June 26, 2020

The Honorable Lamar Alexander
Chairman
U.S. Senate Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Alexander:

On behalf of the more than 82,000 members of the American College of Surgeons (ACS), thank you for your leadership and interest in reflecting on the lessons learned from COVID-19 and the opportunity to share feedback as the healthcare system examines how to best prepare for future pandemics. 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. The ACS puts the welfare of our surgical patients above all else, and we support policies and regulations that promote high-quality care, reduce the regulatory burdens placed on physicians, streamline clinical workflows, and empower patients with data.

Since the COVID-19 public health emergency (PHE) began in the United States, a great deal about preparedness and response has been learned in a very short time. As Congress begins to address the health care system’s response to the PHE, the ACS looks forward to working together to leverage knowledge and best practices in order to strengthen our collective response to future pandemics. To that end, the ACS provides the following feedback on specific recommendations and issues discussed in the White Paper:

**Disease Surveillance – Expand Ability to Detect, Identify, Model, and Track Emerging Infectious Diseases**

**RECOMMENDATION 2.1:** Ensure timely communication between health professionals, states, the CDC, and the public, as appropriate, of case data and information regarding how emerging infectious diseases affect populations, including who is at higher risk for severe disease and death, to help inform state and local response and address any potential disproportionate impact on minority populations.

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When thinking about our national response to the COVID-19 PHE, and as we begin to think about our national preparedness for future pandemics, the ACS continues to focus on a key question: What should we take away from this national public health emergency which applies across much of surgical care? COVID-19 represents a condition/disease and demonstrates how teams of clinicians come together to understand the basic sciences and clinical sciences, as well as solutions for patients. The focus for these teams treating COVID-19 patients includes both a preventive care model and a treatment model, both of which require extensive resources and coordination. In emergency scenarios, prevention and therapeutics can be informed and enhanced by sharing knowledge and lessons learned promptly, allowing us to evolve the care plans and resources needed to implement those plans in real time. Collecting data on key variables has proven to be a critical component of controlling and monitoring COVID-19.

The ACS believes that the existing clinical data registry structure, using standards-based data, could help to ensure timely communication and information sharing of critically important data, if leveraged to store and generate knowledge across the various phases of the pandemic. Using the existing registry structure will help achieve the goal of an environment of testing, shared decision making with an informed patient consent, and outcomes tracking, allowing for the nation to focus on the continuum of COVID-19 care. Collecting data will also allow the nation to share real-time knowledge in the aggregate to access the latest evidence on COVID-19 management. This knowledge management structure—its processes and the data—are the same medical constructs used to deliver trauma care, cancer care, cardiac care, etc., and we must recognize that care is delivered to a patient by a multidisciplinary team. This team-based care is focused on the patient for their specific condition and informed by a health system based on the intense and reliable exchange of knowledge.

In the early stages of the COVID-19 pandemic we learned very slowly that most of the therapeutic interventions did not work, due in-part to our nation’s reliance on a patchwork of observational data collected haphazardly in separate, proprietary data models. If these data were standards-based across the U.S., we would have had accurate data on the successes or failures of therapies weeks earlier than we did. The lack of standards caused unnecessary loss of life, suffering and wasteful use of health care resources.
Using the existing registry structure will help achieve the goal of an environment of testing, shared decision making with an informed patient consent, and outcomes tracking, allowing for the nation to focus on the continuum of COVID-19 care. Collecting data will also allow the nation to share real-time knowledge in the aggregate to access the latest evidence on COVID-19 management. ACS recommends utilizing two general registry approaches to accomplish this goal: A low burden, low cost, easy to scale registry and a proven, in-depth registry. ACS has included COVID-19 variables in its high-fidelity registries, including the ACS National Surgical Quality Improvement Program (NSQIP) registry. ACS asserts that both types of registries are needed during the pandemic to track COVID-19 cases and aggregate results. The least burdensome approach for hospitals and surgical facilities would be a limited number of registry options with multi-specialty capability during this reopening timeframe for surgical services.

Therefore, Congress should support the use of national standards-based data across the U.S. so that institutions can share and aggregate data in order to track COVID-19 and other conditions/diseases in a timely manner. Without the move towards standards-based data, clinical data registries are creating silos of data across different registries that are not based on the same standard and therefore knowledge cannot be easily aggregated or managed. The ACS welcomes the opportunity to discuss the value of standardized data.

Stockpiles, Distribution, and Surges – Rebuild and Maintain State and Federal Stockpiles and Improve Medical Supply Surge Capacity and Distribution

RECOMMENDATION 3.6: Better leverage the support provided by FEMA and their emergency management experience and assets by improving a coordinated process between HHS and FEMA to more rapidly distribute supplies to states, health care providers, and other entities on the front lines, while utilizing HHS expertise with respect to public health and medical care and medical supplies.

How can the Strategic National Stockpile be better managed and how can Congress increase oversight and accountability?

The first step in better allocating resources is to determine what resources are vital or helpful in preventing, managing, and treating this or any disease. Over
the course of the last several months our understanding of COVID-19 has developed greatly, although not as quickly as might have been hoped, and this has led to a series of changing recommendations about how to treat and prevent the disease. At the earliest signs of a potential epidemic or new disease, data collection and analysis to better understand the disease should be a priority. The information gathered and the insights collected will be beneficial in ensuring that supplies in the national stockpile are utilized appropriately. While no two diseases are alike, our experience with COVID-19 and future disease outbreaks should also help to inform what supplies and assets are likely to be necessary or in short supply. This information can also be used to inform states, hospitals, and health systems wishing to maintain their own stockpiles.

Public Health Capabilities – Improve State and Local Capacity to Respond

RECOMMENDATION 4.1: Get Americans back to their routine health care safely, and develop better plans for the future so that doctors and hospitals can continue to provide health care services and outpatient treatment during a pandemic.

It is important to recognize that efforts intended to slow or prevent the transmission of COVID-19 or other viruses may have unintended consequences for population health. These consequences can be both harmful and beneficial. For example, stay-at-home orders have had the beneficial, yet unintended, consequence of lowering the incidence of traumatic injury from automobile accidents, while at the same time having the unintended negative effect of increasing the incidence of interpersonal violence and self-harm.

Another important consequence of the COVID-19 response has been a drastic reduction in ability and willingness of patients to access routine and necessary care, including elective procedures. While the term “elective” may sound to some like “optional,” this term covers a wide range of services such as joint replacements, cancer biopsies, and most procedures that are scheduled in advance because they do not involve an immediate emergency. Delay of elective procedures therefore can have consequences such as additional pain and suffering, delayed diagnosis, or worse outcomes when care is finally received. In addition to loss of access due to cancelation of elective procedures, many patients still feel unsafe seeking care outside of the home, and therefore may avoid care when it is emergent, even after resumption of elective procedures has occurred.
Viral infectious pandemics such as COVID-19 are best prevented and treated at the local level because incidence and prevalence of the disease are local. Therefore, broad sweeping national or state implementation are not always appropriate. Action plans for prevention and treatment require local implementations and the ability to flex-surge the care in a particular community.

Once the pandemic is identified and its epidemiologic models determined, these action plans can be used to map a phased approach to the pandemic which is flexible and enables the community to coordinate and surge into action its pandemic care model. Initially, care for uninfected, non-pandemic patients may continue in the absence of a local prevalence. As the pandemic peaks in a local area, the flexible steps which increase the surge functionality to counter the pandemic will have an impact on routine daily care and limit medical services for some patients. At the same time, the community must have a plan for essential care for other non-pandemic conditions which require timely interventions - strokes, trauma, cancer or cardiac disease as common examples.

One potential way to facilitate a local, flexible response would be to develop a novel payment model triggered by future health emergencies or pandemics. Such a payment model would allow hospitals or health systems to receive payments for caring for infected patients during a pandemic to support things like enhanced safety measures, patient care coordination, regional coordination, the cost of additional equipment or technology, maintaining or enhancing staffing, or whatever is required by the health emergency in question. A hospital that is proficient at treating patients who are infected with, or may become infected with COVID-19, may face a financial disadvantage, due in part to delays in resuming other essential elective care. These facilities are likely to end up seeing a larger portion of these patients from other hospitals, reducing or eliminating their ability to provide other care such as elective surgical care. Later, as many facilities begin to resume normal operations, these facilities are likely to be among the last to still have a significant number of infected patients, putting continued strain on resources and delaying routine care for other patients. This will put these facilities at a disadvantage for recovery for no other reason than that they were proficient at treating those affected by the pandemic.
This proposed payment model would differ from current alternative payment models (APMs) in that it would be seeking to reduce costs and improve the quality of care not when compared to a baseline of normal operations, but instead when compared to extreme circumstances such as the one we currently face due to COVID-19. Facilities wishing to participate might be required to meet additional requirements, such as preserving a stockpile of PPE and other equipment and supplies likely to be needed, maintaining some form of accreditation, developing and submitting annual infection control plans, or agreeing to retain appropriate staffing levels to ensure patient safety.

Health systems and hospitals would be able to prepare in advance and then, in times of a pandemic, access resources to care for those affected. Otherwise, taking the actions needed to care for these patients will put facilities at a financial disadvantage as they incur the costs of becoming proficient at caring for these complex patients. Such a concept would also allow future pandemic response to be less reactive and could serve as the core of a formal process for rapid learning and dissemination of information on disease progression and best practices. As an added benefit, the resources provided could help prevent a recurrence of the number of hospital closures we have seen as a result of the current pandemic. **Given the innovative nature of the model, it would likely require legislation from Congress directing CMS or CMMI to develop and implement such a proposal.**

**RECOMMENDATION 4.4: Remove red tape and allow states to use Public Health Emergency Preparedness and Hospital Preparedness Program (HPP) funds to respond to a public health emergency and report back to HHS on how they were used, rather than having to wait for written approval from Washington.**

A response structure such as a Regional Medical Operations Center (RMOC) is crucial to coordinate the current health care infrastructure and to enhance the public health infrastructure to support adequate testing and contact tracing to prevent major outbreaks. **ACS urges Congress to ensure sufficient PPE for all providers and encourage expansion of academic and private laboratories to support testing capacity.**

What changes can be made to Public Health Emergency Preparedness and Hospital Preparedness Program (HPP) to help states prepare and respond more quickly?
It is important to recognize that the nature of the pandemic may overwhelm the individual hospitals and clinicians in a community. When this phase of a pandemic occurs, the flex-surge should consider a coordinated RMOC. Many trauma systems have developed RMOCs that coordinate the distribution of patients across the healthcare system in the event of a disaster.¹ This framework has organized an effective response to COVID-19 across many communities by integrating a Medical Operations Coordination Cell (MOCC) with Emergency Operation Centers (EOCs) as was recently described by the Assistant Secretary for Preparedness and Response (ASPR) and the Federal Emergency Management Agency (FEMA) Healthcare Resilience Task Force.² MOCC’s coordinate the acute medical response, ensure availability of necessary care unrelated to the inciting event, and monitor for emerging outbreaks in long-term care facilities and other high risk. Such a center can aid with shared resources, bed control, maintenance of essential services in the community, shared learning about the pandemic care model, etc.

ACS believes that the HPP program should provide funding specifically to develop a structure of RMOCs, which would include stakeholders from local hospital and healthcare systems, public health, and emergency management experts. RMOCs must include a data collection process to create real time dashboards that track the number of COVID-19 cases and critical resources in the healthcare system, including ICU and acute care bed capacity, ventilators and PPE, and hospital staffing. Additionally, EMS agencies should report information on daily runs to facilitate the early identification of outbreaks, and all hospitals and EMS agencies must be required to submit these data. These data should roll up from the regions to the State Department of Health, which can then aggregate the state data can to the national level. Based on this data, RMOCs should then coordinate the distribution of patients across all hospitals in the region taking care to maintain capacity for the care of other emergency conditions in specialized center such as trauma and stroke centers.

When a region is reaching capacity, RMOCs should coordinate with the State EOC for patient movement to regions with capacity. RMOCs should also be required to develop a strategy to identify outbreaks in congregate living settings such as nursing homes, homeless shelters, and prisons and should provide support for these organizations in managing the outbreak including

¹ https://www.facs.org/covid-19/clinical-guidance/rmoc-setup
² https://register.gotowebinar.com/recording/256769356898835472
appropriate use of PPE and isolation and quarantine for patients not requiring hospitalization. **ACS urges Congress to consider funding specifically for RMOCs to help states prepare and respond more quickly to a public health emergency.**

*How can the federal government ensure all states are adequately prepared without infringing on states’ rights and recognizing states have primary responsibility for response?*

The federal government can support state preparedness by bolstering RMOCs, which are local entities that and are locally operated. For example, if state is exceeding capacity across their entire healthcare system, they would be able to request federal support for patient movement to neighboring states. **ACS recommends that the federal government establish the standards for a functional RMOC and incentivize states to implement this structure by providing financial support.** Doing so will provide better coordination at the state level.

*How should the federal government ensure agencies like CDC maintain an appropriate mission focus on infectious diseases in the periods between emergencies to strengthen readiness to respond when a new threat arises?*

There is considerable overlap in the role between federal agencies, such as ASPR, FEMA, DHS, and CDC who all have specific responsibilities in preparedness and can often be confusing or unclear as to which agency leads which component of a preparedness response. **The federal government should work to ensure that agencies maintain a “mission focus,” with clearly defined roles for any agency involved with pandemic response.**

**Who Is on the Flagpole? – Improve Coordination of Federal Agencies During a Public Health Emergency**

**RECOMMENDATION 5.2:** A key lesson from Crimson Contagion and COVID-19 is that plans and systems cannot be improved upon if they are not practiced. More training is needed, as well as more opportunities to exercise plans and processes nationwide.

*Is the Assistant Secretary for Preparedness and Response (ASPR) the right position to coordinate a whole-of-government response to a pandemic?*
The ACS believes that ASPR should be the primary office to coordinate a pandemic response. Additionally, the RMOC infrastructure needs to be developed, as described above, so that the ASPR can have a global view of the impact of the healthcare system across the entire country to determine where additional resources are needed and to support movement of patients out of a region that exceeds capacity.

*What is the appropriate role for HHS and how can FEMA be better integrated into a nationwide pandemic response?*

As discussed above, ACS notes that clearly defined roles and responsibilities are needed for every agency with pandemic response involvement. Within HHS, ASPR’s role should be focused on the response of health systems. FEMA, under the umbrella of the Department of Homeland Security, should focus on logistical support, such as the movement of supplies and mobilization of patient movement assets to support ASPR. In the instance of a natural disaster, FEMA should support temporary shelters, as well as food and water distribution, whereas ASPR should oversee the health system response and continue to support the national disaster medical system (NDMS) teams.

The CDC should focus on public health, which in the case of COVID-19 or another pandemic, is to provide guidance to the public and government officials regarding strategies to minimize the spread of the disease and to support testing capability and contact tracing by local health departments.

*Whose job is it to coordinate supply lines so that personal protective equipment, ancillary supplies, and medicines are available and delivered to where they are needed when they are needed?*

Under the RMOC structure discussed previously, ASPR would determine where supplies are needed, and FEMA would be responsible for the distribution of supplies to the designated areas.

*How can federal departments and agencies more effectively work together to respond to public health emergencies?*

In addition to defining clear roles, responsibilities, and expectations, every agency should also have the appropriate clinical expertise available to advise each agency with pandemic response and preparedness.
Thank you again for the opportunity to provide feedback on the lessons learned during the initial COVID-19 PHE. Please contact Carrie Zlatos in the ACS Division of Advocacy and Health Policy at czlatos@facs.org if you have any questions or need additional information. ACS looks forward to working with Congress to strengthen the nation’s preparedness and response to future pandemics.

Sincerely,

David B. Hoyt, MD, FACS
Executive Director