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HEALTH CARE

Readiness of U.S.
Contingency Hospital Systems
to Treat War Casualties

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SUMMARY

At the request of the Chairman, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, GAO examined the adequacy of plans by the Departments of Defense and Veterans Affairs and other organizations to care for wartime casualties returning to the United States.

GAO identified several issues that will likely limit the capability of the Departments and the National Disaster Medical System to handle large numbers of casualties:

- DOD does not know enough about the qualifications or readiness of medical reservists.
- The number of beds expected to be available in DOD, VA, and NDMS hospitals is overstated.
- DOD does not have adequate plans to develop additional specialty care, such as burn treatment.
- Some communities do not have adequate plans to receive and transport casualties.
- Systems to track casualties are inadequate.
- VA medical centers have not planned for the continued care of beneficiaries displaced from those centers.

GAO has discussed these issues with officials from both Departments, who stated that actions will be taken to address them.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here to discuss the adequacy of plans by the Departments of Defense (DOD) and Veterans Affairs (VA) and other organizations to care for wartime casualties returning to the United States. Our review, which you requested, began as an assessment of medical readiness for Operation Desert Storm.

Because of the success of Operation Desert Storm, very few casualties returned to the United States, and the readiness of the health care system to handle large numbers of casualties was never tested. At the Subcommittee's request, we expanded our review to take a broader look at medical readiness, building on some of the lessons learned during Desert Storm.

As you know, we initiated separate efforts to assess readiness to provide care to casualties in theater and in the United States. Last month, we testified before the Subcommittee on Military Personnel and Compensation of the House Armed Services Committee on problems experienced by the Army in preparing to provide care to casualties in theater.¹ My testimony today will focus on readiness as it relates to casualties returning to the United States.

¹Operation Desert Storm: Full Army Medical Capability Not Achieved (GAO/T-NSIAD 92-8, Feb. 5, 1992).

BACKGROUND

Current wartime planning scenarios generally contemplate short, intense conflicts with little warning. This type of conflict could result in large numbers of casualties returning to the United States in a short period, quickly exhausting the peacetime capability of the military health care system.

DOD plans to expand its capacity to treat returning casualties in three ways. First, the military services plan, under a full mobilization, to expand the capacity of U.S.-based military hospitals from their peacetime level of about 13,000 beds to over 89,000 beds by activating reserve units and converting barracks and other buildings into hospital space. This could take up to 1 year to complete. Under the partial mobilization during Operation Desert Storm, the services expected to expand their capacity to about 19,000 beds.

Second, under the authority provided in 1982 by Public Law 97-174, DOD plans to use VA's resources. VA plans to make about 18,000 beds available within 72 hours of DOD's request for assistance in caring for returning casualties and 25,000 beds available within 30 to 45 days.

Finally, if casualties are expected to exceed the combined DOD/VA capacity, DOD plans to turn to civilian hospitals

participating in the National Disaster Medical System (NDMS). NDMS was established in 1984 as a cooperative venture of DOD, VA, the Federal Emergency Management Agency, the Department of Health and Human Services, state and local governments, and private sector organizations to provide care to casualties from civilian disasters or military conflicts. At present, NDMS has commitments from more than 1,700 hospitals in 76 metropolitan areas to provide a minimum of 58,000 beds within 24 to 48 hours of the activation of the NDMS system. All of the 76 NDMS areas are coordinated by officials from local VA or DOD hospitals. These coordinators are responsible for recruiting hospitals into the system, identifying available beds, arranging for adequate reception and transportation systems, and periodically testing the system.

In conducting our study, we reviewed plans and interviewed VA, DOD and NDMS officials and assessed the readiness of DOD, VA, and NDMS to treat returning casualties in six communities (San Antonio, Texas; Orlando, Florida; Washington, D.C.; St. Louis, Missouri; Richmond, Virginia; and Pittsburgh, Pennsylvania). We also looked at the adequacy of plans to meet the health care needs of beneficiaries who might be displaced from VA hospitals to make room for returning casualties.

SUMMARY OF RESULTS

I would like to discuss six issues we identified that will likely limit the capability of DOD, VA, and NDMS to handle large numbers of returning casualties. They are:

- DOD does not know enough about the qualifications or readiness of medical reservists.
- The number of beds expected to be available in DOD, VA, and NDMS hospitals is overstated.
- DOD does not have adequate plans to develop additional specialty care, such as burn treatment.
- Some communities do not have adequate plans to receive and transport casualties.
- Systems to track casualties are inadequate.
- VA medical centers have not planned for the continued care of beneficiaries displaced from those centers.

DOD KNOWS LITTLE ABOUT READINESS
OF RESERVISTS

In wartime, the number of beds DOD can operate in its own hospitals generally first decreases as active duty personnel deploy overseas and then increases as reservists arrive to replace deployed staff. Thus, the capability of military hospitals to receive casualties depends, in large measure, on the readiness of the reserves. The services, however, know little about the qualifications or readiness of medical personnel in their reserve forces.²

Each of the seven military hospitals we visited experienced problems with reserve medical personnel activated during Desert Storm. For example, the Army Selected Reserve medical unit recalled at Brooke Army Medical Center had staff who were not qualified in the specialties to which they were assigned, were not physically able to perform their jobs, did not have proper medical credentialing documents, or had not completed required training. Other medical centers had similar problems.

²The Selected Reserves and the National Guard provide trained and equipped units and qualified individuals to rapidly expand the services in time of crises. These units are considered available immediately. The Individual Ready Reserves, Standby Reserves, and Retired Reserves consist of former service members who would require training to update their skills and would be available at varying times after mobilization.

The services also experienced problems with the Individual Ready Reservists recalled during Desert Storm. An Army planner told us that the first such reservists recalled were those separated from active duty during the preceding year. The Army often did not, however, know the reasons for separation and recalled reservists who had separated for such reasons as poor performance, pregnancies, or physical disabilities. Similarly, the lack of knowledge of reservists' specialties resulted in two highly skilled cardiac specialists being sent to small Air Force bases as general internal medicine physicians.

Military service officials said that the lack of knowledge about the qualifications of reservists resulted in significant unplanned movement of medical staff between units during Desert Storm, shortages of some medical specialties, and delays in adequately staffing expanding military hospitals.

THE NUMBER OF AVAILABLE BEDS IS OVERSTATED

The number of beds likely to be available to care for returning casualties was overstated in each of the six communities we visited. This is because many of the beds are to be made available by increasing the capacity of one system at the expense of another. In other words, there is double and triple counting of beds and the staff to operate them.

First, the ability of military hospitals to significantly expand their bed capacities depends on having both enough qualified reservists and sufficient time to activate them. Army planners told us that they do not have enough reservists to staff the 66,400 beds the Army planned to operate under a full mobilization and that they would have to institute a physician draft. Initiating a physician draft would significantly delay expansion of DOD hospitals and may not be realistic during short wars. Army planners agreed that expansion to 66,400 beds is unrealistic and said they are reducing to 25,000 the number of beds the Army plans to operate under a full mobilization.

It should also be noted that activating reservists or instituting a physician draft to help expand DOD's hospital capacity in the United States will likely result in a corresponding decrease in the bed capacity of VA and community hospitals because of decreased staffing levels in those facilities. None of the NDMS hospitals we visited, however, had considered the reserve status of their staff in making their NDMS bed commitments.

Second, many of the planned DOD and VA beds would be made available by transferring or diverting patients to community hospitals. For example, during Desert Storm, the services planned to make about 5,000 beds available in DOD hospitals by diverting dependents and retirees to community hospitals, while

VA planned to make about 16,500 beds available in its hospitals by stopping most care for non-service-connected veterans. To the extent that such patients obtain care in community hospitals, the ability of the community hospitals to reach their NDMS bed commitments would be reduced.

To illustrate, during Desert Storm, the five military hospitals in the Washington, D.C., area would have had to stop admissions for more than 850 military dependents and retirees to make room for casualties. Similarly, the Washington VA hospital would have had to defer care for about 150 non-service-connected veterans to meet its commitment to DOD. Some of these patients would have had to obtain care in community hospitals. However, the community hospitals we visited in the Washington area were not aware of the VA and DOD plans to transfer up to 1,000 patients to private sector hospitals when they made their NDMS commitments. This, they said, would reduce their ability to meet their NDMS commitments.

The third area in which multiple counting of resources results in unrealistic bed commitments is planning by NDMS hospitals to staff additional beds. These plans depend on the ability of the hospital to obtain additional staff. The hospitals we visited, however, had generally not identified whether staff would be available and most did not know how many staff they were likely to lose to reserve duty. Nor had they

determined if doctors with admitting privileges at multiple hospitals would be available to care for an increased patient load.

Civilian hospitals typically staff based on their average daily census, relying on a staffing pool to expand the number of operating beds in the event of workload increases. Because several hospitals would be drawing from the same staffing pool to meet their NDMS commitments, there is multiple counting of staff resources in making NDMS bed commitments. As a result, enough staff will likely not be available to enable all hospitals to fully meet their NDMS commitments.

A final area in which beds are overstated is that VA incorrectly estimated the number of beds it could make available. This occurred because VA based its estimate on 25 percent of its authorized beds rather than 25 percent of its operating beds. This resulted in VA's overcommitting about 8,000 beds--a situation that it is correcting.

DOD DOES NOT HAVE PLANS TO DEVELOP
ADDITIONAL SPECIALTY CARE

DOD also had not planned to develop additional specialty care, such as burn treatment and neurosurgery, should its existing capabilities be exceeded. This is important because (1)

armored combat and the use of chemical weapons could generate many burn casualties and (2) the military services operated a total of only 40 burn beds in the United States, all at Brooke Army Medical Center in San Antonio, Texas. Before the U.S. deployment to Saudi Arabia, however, neither DOD nor NDMS knew the location or availability of burn beds in private sector hospitals. Not until December 1990, 4 months after U.S. troops first deployed, did DOD complete a survey of the availability of burn care. That survey identified 1,159 burn beds that could be made available in private hospitals. VA has no burn beds.

The Army also planned to expand the capacity of the burn unit at Brooke from 40 to 120 beds. Planning for this expansion was not completed until December 1990, and at the time the air war began, only 40 burn beds were operating. Of those 40 beds, 19 were occupied, leaving only 21 burn beds in the entire DOD system to care for returning casualties.

Although DOD now knows where burn care resources are located in the private sector, it still does not know the location or availability of other types of specialty care it may require, such as neurosurgery.

RECEPTION AND TRANSPORTATION

PLANS ARE INADEQUATE

To this point, I have talked about the ability of the three systems to provide care to casualties once they reach the hospital. We also noted in several of the communities we visited that adequate plans have not been developed to receive and care for casualties at the airport and transport them to the hospitals. These functions are important to patient care because, according to an earlier study, more than 20 percent of returning casualties needed immediate care upon their arrival at airports.

In communities like Washington, D.C., and San Antonio, where extensive military transportation resources are available, the military services have taken responsibility for reception and transportation. However, in other communities, DOD, VA, and NDMS all rely on the same civilian emergency medical service organizations to transport patients.

In 1980, we reported that DOD needed to assess whether local emergency medical service organizations were organized, available, and capable of transporting casualties before seeking agreements from hospitals to care for casualties.³ In five of

³The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System (HRD-80-76, June 26, 1980).

the six communities we visited recently, neither DOD nor VA, in their capacities as federal coordinating centers for NDMS, had determined the capabilities of local emergency medical service organizations.

For example, Kenner Army Community Hospital at Ft. Lee is the NDMS coordinating center for the Richmond, Virginia, metropolitan area. During a full mobilization, Kenner expected to expand from 100 beds to more than 1,000 beds. We found, however, that Kenner (1) has limited transportation capabilities of its own--three ambulances and two patient transport vehicles capable of carrying four ambulatory patients each--and (2) has not, in its role as NDMS coordinator for the Richmond area, assessed the availability of community resources to assist in transporting patients. Although the hospital requested three ambulance buses during Desert Storm, it received only one--in February 1991.

The effects of this shortcoming in the NDMS plan is decreased in the Richmond area, however, because the state of Virginia established a Central Virginia Disaster Committee that includes the Old Dominion Emergency Medical Services Alliance. This group has developed plans to transport casualties to local hospitals, but officials told us that it could take up to 8 hours to transport 100 patients.

In contrast, the VA NDMS coordinator in Pittsburgh had effectively organized local emergency transportation resources into a system that appears capable of transporting large numbers of casualties from the airport to local hospitals.

In addition to problems in transporting casualties from airports to local hospitals, the VA medical centers we visited had not developed plans for transporting non-service-connected veterans to secondary VA hospitals or community hospitals. For example, the St. Louis VA medical center plans to transfer about 200 non-service-connected veterans to secondary VA medical centers in Poplar Bluff and Columbia, Missouri, and Marion, Illinois, within 72 hours. Medical center staff, however, had not discussed with their contract ambulance service its capability to move the patients. The ambulance service expressed concern about its ability to quickly move that many patients to medical centers that are 2 to 4 hours driving time from St. Louis.

Similarly, the Washington, D.C., VA medical center planned to have its contract ambulance service move about 155 non-service-connected patients to the Martinsburg, West Virginia, medical center but had not planned how this would be done. An official of the medical center's contract ambulance service told us that VA had not discussed movement of patients with the ambulance service.

SYSTEMS TO TRACK

CASUALTIES ARE INADEQUATE

In any conflict that results in large numbers of casualties, there will be numerous inquiries as to the whereabouts and status of specific individuals. DOD has not established a unified system that would enable it to quickly track a casualty from the battlefield to a hospital in the United States. The services use multiple tracking systems, making it necessary to follow the whereabouts of casualties through a series of telephone calls.

For example, the Army reported that it had to follow patients through a series of tracking systems from the theater, to an evacuation hospital, to one of the six major U.S. locations established to receive returning casualties, and then to the receiving military hospitals. This process took the full-time monitoring efforts of five people. Army officials said that, if casualties had been significantly greater than they were, it is doubtful that its tracking system could have handled the demand. In addition, the multiple tracking systems made it difficult to track individuals who, for medical or other reasons, left the aeromedical evacuation system before reaching their destinations. This resulted in some patients' whereabouts being temporarily unknown when they reached the United States.

The services have acknowledged that tracking of Desert Storm casualties was a significant problem. As a result they are developing an automated, tri-service tracking system capable of following a patient throughout his or her evacuation and hospitalization.

VA DID NOT PLAN CARE
OF DISPLACED VETERANS

The final issue I would like to discuss is the care of veterans who would be displaced or diverted from VA hospitals to make room for casualties. As I mentioned earlier, to meet its commitment to DOD, VA must reduce its average daily census by as much as 16,500 through reductions in the services provided to non-service-connected veterans.

VA's contingency plans require medical centers to ensure that continuity of care is maintained for all patients discharged or transferred through a comprehensive discharge planning process. The contingency plan requires that VA ensure that care is provided--either in its own facilities or non-VA facilities--to the following groups of veterans:

-- Veterans receiving care in a VA hospital.

- Veterans receiving outpatient care at a VA facility if a delay in providing hospital care would be likely to result in a deterioration of their conditions.

- Veterans who present themselves at a hospital for emergency conditions that pose a serious threat to their lives or health.

Other elective care for non-service-connected veterans would be deferred until space and resources become available to provide that care.

None of the medical centers we visited had made arrangements with community hospitals to provide care to veterans meeting the above criteria and in need of immediate care. Further, they had not developed plans for notifying non-service-connected veterans of the changes in availability of services.

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Mr. Chairman, we have discussed these issues with DOD and VA officials. They generally agreed with our assessments to date and stated that actions will be taken to address the issues we have raised.

This concludes my prepared statement. We will be happy to answer any questions that you or the other Members of the Subcommittee may have.