ACEP Legislative Requests for 2023 PAHPA Reauthorization

Codify Emergency Care Coordination Center (ECCC)

The ECCC was established in January 2009 within the Office of the Assistant Secretary for Preparedness and Response (ASPR, now the Administration for Strategic Preparedness Response) fulfilling requirement #41 of Homeland Security Presidential Directive #21 (2007). The ECCC plays a vital role in supporting the Emergency Care Enterprise (ECE), which encompasses pre-hospital (EMS) and hospital (emergency department and trauma) care. The mission of the ECCC to improve coordination and integration within the ECE is vitally important and it should be the primary advisor to federal agencies regarding ECE matters. For these reasons, ACEP urges Congress to codify the ECCC's programs and authority within federal statute and provide the ECCC with sufficient funding to carry out its mission-critical projects.

Additionally, we encourage ECCC to work with the NIH's Office of Emergency Care Research (OECR) to identify, partner, and fund research projects to assess and develop best practices that facilitate daily emergency patient care and preparation and recovery of community-centered responses to disasters and other public health emergencies. We further encourage Congress to ensure OECR is appropriately funded to carry out its mission to foster basic, translational, and clinical research and research training for the emergency setting.

Congress should also consider how to better coordinate, streamline, and manage other emergency medical operations. For example, the Office of Emergency Medical Services resides within the National Highway Traffic Safety Administration (NHTSA) which sits under the Department of Transportation (DOT), and similarly, the Emergency Medical Services for Children (EMSC) program resides within the Health Resources and Services Administration (HRSA). The fragmentation of emergency care, prehospital care, and emergency care for children (including both prehospital and hospital-based care) makes a cohesive perspective and strategy exceedingly difficult. There may be advantages in creating a more comprehensive home for EMS within HHS and better aligning the full spectrum of the ECE.

Hospital Preparedness Program (HPP)

Emergency physicians provide care to more than 130 million patients each year. Under these conditions, most hospital emergency departments (EDs) already operate at, or over, capacity on a daily basis leaving no room for surge capacity that would be needed during a natural or man-made disaster. The ED boarding crisis is its own public health emergency, with our nation's safety net on the verge of breaking beyond repair. EDs are gridlocked and overwhelmed with patients waiting – waiting to be seen, waiting for admission into an inpatient bed in the hospital, waiting to be transferred to psychiatric, skilled nursing, or other specialized facilities that have little to no available beds, or, waiting simply to return to their nursing home. This poses both a threat to public health and national security, as many emergency physicians are

deeply concerned about the system's ability to respond to a large-scale crisis when the frontline is already at a breaking point on any given "normal" day.

The HPP helps alleviate this strain on emergency care resources by working to improve surge capacity, enhance community health care responses and strengthen health care systems preparedness in states and territories. As a fundamental element of disaster preparedness, it should receive a minimum of $250 million in annual appropriations. ACEP encourages Congress to evaluate the grant delivery model to assess whether HPP grants would be more efficient and effective if provided directly to the Health Care Coalition (HCC) rather than the state health department or political subdivision of the state.

One focus of the HPP grants should be to facilitate the design and incorporation of an all-hazards area into the emergency department that can expand to accommodate more patient care and provide space to buffer limited inpatient/observation resources. The design should provide the emergency department with expanded capability, scalability, and threat control. Structural upgrades are needed to modernize the nation's emergency departments so that they can receive and process everyday patients, as well as develop the physical and process changes needed to deliver "all hazards" preparedness in their respective communities. Additionally, given the experience of the COVID-19 pandemic and threat of other severe infectious diseases (SARS, Ebola, smallpox, and other emerging pathogens), Congress should support and fund the establishment of additional specialized biocontainment units, as there are currently only a few across the country, even in densely populated areas. Furthermore, emphasis should be placed on ensuring health care personnel are able to perform their duties in a safe, violence-free work environment.

ACEP urges Congress to reauthorize and fund grants for regionalized systems for emergency care response (42 USC 300d-6) through the HPP. These pilot projects would design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems. Key elements of these systems include:

- Coordination with public health and safety services, emergency medical services, medical facilities, trauma centers and other entities in a region;
- Regional medical direction or transport communications systems;
- Tracking of prehospital and hospital resources (including inpatient bed capacity, emergency department capacity, trauma center capacity, on-call specialist coverage and ambulance diversion status) with regional communications and hospital destination decisions; and
- Consistent, region-wide prehospital, hospital and interfacility data management systems.

Having access to real-time data regarding all the available health care resources within the region is vital to ensuring patients are transported and treated in the most appropriate setting.

We also urge Congress to bolster this effort by continuing to support the Regional Disaster Health Response System (RDHRS) to help support a more comprehensive health care disaster response system. The HPP works to build solutions within states, and the RDHRS works to build

solutions within regions across states. Several regions still do not have an RDHRS demonstration site, and the ones that do currently exist need continued and additional funding in order to most effectively coordinate care.

National Trauma Emergency Preparedness System (NTEPS)

ACEP believes that it is essential to incorporate the lessons learned during the COVID-19 response to inform the provision of trauma care, and we would welcome the opportunity to work with the Committee to further build out this effort and help support the establishment of a coordinated National Trauma and Emergency Preparedness System (NTEPS) that can provide awareness of resources and surge capacity throughout the health care system, as well as the ability to load balance the system to match patients with appropriate resources and specialty expertise.

Currently, we rely on a patchwork of regional and state trauma systems that have developed to meet the needs of patients in need of acute care. We believe a national trauma system is needed to provide a rapid, effective, and coordinated response to public health emergencies. This coordinated effort should be built upon a framework of an interconnected network of Regional Medical Operations Coordination Centers (RMOCCs) to improve regional care delivery by facilitating the most appropriate level of care based on individual patient acuity, while also maintaining patient safety and keeping patients in local facilities that are capable of providing high quality care.

We envision these RMOCCs as having the following essential functions:

- Operationalize the regional plan for patient distribution and health system load balancing for any mass casualty or large public health event;
- Facilitate clinical expertise and consultation for all health-related hazards and coordinate the expertise into the regional plan through current hazard vulnerability assessments;
- Integrate all levels of healthcare leadership (public health, administrative, physician and nursing) from the regional health systems and hospitals into the framework of the emergency operations center and operational plans;
- Provide real-time situational awareness of health care capability and capacity to all regional healthcare systems and other salient healthcare entities. This function includes data collection, analysis, and dissemination (i.e., hospital and EMS capacity data);
- Support dynamic movement of patients when required and load balance the medical facilities to mitigate the need for crisis standards implementation and resource rationing;
- Provide a single point of contact at both the RMOCC and at each hospital/health system for referral requests and life-saving resource sharing;
- Align and coordinate regional resources (e.g., supplies, equipment, medications, etc.) and personnel with the goal of maintaining regional systems for time sensitive care such

as cardiac, stroke and trauma that may or may not be directly impacted by the surge event; and
- Provide a communication link to other RMOCCs to lead or participate in a broader coordinated multi-regional, state, or national effort. This includes both a multi-state response and nationwide network integration.

Though some of these concepts are included in ASPR's *Draft Guidelines Regional Health Care Emergency Preparedness and Response Systems*, we and our partners in this effort continue to encourage ASPR to make Medical Operations Coordination Centers the centerpiece of the regionalized approach.

As it stands now, our country does not yet have a National Trauma System capable of mounting a rapid, effective, and coordinated response to future pandemics, mass casualty events, or other public health emergencies. Given our extensive experience in responding to these types of events, we would welcome the opportunity to work with you to help realize the promise of a truly coordinated medical preparedness and response system.

Such a system would be of great benefit during times of public emergencies and disaster scenarios, especially large-scale incidents, but these fundamental pieces would also bolster the day-to-day operation of the health care system at large and would help address many of the challenges associated with the emergency department boarding crisis occurring across the country. The COVID-19 pandemic pushed many emergency departments to, or even past, the brink, leaving lasting impacts on the health care safety net. For many, the conditions have not improved even as the overall strain of the pandemic has waned.

Establishing an NTEPS built upon the interconnected network of RMOCCs would build critical health care system infrastructure that would pay dividends both in times of emergencies and in everyday operations. The core functions of this system, such as real-time situational awareness of capacity and capabilities, dynamic movement of patients and load balancing processes, coordination and integration of local and regional health personnel and resources can help make our health care system more effective and efficient today, and importantly, ensure that we are better prepared during the next disaster or public health emergency.

Trauma Availability & Training

While trauma care in the U.S. remains a patchwork of regional systems, mortality and disability in patients with traumatic injury can be greatly reduced by bolstering civilian trauma centers with military trauma teams. ACEP urges Congress to reauthorize the successful MISSION ZERO program at its existing authorization level ($11,500,000 million per year), and further, we encourage congressional appropriators to ensure this program is fully funded to maximize its effectiveness.

The MISSION ZERO program serves three purposes: First, it makes additional trauma care personnel available to treat severely injured civilian patients. Second, it allows military trauma

teams to maintain their skills between rotations to conflict areas. Third, it improves our military readiness, allowing trauma team members to train together so that when they are deployed, all members of the team can perform their duties in a coordinated manner with other members, ultimately improving care to injured military personnel.

National Disaster Medical System (NDMS)

The first element of the National Disaster Medical System (NDMS) is medical response and the primary component of that assistance is derived from the Disaster Medical Assistance Teams (DMATs). DMATs are comprised of professional and para-professional medical personnel who provide medical triage, treatment, and preparation for evacuation using a standard equipment cache. However, there are currently only a limited number of centralized warehouses that deploy these medical support assets needed by DMATs and training by medical personnel with the necessary equipment in these caches is limited. ACEP strongly encourages Congress to increase the number of equipment caches around the country to shorten deployment times and to increase access to training with this equipment.

Additionally, as the Healthcare Ready report, "Protecting National Public Health and Health Care Infrastructure for the Next Disaster" notes, the ability of NDMS to respond appropriately is hampered by a lack of clear, specific strategic objectives and should be more closely aligned with ASPR's agency-wide goals. We urge Congress to ensure that NDMS' mission and objectives are clearly defined to meet future workforce augmentation needs during public health emergencies. NDMS response may also promote greater access to communities that may be historically disadvantaged or otherwise discouraged from seeking care, even during emergencies. In the case of the COVID-19 response, for example, while NDMS was utilized, in many cases the National Guard was used to support medical surge needs. But as the report notes, there is some evidence that "…the presence of uniformed services in health care settings may deter some communities from seeking care." ACEP agrees that a study on how deployment of the National Guard affects equitable approaches to increasing medical surge capacities could help us better understand what disaster response teams are appropriate or most beneficial to individual communities.

Our country needs a modern approach to incentivizing facilities to participate as receiving sites when patients need to be appropriately distributed between them. Congress should consider providing ASPR with a fund that can be immediately spent, similar to a disaster relief fund through the Federal Emergency Management Agency (FEMA), to help incentivize facilities within a community to receive these patients. Congress should also consider specially-designated and -funded national security hospitals tasked with maintaining surge capabilities, as well as incorporating other novel incentives and mechanisms into NDMS agreements that are triggered by large-scale disaster events.

Medical Liability Reforms

During many disasters, local health resources can quickly become overwhelmed. Assistance from DMAT and other NDMS teams helps complement local health providers, but that is not always sufficient for a large population of patients or where health care resources were already scarce. Often, these services must be supplemented by physician and other health care providers volunteers. Unfortunately, physicians from out of state are discouraged from volunteering in these disaster areas because they do not have professional liability coverage (as their own policies are contingent on where they typically practice).

Section 208 of the Pandemic and All-Hazards Preparedness and Advancing Innovation (PAHPAI) Act helped addressed a piece of this for health care professionals who volunteer during federally-declared disasters, clarifying liability protections for health care professionals who are members of the Medical Reserve Corps or who are registered under the Emergency System for Advance Registration of Volunteer Health Professionals. This clarity is appreciated; however, these protections are still limited to those who are *already* prepared to volunteer during a disaster. Out-of-state health care professionals who may be spontaneously motivated or personally compelled to volunteer their services still lack reasonable federal liability protections appropriate for volunteering during a federally-declared disaster. ACEP therefore urges Congress to include Good Samaritan liability protections for health care professionals who volunteer to serve in a federally-declared disaster area. These protections would be in addition to those provided by the Volunteer Protection Act of 1997, which is limited to those who assist nonprofit organizations or government agencies.

ASPR's mandate contains two components for it to be effective in its mission: preparedness and response. A key element of both qualities is for emergency departments throughout the country to maintain daily capacity at these facilities and have the ability to provide additional capacity when there is a surge of patients. For this reason, it is vital to establish policies that increase emergency physicians and on-call physicians' availability. One potential way to achieve this result is by offering physicians who provide health care services mandated by federal law, such as the Emergency Medical Treatment and Labor Act (EMTALA), liability protections while they provide care under this federal mandate.

Access to Emergency Medications

ACEP applauds the work Congress has done previously to provide clearer authority for the FDA to issue Emergency Use Authorizations (EUAs) for medical countermeasures (MCMs) before a chemical, biological, radiological, and nuclear (CBRN) emergency occurs. This important policy helps health care providers prepare for the use of unapproved medical products or unapproved uses of approved products, and was an essential, lifesaving component of the COVID-19 response.

Permitting federal, state, and local entities to pre-position MCMs in anticipation of FDA approval or clearance allows for rapid deployment during an actual CBRN emergency. In addition, allowing emergency dispensing, including mass dispensing at a point of dispensing

(POD), of MCMs during a CBRN emergency without requiring an individual prescription for each recipient of the MCM (if permitted either under state law or in accordance with an order issued by the FDA) can significantly save time and lives.

Essential Emergency Medication Shortages

U.S. hospitals and emergency medical services (EMS) continually suffer from nationwide shortages of essential medications that are frequently used in the care of critically ill patients. ACEP considers any medication that is used to treat a life-threatening condition and for which there is no adequate substitute to be an essential emergency medication. Additionally, many hospitals frequently suffer from shortages of drugs and products used daily in "routine" emergency care, with products as simple as sterile saline solution often in short supply.

These shortages can last for months at a time and constitute a significant risk to patients. ACEP urges Congress to take the additional steps necessary to end these life-threatening drug shortages by seeking a coordinated response from ASPR, the Food and Drug Administration (FDA), and the Drug Enforcement Administration (DEA), informed by the FDA's 2019 report (updated 2/21/20), "Drug Shortages: Root Causes and Potential Solutions," which provides a number of recommendations for lasting solutions to prevent and mitigate drug shortages. Emergency physicians and EMS teams must have adequate, stable supplies of essential emergency medications available at all times.

Combating Antimicrobial Resistance

Antimicrobial resistance and the reduction of remaining effective antimicrobial armamentarium represent a critical threat to public health and the health of patients in emergency departments throughout the U.S. and the world. Antimicrobial stewardship programs aim to optimize antimicrobial usage for clinical efficacy while minimizing adverse drug events, selective pressures that drive the emergence of resistance, and costs due to suboptimal antimicrobial use. ACEP supports and encourages the engagement of emergency physicians and EDs in antimicrobial stewardship at all levels.

As the Presidential Advisory Council on Combating Antibiotic-Resistant Bacteria (PACCARB) noted in a 2021 letter to HHS Secretary Xavier Becerra, the U.S. continues to face a "…severe lack of new antimicrobial drugs." This growing deficit is exacerbated by increasing antimicrobial resistance to existing treatment options, leaving health care professionals more limited ability to treat infections. To help address the investment and development pipeline challenges for new antimicrobial drugs, ACEP urges Congress to include the Pioneering Antimicrobial Subscriptions to End Upsurging Resistance (PASTEUR) Act in PAHPA. The PASTEUR Act would establish an innovative, subscription-based payment model for novel antimicrobials, allowing the federal government to enter purchasing contracts with companies that delinks payment from sales volume. This will help reduce risks for companies seeking to develop new

antimicrobials, while also ensuring the federal government only pays for successful FDA-approved treatments that are available to patients and meet unmet antimicrobial resistance needs. The PASTEUR approach is similar to Project Bioshield, which helps support the development and procurement of medical countermeasures for other biological and radiological threats.

Authorize the "Prevent BLEEDing Act"

The Prevent Blood Loss with Emergency Equipment Devices (Prevent BLEEDing) Act supports the "Stop the Bleed" campaign that provides lifesaving bleeding control kits for easy public access and training, both before the immediate need as well as in a "just in time" format. The campaign boosts national resilience by better preparing the public to help save lives by taking basic actions to stop life-threatening bleeding following everyday emergencies or disaster events. ACEP believes that severe hemorrhage control kits should be readily available to the public in easily accessible locations such as public access automatic external defibrillator (AED) locations in businesses, schools, airports, and other public buildings. The Prevent BLEEDing Act would establish a grant program within ASPR to provide anti-blood loss supplies (tourniquets, gauze, stop the bleed kits, etc.) for use in a medical emergency and implement training on bleeding control techniques.

Inclusion of the "Bipartisan Solution to Cyclical Violence Act":

ACEP believes emergency physicians have a public health responsibility to reduce the prevalence and impact of violence through advocacy, education, legislation, and research initiatives, and we support violence prevention programs and interventions to reduce future violence and repeat injury. Violence and violent injuries pose a significant strain for the health care system in terms of both efforts and costs, but also deeply affect and inflict lasting trauma on the individuals affected by violence, their families and friends, and their communities.

Individuals who are violently injured are significantly more likely to be reinjured within five years (reinjury rates are nearly 50%) as the general population. Hospital-based violence intervention programs have shown success in capitalizing on the "teachable moment" when injured individuals are responsive to interventions, reducing risk factors for reinjury through whole-person trauma-informed approaches that address physical, psychological, and cultural/social factors. These programs are effective in saving lives, reducing recidivism, increasing individual and public safety, and lowering the overall costs and burdens on the health care system, particularly in the emergency department and trauma care settings.

ACEP supports the inclusion of the "Bipartisan Solutions to Cyclical Violence Act" that would establish grant programs under HHS for trauma centers and nonprofits to establish or expand violence intervention and prevention programs related to intentional violent trauma.

Coordination with Office of Pandemic Preparedness and Response

Given the frontline experiences of emergency physicians throughout the COVID-19 pandemic, ACEP appreciates Congress' efforts throughout to better prepare for the next pandemic and other threats. As this experience has shown, improving coordination among federal, state, and local entities is crucial. To this end, we strongly urge Congress to more clearly articulate how ASPR and the newly-established White House Office of Pandemic Preparedness and Response will coordinate and interface with one another.

Additional considerations should take into account whether or not this should also incorporate all hazards (not just pandemics), and if so: how this office may bridge national security to national health security with ASPR as the lead advocate for increasing the health care system's response capabilities to surges; how other partner agencies can be convened in support of the national health security mission (i.e., FEMA, DoD, VA, CDC, FDA, CMS, etc.); and if this office (or other appropriate office) should serve as a single point of contact or information for communicating with the public regarding public health threats (along with CDC), health care response (ASPR), and emergency management and disaster response (FEMA).

Cybersecurity Threats

Emergency medicine is focused on responding to worst-case scenarios and emergency physicians are trained to provide lifesaving care even with limited resources. But, like all other facets of modern life, our emergency care system and health care system overall are increasingly dependent upon an ever-growing network of technology and telecommunications. The increasing threat of cyberattacks and their ability to completely paralyze a hospital or health care system pose both a threat to public health and to our overall national security alike. Sophisticated cyber attacks have forced hospitals to completely shut down their computer systems, taking electronic medical record (EMR) systems offline and forcing emergency physicians to fall back on "low tech" procedures to maintain continuity of emergency care delivery and operations and ensure patient safety.

In addition to promoting the development of necessary fallback measures to ensure patient care and safety in the event of cyber attacks, we urge Congress to expand efforts and provide necessary resources to help protect health care systems and other critical infrastructure from cyber attacks.