarded to provide resources for high-risk interconceptional care. These programs ended this past year and we are now compiling the lessons learned from these projects to share with other communities across the nation.

Healthy Start programs are located in and are responsive to the needs of mothers and infants in the poorest neighborhoods in the United States. Healthy Start has been successful at enrolling women with the highest risk of adverse pregnancy outcomes, women who were less likely to receive care in a private medical office, to have less than a high school education and to have lower incomes.

Getting women into prenatal care in the first trimester of pregnancy, or as early as possible, is critical - - since prenatal care is critical to improving birth outcomes. Healthy Start has made proven impacts on participants' access to prenatal care: in 1998, participants' first trimester entry into prenatal care was only 41.8 percent; by 2003, this number had risen to 71.4 percent, an increase of 73 percent in five years.

One of the first 15 sites, Washington, D.C., reported for the year 2000, its lowest infant mortality rate ever, and in that same year, no babies born to Healthy Start clients died. Central Harlem is another example of a Healthy Start success story. The infant mortality rate there has dropped significantly since its project began in 1991, when there were 27.7 infant deaths per 1,000 live births. By FY 2003, the rate had dropped to 7.3 deaths per 1,000 births – a 273 percent decline.

Other locations have had real success in reducing low birth weight. In Baltimore, the percentage of very low birth weight babies was 2.0 percent among participants with single births enrolled in Healthy Start – 99 percent of whom are African-American – compared to a 3.7 percent rate of very low weight births among African-American women throughout the city. President Bush has asked for $101.5 million for Healthy Start in his FY 2007 budget – an amount equal to the FY 2006 appropriation.

I would be happy to respond to your questions.

**Testimony**
**Before the Committee on Homeland Security and Governmental Affairs**
**Subcommittee on Federal Financial Management, Government Information and International Security**
**United States Senate**

# Responsible Resource Management at the Nation's Health Access Agency: Bioterrorism and Hospital Preparedness

*Statement of*
**Joyce Somsak, M.A.**
*Associate Administrator*
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U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

**For Release on Delivery**
**Expected at 2:30 pm**
**Thursday, July 27, 2006**

Good afternoon, Mr. Chairman and members of the Committee. I am Joyce Somsak, the Health Resources and Services Administration's (HRSA) Associate Administrator for the Healthcare Systems Bureau in the Department of Health and Human Services. Thank you for the opportunity to testify today concerning responsible resource management at HRSA, the nation's health access agency.

My remarks will be focused on Bioterrorism and Hospital Preparedness, one of the programs within the Healthcare Systems Bureau.

HRSA recently announced the latest round of grants for its National Bioterrorism Hospital Preparedness Program (NBHPP). This is the fifth consecutive year that HRSA has provided funding for the program, which was created after the terrorist attacks of September 11, 2001.

Since then, the NBHPP has delivered over $2 billion to hospitals and health care systems in all 50 states, as well as five territories, three freely associated states and four large metro areas: New York City, Chicago, Los Angeles County and Washington, D.C.
This year HRSA has awarded $460 million to these jurisdictions to strengthen the ability of hospitals and other health care facilities to respond to bioterror attacks and other public health emergencies. Hospitals play a critical role in both identifying and responding to any potential terrorist attack or infectious disease outbreak.

During the first four years of the program, states used grant funds to develop surge capacity (increased volume of patients) to deal with mass casualty events, such as expanding the number of hospital beds and developing isolation capacity at hospitals. Other priorities included identifying additional health care personnel who could be called into action in the event of an

emergency, as well as establishing hospital-based pharmaceutical caches for hospital personnel and associated EMS.

Recipients also used the funds to increase coordination of disease reporting among hospitals and local and state health departments and to improve coordination and communication between public health laboratories and hospital-based laboratories.
Jurisdictions were required to improve their ability to provide mental health services, strengthen trauma and burn care, and increase their supplies of personal protective equipment and pharmaceuticals. Money could also be used to support training, education, and drills and exercises.

This year the program's focus turns to efforts to improve the capability (ability to manage unusual or very specialized medical needs of patients) of local and regional health care systems to manage mass casualty events and integrate preparedness activities across disciplines and agencies. The goal is to ensure that each jurisdiction has a system in place that will result in fewer deaths, long-term disabilities and required hospitalizations.

Progress has been made in getting the NBHPP funds to the local healthcare system. In the early stages of this program, awardees had some difficulty in quickly expending the large infusion of funds because State health departments were not set up to quickly establish large grant programs. States cited three main reasons for initial delays: (1) some State governments were reluctant to quickly hire the necessary staff to operate these programs; (2) due to procurement processes at the State level, some delays were encountered in trying to award contracts to hospitals and (3) before disseminating funds to hospitals, States were first required to conduct a State-wide Needs Assessment of their ability to respond to a bioterrorist event, infectious disease outbreak, or other public health emergency. These three barriers have

diminished with time and States are now reporting greater success at getting bioterrorism preparedness funds to their local healthcare system.

The NBHPP program has built upon the needs assessments and implementation plans developed by grantees during previous years and the updates of these assessments and plans during FY 2003 through FY 2005. Proposals are approved and funded in accordance with preparedness priorities developed by the States and other jurisdictions. Information on the improvements in hospitals' capacity to respond to public health emergencies in general, and to bioterrorism in particular, is part of the progress reports submitted by the States and other jurisdictions.

The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program is a component of the NBHPP. This program, focused on developing the personnel component of medical surge, has provided grant funds to States for purposes of establishing a standardized, volunteer registration system that includes verified information on volunteer health professional identity, license status, certification, and privileges in hospitals or other facilities. The establishment of these standardized State systems will give each State the ability to quickly identify and better utilize health professional volunteers in emergencies and disasters and will lead to a virtual national system that will allow the easy exchange of volunteers across States and through the Federal government as necessary. The value of these State based registries was demonstrated in the aftermath of hurricanes Katrina and Rita when 21 State registries deployed over 8,300 health professionals to the affected areas.

The NBHPP focus this year and moving forward is to continue to enhance medical surge capacity and capability as well as to develop a response structure that allows the

conceptualization and ultimate implementation of complex health and medical response through a single system.

Since the inception of the program in FY 2002, the NBHPP has established and awarded cooperative agreements to 62 States, Territories and select cities. These cooperative agreements have been essential for developing and coordinating healthcare emergency response plans at the State, regional and local level for the management of mass casualty events that might otherwise overwhelm the healthcare system.

Significant progress has been made by awardees in establishing plans, developing partnerships and collaborations, and assessing crucial needs and how to address them. The majority of jurisdictions have in place, or are finalizing, a system to receive and distribute pharmaceuticals made available from Federal sources, such as antibiotics and smallpox vaccines.

States are putting mechanisms in place to address the gaps in communications systems among hospital emergency departments, outpatient facilities, emergency medical services (EMS) systems, and State and local emergency management, public health and law enforcement agencies. States are also developing strategies to implement memorandums of understanding (MOU) and mutual aid agreements to foster intrastate and interstate collaboration in meeting medical surge needs. These include personnel, equipment and supplies, training and exercises.

A Program Assessment Rating Tool (PART) review of the program was conducted for the FY 2004 budget. The program received a rating of "Results Not Demonstrated". The assessment indicated that the program had not yet demonstrated results due to its relative newness and the inherent difficulty in measuring preparedness for events that do not regularly occur. New performance measures focused on developing medical surge capacity were developed. However, these measures were developed during the PART review and early in the

life of the program and the overall evolution of preparedness response. They are not the best measures as we go beyond developing capacity and work to develop medical surge capability. We are in the process of developing new medical surge capability measures. In January of this year, the program convened an expert panel of awardees, hospitals, State hospital associations, the American Hospital Association, academia and others to develop measures. The draft measures were cross checked against other measures and standards including CDC's performance measures, the Targeted Capabilities List, and JCAHO standards. We underwent a national vetting of the draft measures and just this week we reconvened the expert panel and expect these measures to be in final in the next month.

Health and Human Services Secretary Mike Leavitt recently announced this year's funding for bioterrorism preparedness. On June 7th, Secretary Leavitt said in the award announcement: "Improving our nation's response to public health emergencies is an important part of securing America. All emergency incidents -- whether naturally occurring, accidental, or terrorist-induced --begin as local matters and with this program, States and communities will build on the preparedness gains they've made over the past four years."

This concludes my statement and I would be happy to respond to any questions.