OVERVIEW

In February 2021, the Healthcare Leadership Council (HLC) and the Duke-Margolis Center for Health Policy published a Framework for Private-Public Collaboration on Disaster Preparedness and Response. The report outlined key actions for private and public sector leaders to take in order to better prepare the U.S. for future public health emergencies. The report laid out three priority action areas:

- Improving data and evidence generation,
- Strengthening innovation and supply chain readiness, and
- Innovating care delivery approaches.

Since that time, private and public sector leaders have made some progress on those priorities. The Administration has prioritized supply chain readiness and resilience, and a series of reports in 2021 and 2022 by the White House and the U.S. Department of Health and Human Services (HHS) set forth concrete steps for continued progress. Private sector stakeholders, both independently and through private-public partnerships, have pioneered innovative approaches for care delivery during emergency circumstances, especially through digital modalities of care. HHS elevated the Administration for Strategic Preparedness and Response (ASPR, formerly known as the Assistant Secretary for Preparedness and Response) to an operating division of the Department, and Congress established a new, permanent White House Office of Pandemic Preparedness and Response Policy.

Gaps in preparedness remain, however, as the U.S. still is not sufficiently ready for future disasters or to rapidly and effectively respond to emerging threats. Federal coordination for disaster response often lacks clarity and coordination, with no explicitly designated lead agency – particularly challenging for potential disasters that may require military and civilian response and care infrastructures to quickly integrate. Furthermore, real-time information is needed to guide disaster response – for example, using timely data on health system capacity, types of cases, and medical product inventories to inform responses, guide patient care, and direct supplies. And progress in health system resiliency is needed, with many facilities still encountering staffing shortages and workforce burnout issues that hinder access to care.

Addressing these persistent issues will require further legislative action by Congress, policy and regulatory action from the Administration, and continued innovations by private sector stakeholders involved in disaster preparedness and response. It will also require more significant investments in public health infrastructure, as health care organizations are an increasingly important part of disaster preparedness and response capabilities.

Given the need for further action and collaboration by private and public sector leaders, HLC and Duke-Margolis have updated recommendations from the 2021 report to identify the highest-priority areas for additional near-term action. This effort included two stakeholder workshops in October 2022 and February 2023, as well as expert interviews and focus group discussions. The result is a set of targeted, high-priority, broad-based recommendations to strengthen disaster response policy, with a specific focus on legislative and regulatory steps that can be achieved in 2023. Our recommendations leverage new medical and technological capabilities and insights from past emergency response efforts to enable:

- Coordinated, informed, scalable, and rapid national, state, and local responses by establishing a clear, collaborative, and coordinated leadership structure, with pre-specified divisions of responsibilities and information pipelines, for federal emergency response;
- Robust manufacturing and distribution practices, with better ability to anticipate and avoid shortages; and
- Greater health care resilience to respond to emergencies through improved rapid information-sharing capabilities to optimize deployment of health care resources and VVHVWRRHQDEOHPRUHHFWLYHMHPUHJHQF\FDUHDQGUSHFXFH4VWWUHSVQGHUExUQRXW

Key recommendations are summarized in Table 1.

May 3, 2023
### TABLE 1

**KEY RECOMMENDATIONS**

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Federal Coordination and Support for Local Response

There is general consensus among private and public sector experts on the need for a single point of contact and coordination within the federal government that is responsible for the health components of disaster response policy. Designating a lead federal agency would help establish a clear line of incident command, better delineate roles and responsibilities of federal agencies, and streamline private-public communication. The White House Office of Pandemic Preparedness and Response, recently established by the Consolidated Appropriations Act of 2023, will coordinate preparedness and response for future biological threats across departments, but has not yet received appropriations. Given its mission and resources, the ASPR should have its remit expanded to lead operations and serve as the point of coordination for the health components of any disaster response, not just biological threats. ASPR has a history of partnering with key leaders in private sector health care and public health as well as the capability to rapidly mobilize for emergency response.

This should include clarifying ASPR’s disaster-based operational command where there are overlapping areas of responsibility among agencies. However, ASPR should continue to leverage other agencies’ expertise through FORVFROODERUDWLQVRWXXSRUWHFQWLHYSHXOELFPHVVD incident command structures, data sharing, and timeliness of decision-making and response. Additionally, critical to DGYDQFLQJSDUQGHSVVDQWHVSRQVHQLQVLQXULQ]HFWLHYH communication channels between the federal government DQUHJLRQDQGVDWHR]FDQVQGKHLUSULYLDWHVFH should work with federal public health authorities, the Centers for Medicare and Medicaid Services (CMS), state and local public health and departments of health, and health systems to improve these channels of communication and strengthen and pressure-test regional and state abilities to quickly allocate needed supplies, coordinate emergency care, and communicate with private sector partners and the general public, among other key capabilities.

The following actionable recommendations could achieve a more organized and coordinated federal response reflecting these goals:

RECOMMENDATIONS FOR LEGISLATIVE ACTION

• ASPR should serve as the operational lead for health-related components of disaster response, including coordinating federal health agency actions, while the White House can amplify messaging and assure cross-department collaboration. ASPR should also serve as an organizing entity for seamless integration of private and public health care capacity in emergent disasters.

• During a public health emergency, ASPR should be given clear authority to serve as lead coordinator of the disaster response activities of CMS, CDC, and other HHS agencies and sub-agencies as they become involved.

• ASPR should be accountable for creating and maintaining a two-way communications system with the private sector (building on its existing regional preparedness programs), to ensure that the expertise and engagement RIWKSULYDWHVFWRULV$4POLQFRUSRU$8WHGLQ$63SVZRUN

• Through RHCEPRS, the federal government should provide accountable funding to states and/or regions to establish HPHUHJHFQUPHLSQVRQVHPHFDQLVPVKGWHDHFWLYH[FRUUGQDWHVWDHDCQFODQHULQVHLQFOXQL]QDVJRYHUORUVR[FRUUGQDVWHRHDSUWPHQVRIKHDWORSXOELFKHDWDFK]HFWLHYFRXQWDFGRUPD]RUDOR]FVZRULQ]$ZLWK regional private health care leaders.

• Accountability for preparedness can occur through “stress test” exercises for major types of health disaster response, key emergency performance capabilities in Medicare Conditions of Participation (CoPs), and other mechanisms as appropriate.
RECOMMENDATIONS FOR REGULATORY AND EXECUTIVE ACTION

- ASPR, FEMA, and DoD should work together more closely before and during disaster response to leverage FEMA/DoD expertise in emergency command, and authorities and appropriations must be aligned.

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Avoiding Shortages and Promoting Supply Chain Resiliency

A disaster may cause an immediate spike in demand for certain medicines, and could also drastically reduce supply. As such, near real-time information on medical product inventories and supply chain capacity is needed – a clear and up-to-date understanding of potential shortages enables decisionmakers to allocate existing national inventory or surge manufacturing as needed. Data collection should be conducted as efficiently as possible to reduce burden on those asked to report it, and proprietary data must be protected appropriately. Implementing a process that builds shared understanding of data uses and trust with health system leadership is also critical – for example, to address concerns about inventory being seized and reallocated, rather than coordinated steps to mitigate shortages and increase supply when needed. This likely requires continued collaboration, education, and tabletop exercises or other stress tests between emergencies.

The following recommendations can achieve these aims:

RECOMMENDATIONS FOR LEGISLATIVE ACTION

- ASPR should be granted the authority, with public comment and collaboration, to require reporting of some key information on drug and medical product supply and inventory in health-related emergencies. Greater transparency on these points – along with greater coordination as described in the preceding and following sections – will allow private sector entities (such as distributors, wholesalers, group purchasing organizations, and health systems) and public sector entities (such as ASPR’s Strategic National Stockpile) to make more informed decisions and surge supplies to where they are needed most.

- Existing Hospital Preparedness Program (HPP) health care coalitions and RHCEPRS partnership pilot sites should be used to enable collaboration with private stakeholders (group purchasing organizations, wholesalers, and distributors as well as hospitals and health systems) on expectations for reporting in potential public health emergencies (PHE), what conditions will trigger the start and end of such emergency reporting requirements, how the information they share will be used to provide local and national situational awareness and guide allocation of Strategic National Stockpile (SNS) supplies and federal procurement, and how proprietary information will be protected. It may also be possible to have a tiered system, so as emergencies escalate more extensive data would be available.

- ASPR and other relevant HHS components should work with health system leaders through RHCEPRS and HPP to for the individual health systems, while keeping government agencies informed regarding priority allocation needs. It also may be possible to have a tiered system, so as emergencies escalate more extensive data would be available.

- During emergencies, ASPR should require reporting of key information for avoiding shortages and maintaining supply of commonly used products that may experience significant competition and supply chain constraints in major types of disasters, as well as prespecified disaster-specific supplies (e.g., PPE needed after a radiologic event, supplies and treatments required when there are widespread crushing injuries, etc.).

- The SNS should be more substantially and more consistently funded, and should engage manufacturers in longer-term committed contracts with frequent, scheduled ordering rather than occasional bulk purchases. This will ensure a fresh supply of products to the SNS and will maintain a “warm base” manufacturing capacity for certain essential medicines and supplies, allowing more rapid scale-up of production in case of a sustained surge in demand caused by an emergency.
Creating health system capacity responsive to an all-hazards approach for disaster preparedness is challenged by pressures to use resources efficiently and stresses on the health care workforce under nonemergent conditions. Experts agreed further policy action is necessary to develop more resilient health systems, especially policies that can strengthen care delivery pathways that mitigate overwhelming the health system during surges, but also noted eliminating the stresses of emergency surges is not realistic. To protect the workforce from burnout and reduce the stresses of emergency surges, federal and private sector efforts should focus on supporting a dynamic health system with relevant operational capabilities, such as care management for higher-risk patients, telehealth, and remote monitoring services, linked to readiness to surge, such as scalable staffing structures and cross training.

Timely and reliable sharing of key, limited data for situational awareness is also critical for the effectiveness of a comprehensive approach, with particular emphasis on guiding operational response. In times of crisis, it is critical to implement essential data-sharing without unnecessary diversion of vital resources or the creation of an efficient, scalable health information-sharing mechanism supported by CMS and the Office of the National Coordinator for Health Information Technology (ONC). This approach would reduce public health regulatory reporting burden while sharing only minimum necessary, anonymized information. Health care facilities would report only key information such as caseloads, staff, and bed capacity, along with disaster-specific information on patient information relevant to the response, using existing electronic data systems. Timely standardized laboratory reports of test results would inform responses to certain public health emergencies such as bioterrorism events and infectious disease outbreaks.

The following recommendations can achieve these aims:

**RECOMMENDATIONS FOR LEGISLATIVE ACTION**

**Reduce health care workforce burnout**
- The HPP should provide additional resources to hospitals and health systems to support mental health care for their workers. The federal government should continue to support research into workforce issues arising from health emergencies and disasters to build an evidence base for appropriate interventions and identify opportunities to help address these issues in a more systematic way.

**Workforce capacity**
- The federal government should direct hospitals and health systems to seek mental health care without facing unnecessary punitive action.
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**The following recommendations can achieve these aims:**

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**RECOMMENDATIONS FOR REGULATORY AND EXECUTIVE ACTION**

**Enhance health system capacity for disaster response**

- CMS should reform existing hospital emergency preparedness CoPs to align with the enhanced private-public response cross-training procedures, increase bed capacity and services to other settings, and coordinate with new and existing preparedness private-public partnerships noted above (similar to how existing CoPs require plans to coordinate with HPHU|HQFR|FLDQV).

- GAO should conduct a review of previous and ongoing work by RHCEPRS, HPP, National Disaster Medical System, and RWK HUH|FWLY|HSULY|DWSX|EOL|FSD|U|QHV|K|L|S|W|RLG|H|L|E|H|WS|DF|L|FH|V|I|U|K|HD|W|K|PHU|HQFU|HSR|QV|HLD|QFOX (guidelines and clinical cross-training guidance), opportunities to scale up or expand those best practices, and any VLJ|Q4FD|U|PD|LQ|QJ|DSVLQS|ULY|DWSX|EOL|FUH|VS|QV|H|DSDEOL|W|LV.

**Support timely data sharing for local and regional awareness, to direct additional resources to where they are most needed, and help regional organizations, funded through RHCEPRS or HPP, optimize patients’ care across sites**

- In order to ease burden and confusion, CMS should serve as ASPR’s implementation entity within the federal government responsible for critical health care data collection and sharing in a public health emergency. CMS should use its existing authorities, including HHS authorities under the PREVENT Act if needed, to enable a consistent data reporting approach through existing electronic health care data systems. Implementation should be guided by notice and comment rulemaking in collaboration with health care organizations, ONC, and public health agencies. This single approach for standard data reporting for health systems would improve the quality of reporting, and quicken the bi-directional 5RZRIU|O|EOL|LQ|RUP|PDWLRQ

  - CMS should consider contracting a third-party entity to support data aggregation and production of real-time “heat maps” for local and regional situational awareness.2

  - ASPR and CMS should collaborate with other agencies, such as CDC’s Center for Forecasting and Outbreak Analytics, for analysis and timely, actionable insights from the aggregated data reports to inform local responses.


- To avoid unnecessary burdens on providers, CMS must ensure that reporting is purposeful, focusing on key emergency-relevant data that can be extracted reliably and easily from existing electronic data systems.

**Support care delivery models that enable equitable early interventions to prevent surges from overwhelming health system capacity**

- CMS should develop a payment plan for additional provider payments for screening and counseling, “test to treat” capabilities for high-risk individuals, and timely electronic reporting for potential major public health threats (e.g., emerging infectious disease threat, radiation exposure, other hazards), in conjunction with the development of emergency data reporting and with consultation from health care providers.

- CMS should release a request for information to inform its proposed regulations related to (1) how existing payment programs and its value-based payment approaches can support preparedness and (2) how payment changes can support care innovations designed to prevent and mitigate burnout and promote resiliency.

- CMS should develop timely processes for licensure flexibility during emergencies, for example through streamlined enrollment in billing, such as the ability for qualified retired health care providers to support disaster response by boosting workforce capacity.


• CMS should work proactively with ASPR, state medical boards, and the Federation of State Medical Boards to create model waivers to allow for expanded telehealth, including across state lines. Waivers should be tied to data sharing and performance measures around continuity of care and, in the case of public health-related emergencies, to provide access to appropriate treatments.

• CMS should issue waivers for expanded home care services to improve access to care and reduce hospital stresses during a disaster.
  - Waivers should be contingent on adequate regional pre-disaster planning for how to prioritize home care patients based on medical need, risk levels, etc., as well as appropriate safeguards to ensure quality is not compromised.

• DoD should implement health emergency response training for National Guard members.

• ASPR should have the authority to call upon federal health care personnel to be brought in to increase the workforce during a surge.

Toward a Long-Term Vision for Coordinated Private-Public Health Emergency Response

These legislative and regulatory actions to improve federal coordination, avoid shortages, and promote health system resiliency should be undertaken in the near term to shore up key vulnerabilities in U.S. emergency response capabilities. There is, however, more work to be done in the longer term to build a robust capacity to address both repetitive strains on health care and public health systems (such as seasonal Flu or RSV surges) and less predictable but serious emergency threats (such as radiological events or natural disasters). With concerted policy making and sustained private-public collaboration, the United States has the opportunity to create a more robust and equitable preparedness and response strategy capable of handling the next health-related disaster or emergency. The Duke-Margolis Center and Healthcare Leadership Council stand ready to help stakeholders move these recommendations into reality and achieve that aim.

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About

Duke Margolis Center for Health Policy

The mission of the Robert J. Margolis, MD, Center for Health Policy at Duke University is to improve health, health equity, and the value of health care through practical, innovative, and evidence-based policy solutions. The Duke-Margolis Center for Health Policy values academic freedom and research independence, [available here](#).

Healthcare Leadership Council

The Healthcare Leadership Council (HLC) is a coalition of chief executives from all disciplines within American healthcare, who care about a shared vision for the future. We provide the only forum of its kind, convening industry leaders to collaborate on policies, plans, and programs that will bring positive change to the healthcare system. Since HLC was founded in 1988, our purpose has been to bring together key stakeholders and decision makers that prizes innovation; and that delivers value to all. If you share this vision, please visit [www.hlc.org](http://www.hlc.org) to join us.