

☞ **05hr_ab0385_AC-PH_pt01**



Details:

(FORM UPDATED: 07/12/2010)

**WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS**

2005-06

(session year)

Assembly

(Assembly, Senate or Joint)

**Committee on ... Public Health
(AC-PH)**

COMMITTEE NOTICES ...

- *Committee Reports ... CR*
- *Executive Sessions ... ES*
- *Public Hearings ... PH*
- *Record of Comm. Proceedings ... RCP*

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- *Appointments ... Appt*
- *Clearinghouse Rules ... CRule*
- *Hearing Records ... bills and resolutions*
(ab = Assembly Bill) (ar = Assembly Resolution) (ajr = Assembly Joint Resolution)
(sb = Senate Bill) (sr = Senate Resolution) (sfr = Senate Joint Resolution)
- *Miscellaneous ... Misc*

Vote Record Committee on Public Health

Date: 5/18/05

Moved by: Freese

Seconded by: Wasserman

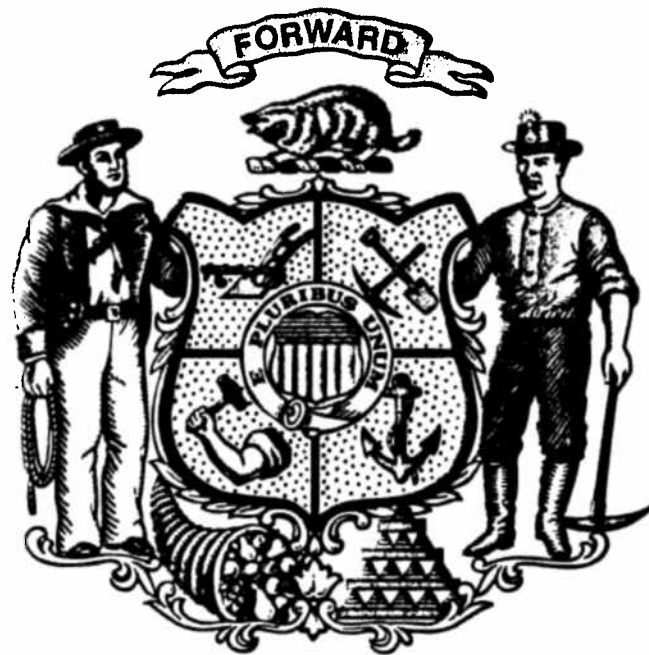
AB 385 SB _____ Clearinghouse Rule _____
 AJR _____ SJR _____ Appointment _____
 AR _____ SR _____ Other _____

A/S Amdt _____
 A/S Amdt _____ to A/S Amdt _____
 A/S Sub Amdt _____
 A/S Amdt _____ to A/S Sub Amdt _____
 A/S Amdt _____ to A/S Amdt _____ to A/S Sub Amdt _____

Be recommended for:
 Passage Adoption Confirmation Concurrence Indefinite Postponement
 Introduction Rejection Tabling Nonconcurrence

<u>Committee Member</u>	<u>Aye</u>	<u>No</u>	<u>Absent</u>	<u>Not Voting</u>
Representative J.A. Hines, Chair	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Representative Gregg Underheim	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Representative John Townsend	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Representative Stephen Freese	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Representative Terri McCormick	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Representative Sheldon Wasserman	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Representative Tamara Grigsby	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Representative Charles Benedict	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Totals:	<u>7</u>	<u>0</u>	<u>1</u>	<u> </u>

Motion Carried Motion Failed





Mike
HUEBSCH

STATE REPRESENTATIVE

Assembly Majority Leader

May 18, 2005

Dear Members:

Please accept the following testimony on 2005 Assembly Bill 385. It is submitted from two constituents of mine, Dr. William Agger, Director of Microbiology, Chief Section of Infectious Disease, Gundersen Lutheran Medical Center, and Marilyn Michael, Infection Control, Gundersen Lutheran Medical Center, La Crosse.

Assembly Bill 385 is a redraft of legislation from the previous session that passed the Public Health committee unanimously.

Thank you for your attention to this matter

Sincerely,

Mike Huebsch
Majority Leader
State Assembly

Serving The Coulee Region's 94th Assembly District

P.O. Box 8952, State Capitol • Madison, WI 53708-8952 • Telephone: 608-266-2401 • Toll-Free: 888-534-0094

E-mail: Rep.Huebsch@legis.state.wi.us



Preparing for the Next Pandemic

Why would the legislation to allow nurses, pharmacists, and physicians who have a valid prior license to practice within the last 10 years, be helpful? An example of the severity of a pandemic of disease has been well documented with the 1918 swine flu epidemic (see Gina Colatta's "The Flu", or Barry's "The Great Influenza").

1. If a pandemic occurred of a similar severity of the swine flu of 1918, it would kill in one year more cases in the U.S.A. than heart disease, cancer, stroke, chronic obstructive pulmonary disease, AIDS, and Alzheimer (more than 1.5 million). The 1918 swine flu killed more individuals than the combined deaths of World War I, World War 2, Korean War, and the Vietnam War.
2. In 1918 the swine flu pandemic, when the world population was approximately one billion, there was between 20 and 100 million worldwide deaths. That would translate today into between 70 and 350 million deaths (probably towards the lower incidence of death in the United States where antibiotic therapy are available for the secondary bacterial infections). During the 1918 swine flu, 25% of the entire U.S. population became ill, and 40% of Navy and Army recruits became ill as well. That flu outbreak had a higher instance and appeared to be more severe in young adults. With an approximate 10% mortality from the 1918 swine flu pandemic, the U.S. life span fell 12 years, down to 39 years, the only drop in a century. In Philadelphia, one day in October, 759 people died. In the

worst week, 2600 died, and in the entire month of October, 11,000 people died. Undertakers and morgues piled up three to four days backlog and funerals were limited to 15 minutes. The undertakers were requested to be stationed at hospital doors so that the dead could quickly be removed from the beds to make room for recently infected cases.

3. This outbreak led to a severe nursing shortage. Visiting nurses in Philadelphia reported that they were sent out with an average list of 11 contacts to be made, but it often had expanded to 50 visits. To quote Barry, “There were almost no nurses”. Two thousand nine hundred fifty-five public health calls were made during the peak of the pandemic and 2,758 were not filled, meaning that only 7% of the contacts for nursing care could be filled. A call went out for “emergency care for **amateur** nurses”. It read, “Every healthy woman of assistance was requested to help.” Unfortunately, most such “nurses” could not mentally handle the frequent deaths of patients that occurred during one shift. The void was somewhat filled with student nurses, pharmacy, and medical students. (Schools were closed, and the students were sent to the hospitals to assist.) There were even a few instances of nurses being kidnapped to help care by desperate families. Most physicians stayed on the job, unfortunately hundreds died. (Obituaries were listed on multiple pages in the “Journal of the American Medical Association”.)

Comment: Moderate pandemics occur approximately every 50 years and more severe pandemics can be expected approximately once a century. Therefore, the world is

overdue. Wisconsin, and eventually the nation, should take steps to legally allow every able body person to help out if such dire circumstance recurs.

Albert Camus was correct: "What is true of all evils in the world is true of plague as well. It helps men rise above themselves." We believe that Wisconsin citizens, even those with an expired license, will rise above themselves if given the opportunity. This legislation will help make that possible.

Respectfully,



William A. Agger, MD
Director of Microbiology, Chief Section of Infectious Disease
Marilyn Michaels
Infection Control
Gundersen Lutheran Medical Center





ASSEMBLY BILL 385

Why do we need this bill?

- Pandemic influenza is likely to occur, we just don't know when. The most notable pandemic occurred in 1918, with some experts speculating an occurrence every 50-75 years. Part of the national influenza pandemic plan calls for each state to develop its own state-specific plan to deal with influenza pandemic. Unlike typical influenza, pandemic strains tend to strike the work force age group (19-64 yr old). This was seen with SARS and currently seen with Avian Influenza A (H5N1) in Asia.
- CDC's working assumption is that 15%-30% of the population will be at high risk for developing complications related to influenza. That means that more than 800,000 (15%) of the 5 million people living in Wisconsin are at high risk of complications. Those at high risk tend to have chronic medical conditions but this may vary with the each pandemic. Early epidemiologic information will determine those at highest risk. We know that healthy 20-45 year olds were particularly susceptible to the 1918 strain of the virus but healthcare workers had a higher attack rate during the SARS outbreak.
- CDC's working assumption is 50% of those at high risk will die. Currently H5N1 has a mortality rate of approx 70%. At a 15%-30% attack rate, we could anticipate 2,000-8,000 deaths in Wisconsin.
- The number of those requiring hospitalization will be much higher. We can anticipate an additional 9,000-27,000 patients in the state of Wisconsin requiring hospitalization during a 'flu' season lasting 8-12 weeks. During the same 8-12 week period we can anticipate an additional outpatients, which will further overwhelm the healthcare system.
- Those seeking outpatient medical care in Wisconsin is anticipated to be between 300,000 to 1,400,000 based on CDC estimates. Even if we pushed all of our current physicians in the state to see one patient every 15 minutes with a 6-day workweek, we will need an additional 2-5% beyond our current maximum capacity.

Are there enough health care workers to handle the increased demand?

- Obviously not. We already are experiencing a shortage of primary health care providers, nurses and other health related workers in the state. WHA estimates there are approximately 184 physicians/100,000 but only 31 primary care physicians/100,000.
- During the 1918 pandemic, there was a mass shortage of doctors and nurses. Medical schools closed and sent students to staff the hospitals and clinics. The mayor of Philadelphia drafted physicians during the outbreak. There was a call to laypersons to assist but many left after working only a few hours due to the work related stress (emotional and physical).

Where will the manpower come from?

- The Agency for Healthcare Research and Quality (AHRQ) from the U.S. Dept of Health and Human Services issued a statement on Altered Standards of Care in Mass Casualty Events (April, 2005) which indicates that the use of previously trained healthcare workers should be considered as an option. This includes those that have retired or allowed their license to lapse.
- Nurses are already being asked to work full time. The 2001 Registered Nurse Workforce Survey found that approximately 40% of the nurses work less than 36 hr/week. However in the month prior to this survey, 39% of the hospital nurses and 31% of the outpatient nurses had worked over 40 hours/week. Unfortunately, 17% of those surveyed planned on reducing their

hours within the next year due to job stress (physical and other), family obligations, work hours, school and inadequate salary. The Robert Wood Johnson Foundation reports that 20 to 50% of new nurses leave within two or three years. This explains why the average age of nurses in Wisconsin is 44.7 years. Nurses tend to leave their profession at a younger age and do not maintain their license. In a study done by the American Federation of Teachers - Healthcare, 74% of nurses surveyed who considered leaving would reconsider if there were improvements in pay and staffing. Even 71% of the potential leavers, indicated the most enjoyable aspect of being a nurse was helping patients and their families. Dissatisfaction arises when not being able to help patients and inadequate staffing tops the list of frustrations/dissatisfies. Therefore supporting nurses with additional trained staff during a time of crisis will be crucial to preserve the currently stressed workforce. Nurses will be hesitant to return unless there is adequate staffing.

- Retired physicians will be asked to return. A recent survey done at Gundersen Lutheran found that 85% (27/32) would be willing to return to our facility to assist. A local response and plan is crucial to the success of a mass casualty plan. Of those that responded to our survey, the average time physicians were retired was 3.5 years.
 - Physicians felt comfortable in volunteering for:
 - Observation of non-infected patients discharged early from the hospital (67%).
 - Managing non-acutely ill hospitalized patients requiring simple care (63%).
 - Triage (33%).
 - Managing moderately ill patients not requiring intensive care (22%).
 - Managing a stable patient in intensive care (7%).
 - Medical management of patients requiring surgery, pediatric care, comfort measures, and a general gofer were also listed.

The reasons identified by the five who were unwilling to return included precarious health status and a prolonged period since last practiced.

What is needed to trigger a call for volunteers?

- A community disaster requires an immediate community response to mitigate loss of life and disease. A local response is expedient and easier to maintain; however support at the state level is required.

What is important for planners to consider when requesting health care workers to volunteer?

- Safety and well being of the volunteer is crucial. This will require 'just in time' training, adequate physical protection and measures to prevent harm to the volunteer or their family.
- Healthcare workers are sensitive to practicing within their scope of practice and comfort level. During a time of crisis and altered standards of care, there needs to be freedom from threats of malpractice. The health care system will be forced to provide care for the greatest number and not necessarily the individual with the greatest need. The plan needs to provide 'hold harmless' agreements or grant immunity from civil or criminal liability under certain conditions.

What future support will be required from the state?

- A system is needed to cope with a prolonged disaster. This includes a process to eventually hire volunteers without a current license.



Bioterrorism and Other Public Health Emergencies

**Altered Standards of Care in Mass Casualty
Events**

Prepared for:

Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
www.ahrq.gov

Contract No. 290-04-0010

Prepared by:

Health Systems Research, Inc.

Funding to support the Altered Standards of Care in Mass Casualty Events report was provided by the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, under Contract No. 290-04-0010.

The authors of this report are responsible for its content. No statement in the report should be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

This document is in the public domain and may be used and reprinted without permission except those copyrighted materials noted, for which further reproduction is prohibited without the specific permission of copyright holders.

Suggested Citation:

Altered Standards of Care in Mass Casualty Events. Prepared by Health Systems Research Inc. under Contract No. 290-04-0010. AHRQ Publication No. 05-0043. Rockville, MD: Agency for Healthcare Research and Quality. April 2005.



The Model State Emergency Health Powers Act (Model Act) grants specific emergency powers to State governors and public health authorities in the event of a large public health emergency. The Model Act was developed for the Centers for Disease Control by The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities to ensure an effective response to large-scale emergency health threats while protecting the rights of individuals. It provides a broad set of powers for an entity called the Public Health Authority.

As it may relate to altered standards of care, the Model Act provides that a declaration of an emergency activates the disaster response and recovery aspects of State, local, and interjurisdictional disaster emergency plans. There is no mention of local-level involvement. The Public Health Authority is empowered to take control over facilities (health care and other) and "materials," such as food, fuel, clothing and other commodities, and roads. It may control health care supplies by rationing resources; establishing priority distribution to health care providers, disaster response personnel and mortuary staff; and establishing a general distribution to all others. It may establish and enforce quarantine and other infection control measures.

The following provisions of the Model Act have provoked considerable discussion among public health scholars and practitioners:

- **Quarantine.** "Special Powers" of the Public Health Authority apply to: performing physical examinations, necessary tests, and/or vaccination. Any person refusing examination, tests, or vaccination may be isolated or quarantined. These sections (601, 603) have been subject to media and public scrutiny. States have designed widely differing solutions. However, the Model act has helped to modernize State laws on quarantine and encourages greater consistency among State laws regarding quarantine provisions.
- **Liability.** Health care providers are not held liable for any civil damages, except in cases where they are found to be negligent in treating or in failing to provide treatment. This includes out-of-State health care providers for whom relevant permits to practice have been waived by the Public Health Authority. The Model Act also explicitly states that except in cases of gross negligence or willful misconduct, the State (and the State and local officials specified in the act) is not liable for any property damage, death, or injury incurred as a result of complying with the Act (§804(a)).
- **Compelling Provider Participation.** The Model Act states (§608 (a)) that the Public Health Authority can compel in-State health care providers to assist in vaccination, testing, treatment, or examination of an individual as a licensure condition.
- **Other Provisions.** Other provisions of the Model Act include the use of otherwise protected private medical information, public information obligations, access to mental health services and personnel, compensation for private property (calculated according to nonemergency eminent domain procedures) and reimbursement for health care supplies.

For more information, see <http://www.publichealthlaw.net/Resources/Modellaws.htm>