

December 21, 2018

Robert Kadlec, MD
Assistant Secretary for Preparedness and Response
200 Independence Ave, SW
Washington, DC 20201

Re: Hospital Preparedness Program

Dear Dr. Kadlec,

On behalf of the National Association of County and City Health Officials (NACCHO), I write to comment on proposed changes to the Hospital Preparedness Program (HPP) including the funding formula and funding opportunity announcement. NACCHO represents the nearly 3,000 local health departments that safeguard the public's health in communities across our nation. These city, county, metropolitan, special district, and tribal departments work every day to protect and promote health and well-being for all people in their communities.

As you know, the HPP provides vital capacity to communities across the nation and is an important compliment to the Public Health Emergency Preparedness Program at the local level. HPP is the first comprehensive strategic approach to coordinating the nation's health security system to prevent, mitigate, and recover from incidents with potentially negative public health consequences. In the past five years, the HPP program has been subject to funding cuts and programmatic changes. Local health officials are concerned about how these changes will affect their community's healthcare and medical surge planning, as well as their ability to be prepared for any emergency they may face.

While we support the ASPR's efforts to improve program outcomes and efficiently direct funding based on risk, after collecting and reviewing feedback from local health departments, NACCHO has the following suggestions to help ensure the program continues to fulfill its intended mission and ensure public health preparedness at the local level.

Changes to the Funding Formula

NACCHO acknowledges that changes to the funding formula seek to recognize that all local communities are at risk for a catastrophic event and base funding is needed for every state. In addition, NACCHO recognizes the concerted effort by ASPR to identify national level data sources that reflect the medical surge capabilities of systems and communities across the country. However, based on feedback from local health departments, there is concern that national level data sources may not always recognize community level priorities based on their identified risks.

Therefore, NACCHO encourages ASPR to:

- Change the "distance" to medical center in urban and rural areas to a "time" to medical center as distance discounts different medical transport challenges and telemedicine technologies.



- Include climate change indicators such as those available from the National Oceanic and Atmospheric Administration. The extreme weather events of the past several years including hurricanes, drought, and wildfires reveal the need to pay attention to the increasing risk of these events.
- Include indicators that reflect infectious disease threats. As climate change alters the geographic range of vectors that carry Lyme, dengue, typhus, etc., populations and the healthcare systems in impacted areas will be at greater risk and require coordination and collaboration.
- Reconsider inclusion of trauma system metrics. Of the 309 million people in the US in 2010, 29.7 million lacked access to trauma care, a majority of whom were in lower-income communities.

NACCHO also offers the following comments about proposed metrics:

Measures of Vulnerability and Access: While metrics about states' social vulnerability and access to care are being used to determine a state's funding formula, it is important to note that these factors do not necessarily mean that awardees will direct funds to those communities within the state with higher social vulnerabilities or greater risk for difficulties accessing healthcare during a disaster. NACCHO recommends that the upcoming Funding Opportunity Announcement should encourage awardees to consider county-level social vulnerability and access to care data in determining funding distribution within a state.

- **Vulnerability Metric 1: Capacity for Providing Care:** The simple number of beds does not reflect the actual capacity of a hospital to provide care in an average day or emergency. Staffed beds are a better reflection of the number of beds available for use by patients. This measure is included in the National Health Security Preparedness Index and comes from the American Hospital Directory.
- **Vulnerability Metric 3: Vulnerable Populations:** NACCHO recommends expanding the definition of children beyond age five to at least 12 years old. Children require specialized care in emergencies, as well as special considerations around family reunification and consent, well beyond the age of five.
- **Vulnerability Metric 4: Access to Care:** NACCHO applauds inclusion of the Centers for Disease Control and Prevention's Social Vulnerability Index as a measure of the potential challenges to the resilience of a state during an emergency. The data included in this Index, including socioeconomic status, vehicle access, and household composition, are an important indicator of a state's overall vulnerability that could result in a strain upon the healthcare system in a disaster. In communities that lack transportation needed to evacuate, for example, the healthcare system in the home state may face an additional surge of patients unable to evacuate.

Programmatic Changes to HPP

NACCHO is also concerned about proposed administrative changes to the HPP including requirements for increased medical collaboration with coalitions and requirements for the addition of a clinical advisor and identification of a healthcare organization co-lead for coalitions. While overall clarification is sought on the purpose and goals for the proposed changes, specifically, NACCHO seeks:

- Clarification on the definition of healthcare organization co-lead. Existing programmatic requirements already require participation of healthcare organizations as part of the coalition. Many coalitions have multiple healthcare systems participating in the coalition, often competing

for business in the same geographic area. Therefore, designation of one as a coalition co-lead appears redundant to current requirements and could be problematic for continued cooperation.

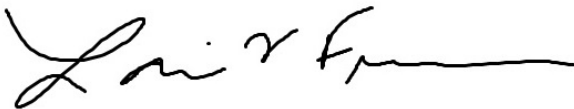
- Flexibility in staffing the clinical advisor. Funding cuts and changes to the administrative cap in the past several years have reduced administrative capacity within coalitions. The addition of clinical advisor for increased oversight has the potential to increase administrative burden while being duplicative of state and local internal oversight and partnerships that exist to ensure the needs of the community are met. Additionally, further clarification on the role and direction of the advisor would be beneficial. While many healthcare systems and EMS agencies follow established trauma guidelines, modifications are frequently made based on geographic needs, organizational capacity and coalition stakeholder support. An additional clinical advisor may impinge on authorities granted by state and local rules and ordinances to the agency Medical Director who is also responsible for quality assurance/improvement programs.

National Partnership and Leadership

Finally, NACCHO urges further transparency from ASPR on the goals and objectives for the HPP program. Potential programmatic and funding changes have led to concerns that the HPP is narrowing its focus to reflect preparing for catastrophic events resulting in a loss of capacity to respond to everyday emergencies at the local level, particularly for at-risk communities. Engaging with communities to understand existing systems and partnerships, administrative and legal barriers, and lessons learned from past responses are vital tools to inform national programmatic guidance that will meet the needs of communities.

NACCHO appreciates the opportunity to comment on these proposed changes to the HPP. As an essential partner in ensuring the safety of our communities, NACCHO looks forward to continuing to work with HHS to strengthen public health preparedness and response to disease outbreaks, emergencies, and acts of terrorism. If you have any questions, please contact Dr. Oscar Alleyne, DrPH, MPH, Senior Advisor for Public Health Programs (oalleyne@naccho.org) or Laura Biesiadecki, Senior Director for Preparedness (lbiesiadecki@naccho.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Lori Tremmel Freeman". The signature is fluid and cursive, with a long horizontal line extending from the end.

Lori Tremmel Freeman, MBA
CEO