June 13, 2023

The Honorable Cathy McMorris Rodgers
Chair
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Brett Guthrie
Chairman
Energy and Commerce
Subcommittee on Health
U.S. House of Representatives
2434 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna G. Eshoo
Ranking Member
Energy and Commerce
Subcommittee on Health
U.S. House of Representatives
272 Cannon House Office Building
Washington, DC 20515

Dear Chair McMorris Rodgers, Ranking Member Pallone, Chairman Guthrie, and Ranking Member Eshoo:

On behalf of the more than 87,000 members of the American College of Surgeons (ACS), thank you for your leadership and commitment to improving public health preparedness and response by convening a hearing on "Legislative Solutions to Bolster Preparedness and Response for All Hazards and Public Health Security Threats." The ACS is a scientific and educational association of surgeons, founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. As work continues to reauthorize the Pandemic All-Hazards Preparedness Act (PAHPA), ACS offers the following statement:

Driving Innovation and Strengthened Coordination

Large-scale events pose numerous challenges for health systems, including fragmented command structure; lack of effective communication between agencies, clinicians, and facilities; inadequate and fragmented data concerning patient location and condition; limited or absent medical surge capability; limited integration of public health with acute private and public health sector care; inadequate integration between local and federal emergency management systems; and lack of ability to coordinate and track patient movement. To address issues with coordination during the earliest days of the COVID-19, some states, such as Washington, established Regional Medical Operation Coordination Centers (RMOCCs).

RMOCCs are local/regional operations that bring together emergency management, public health, and acute medical care systems to balance the distribution of resources and patients in the acute healthcare system. RMOCCs function as the "air traffic control" for inclusive coordination of the health and medical response in affected areas across all healthcare partners.

RMOCCs enable a faster response by coordinating the activities of the whole health system and share a real-time communications system, enabling reporting of critical information, such as EMS and transportation resources, hospital bed capacity, essential logistic availability

facs.org

CHICAGO HEADQUARTERS
633 N. Saint Clair Street
Chicago, IL 60611-3295
T 312-202-5000
F 312-202-5001
E-mail: postmaster@facs.org

WASHINGTON OFFICE
20 F Street NW, Suite 1000
Washington, DC 20001
T 202-337-2701
F 202-337-4271
E-mail: ahp@facs.org

(e.g., PPE and ventilators), and patient volume and acuity. As seen during COVID, the daily needs of patients do not stop during a large-scale event, so RMOCCs can and should function daily to coordinate regular community healthcare needs for patients with time-sensitive conditions (e.g., injury, heart attack, and stroke) and existing inpatients who may need to move between healthcare facilities.

This RMOCC framework, which was outlined in the Medical Operations Coordination Cells (MOCC) toolkit and developed by the Federal Emergency Management Agency (FEMA) Healthcare Resilience Taskforce, should be the cornerstone of the medical response executed through the Hospital Preparedness Program (HPP). Functionally, the HPP should work to monitor regional health system capacity (such as hospital bed capacity, supplies, equipment, medications, personnel, and transportation resources); coordinate key stakeholders during an emergency response; collect, analyze, and disseminate relevant data to improve preparedness and response, including by evaluating operational readiness and the state and regional level, developing and implementing strategies to support rural hospitals and workforce shortages in rural areas, and supporting state-level EMS systems; support transportation of patients as necessary; and facilitate domestic mutual military-civilian readiness integration. **ACS urges Congress to build upon the path it created in 2019 for stronger coordination of regional response in an emergency by driving the HPP and other preparedness programs from solely planning for catastrophic events to having an active role in managing the day-to-day coordination for the care of patients.**

As stated previously, RMOCCs were extremely successful in managing emergency response during the early days of the COVID-19 pandemic, making up in large part for the lack of an overarching body to assist with coordination for medical events. **As Congress develops its vision for the future of our nations preparedness and response, ACS urges the establishment of a National Trauma and Emergency Preparedness System (NTEPS), housed within ASPR, to oversee the coordination of resources and health system capacity.** Furthermore, the NTEPS should develop best practices and performance metrics for health systems; support research on trauma care, injury prevention, and patient reported outcomes; and collect and disseminate information to prepare health systems for time-sensitive emergencies and mass population events, including by facilitating data sharing agreements between health systems and other stakeholders. The activities supported by NTEPS should be coordinated by a Trauma and Emergency Preparedness System Coordinator, appointed by the Secretary, to manage, provide administrative oversight, define measures of accountability and responsibilities for regional health systems, and integrate NTEPS activities throughout ASPR. Once implemented, NTEPS would extend this success by supporting public health readiness during major events by acting as the overarching body to support RMOCC's coordination of state and local response needs.

Reauthorization of the *MISSION ZERO Act* (H.R. 2416)

In 2016, the National Academies of Science, Engineering, and Medicine (NASEM) released a report titled, "A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury." This report suggests that one in four military trauma deaths and one in five civilian trauma deaths could be prevented if advances in trauma care reach all injured patients. The report concludes that military and civilian integration is critical to saving lives both on the battlefield and at home, maintaining the nation's readiness and homeland security.

The *Pandemic and All Hazards Preparedness and Advancing Innovation (PAHPAI) Act* (Public Law No:116-22) authorized the *MISSION ZERO Act*, which, based on the NASEM Report recommendations, established a grant program within ASPR to cover the administrative costs of embedding military trauma professionals in civilian trauma centers. These military-civilian trauma care partnerships allow military trauma surgeons to gain exposure to treating critically injured patients and increase readiness for when these units are deployed, further advancing trauma care and providing greater patient access. Ensuring access to trauma care requires many crucial components including trauma centers and appropriately trained trauma surgeons. By defraying the associated costs for the civilian hospital of embedding military surgeons, the military-civilian partnerships funded by the grant.

Reauthorizing the MISSION ZERO grant program will allow for continued implementation of military-civilian trauma partnerships, preserve lessons learned from the battlefield, translate those lessons to civilian care, ensuring that service members maintain their readiness to deploy in the future. **ACS fully supports the MISSION ZERO Act (H.R. 2416) and encourages Congress to reauthorize this important program as part of PAHPA.** Doing so signifies a strong commitment to public health preparedness, military readiness, and access to critical trauma care for the nearly 45 million Americans who live more than hour away from a Level I or II trauma center.

Concluding Comments

A coordinated healthcare system at the baseline will be able to scale up immediately during a disaster or other mass population event without the need for additional resources to initiate. In addition to strengthening regional coordination and establishing an NTEPS within ASPR, I encourage Congress to remove the barriers that prevent healthcare providers from volunteering their services across state lines in a disaster. Thank you again for your leadership and we look forward to continuing to work with the Committee to realize the promise of a truly coordinated and responsive health system. If you have any questions, please contact Emma Zimmerman at ezimmerman@facs.org.

Sincerely,

Patricia L. Turner, MD, MBA, FACS
Executive Director & CEO