

May 4, 2018

The Honorable Lamar Alexander
Chairman
Senate Health, Education, Labor,
and Pensions Committee
SD-428
Washington, D.C. 20510

The Honorable Patty Murray
Ranking Member
Senate Health, Education, Labor,
and Pensions Committee
SD-428
Washington, D.C. 20510

The Honorable Richard Burr
SR-217
Washington, D.C. 20510

The Honorable Bob Casey
SR-393
Washington, D.C. 20510

Dear Chairman Alexander, Ranking Member Murray, Senator Burr, and Senator Casey:

On behalf of the American College of Emergency Physicians (ACEP), our 38,000 members, and the more than 140 million patients we treat each year, I write to thank you for your work on the “Pandemic and All-Hazards Preparedness and Advancing Innovation (PAHPAI) Act of 2018” and for seeking input from ACEP and other stakeholders.

As noted in our previous [recommendations](#) to you, regionalized systems for emergency care response are vital to ensuring patients are transported and treated in the most appropriate setting. While it is important to maximize our resources and capabilities on a daily basis, it becomes imperative when health care providers respond to a natural or man-made disaster. We therefore thank the committee for emphasizing the establishment and enhancement of these systems.

Key elements of such systems under guidelines developed by the Assistant Secretary for Preparedness and Response (ASPR) should 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.

ACEP is very interested in the “trauma system improvements” the committee intends to insert in PAHPAI. We would like to restate our support for inclusion of the MISSION ZERO legislation that would facilitate the use of military trauma teams in civilian trauma centers. This policy 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 in between rotations to conflict areas. Third, it allows trauma team members to train together so that when they are

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deployed, everyone performs his/her duties in a coordinated manner with the other members, thereby improving care to injured military personnel.

U.S. hospitals and EMS continually suffer from national essential drug shortages 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 (EEM). These shortages can last for months, or longer, and constitute a significant risk to patients. As such, we believe Congress should recognize this as a substantial threat to our nation's preparedness and response capabilities and explore a coordinated response from ASPR, the Food and Drug Administration (FDA), and the Drug Enforcement Administration (DEA).

We appreciate the efforts to improve the Centers for Disease Control and Prevention's (CDC) biosurveillance capabilities. Providing medical care on the front-lines of the nation's health delivery system, emergency physicians are the ones who must confront and treat patients who have been exposed to chemical, biological, radiological, and nuclear (CBRN) materials, as well as new viruses and infectious diseases. An effective biosurveillance network will facilitate public health situational awareness and help public health officials and emergency physicians identify and treat new threats with as much advanced warning as possible.

ACEP urges the committee to provide sufficient authorization levels for the Public Health Emergency Preparedness (PHEP) cooperative agreement, Hospital Preparedness Program (HPP), National Disaster Medical System (NDMS), and Medical Reserve Corps (MRC) to ensure their effectiveness. A minimum, guaranteed federal funding stream would be ideal, but we recognize the financial constraints facing Congress may make that unlikely. We applaud your efforts to enhance public-private partnerships to maximize limited resources, but without an appropriate amount of federal funding for these critical programs, we are greatly concerned that the nation as a whole, and emergency medical providers specifically, will not have the infrastructure, personnel, or tools necessary to provide optimal care during a natural or man-made disaster.

ACEP also recognizes the strain on the public health emergency workforce due to increased operations. One way to supplement the NDMS and MRC would be to provide Good Samaritan liability protections for health care providers who volunteer their services during a federally declared disaster. We support your efforts to enhance the Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP) to standardize the volunteer registration program that would allow state coordinators to verify identities, licenses, credentials, and hospital privileges in advance, but exposure to additional professional liability remains a significant barrier to increasing the number of volunteers available to help during a disaster.

Furthermore, ACEP supports your efforts to provide the ASPR with greater flexibility to pre-position response teams in advance of a public health emergency. We believe it is wise to preemptively position these teams when there is a significant potential for a public health emergency to access these resources more quickly. However, as we previously stated in our comments to the committee, more equipment caches should be made available to shorten acquisition time and more training provided for the Disaster Medical Assistance Teams (DMATs).

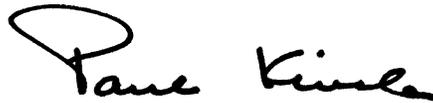
When defining the expertise of the Children's Preparedness Unit at the CDC, we would encourage the committee to ensure at least one of the pediatricians on the team is a

pediatric emergency physician who is certified as such by either the American Board of Emergency Medicine (ABEM) or the American Board of Pediatrics (ABP).

Finally, we would urge the committee to fully utilize the value and knowledge provided by ASPR's Emergency Care Coordination Center (ECCC). Their expertise on the nation's emergency care system and its integration into the broader health care system will be invaluable assisting the ASPR integrate and execute PAHPAI's policies and programs.

Should you have any questions or require any further information, please do not hesitate to contact Brad Gruehn, ACEP's Congressional Affairs Director, directly at (202) 370-9297 or at bgruehn@acep.org.

Sincerely,

A handwritten signature in black ink that reads "Paul D. Kivela". The signature is written in a cursive style with a large, looped initial "P".

Paul D. Kivela, MD, MBA, FACEP
ACEP President