American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

April 26, 2023

The Honorable Mariannette Miller-Meeks, M.D.
1716 Longworth House Office Building
Washington, D.C. 20515

Dear Representative Miller-Meeks,

On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 members, I would like to thank you for the opportunity to respond to your request for information (RFI) regarding improving the Centers for Disease Control and Prevention (CDC), especially considering the response to the COVID-19 pandemic. As you well know, emergency physicians have served on the frontlines of the COVID-19 response since it first arrived in the United States more than three years ago and continue to stand at the ready to provide patients with the lifesaving emergency care they need. Our combined experience as physicians delivering direct patient care and participating in state, regional, and local planning of responses to various disasters and threats, equips us with distinct perspectives on the triumphs, shortcomings, and obstacles encountered in the United States' response to the pandemic. We must collectively learn from this experience and be better prepared for future public health emergencies, as the next infectious disease outbreak is a matter of *when*, not *if*. We appreciate the opportunity to offer practical policy solutions to improve our nation's disease control and prevention endeavors through the CDC.

Unfortunately, our nation's approach to managing infectious disease outbreaks, and other public health emergencies, has been consistently reactive and continues to be so. The COVID-19 pandemic exposed critical weaknesses, systemic failures, and a general lack of preparedness worldwide, despite previous outbreaks such as Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome Coronavirus (MERS-CoV) serving as clear indications that larger catastrophes were probable, particularly given the ease of global travel. Overall, the pandemic's global death toll and disruption of daily life were staggering, and its full impact is almost immeasurable and will likely be felt for decades to come.

The CDC must continue its mission, while improving collaboration and communication at the federal, state, and local levels, creating a stable and resilient data collection and information dissemination plan, and investing substantially in and better partnering with our nation's community emergency departments (EDs) that serve as the health care safety net. These are significant challenges, especially in the face of national and international threats, but they must be managed appropriately. Our recommendations for several priority areas are outlined on the following pages.

CDC Mission

The CDC's mission as the nation's health protection agency is vital in ensuring the overall health, safety, security, and well-being of our patients and communities. The

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CDC's work is particularly informative for emergency physicians who are on the frontlines of the health care system and typically the first or at least among the first to see emerging health threats and concerns. Not only is it helpful from a personal perspective as CDC guidelines can help clinicians protect themselves in care delivery settings, it also better equips emergency physicians with up-to-date knowledge on disease symptoms and treatment protocols.

The CDC's expanded mission beyond just communicable diseases has also benefited the public health infrastructure and knowledge base. For example, the CDC's focus on injury prevention is also integral to emergency medicine. efforts to conduct data surveillance and public health research on firearm morbidity and mortality prevention are vitally important, and we strongly encourage Congress to continue supporting and funding this much-needed work. While the CDC has long conducted data surveillance on this issue, the public health research function for morbidity and mortality prevention has only recently begun and the knowledge base is at a deficit due to a lack of federal funding for more than two decades. A comprehensive, rigorous, and evidence-based research approach will help develop the non-partisan opportunities and resources we need to address the public health issue of firearms violence, including preventable firearms-related injuries, suicides, violent crime, and accidental shootings. ACEP is deeply grateful for Congress' bipartisan work, especially that of congressional appropriators, to provide funding for the CDC in this capacity for four years now.

The agency also provides timely information on other public health threats and emergency preparedness, such as natural disasters, severe weather, chemical or radiation emergencies, and others. While there is overlap between other federal agencies, and there should be better coordination and determination of primary response roles at the federal level, all of these have a public health impact and are relevant to emergency medicine and to our communities as well.

An area for improvement for protecting the country from public health threats is improving the ability of the agency to update its internal processes in order to swiftly respond to urgent public health needs. The challenges faced by the CDC in developing its own COVID-19 test at the beginning of the pandemic underscore the need for the agency to make necessary updates to its processes. Delays caused by internal difficulties in developing the test highlighted weaknesses at the federal level. It is crucial that the problems encountered with the CDC's initial test are fully understood to avoid their recurrence in the future. We appreciate Congress' efforts to enhance third-party consultation to ensure the validity, accuracy, and reliability of in vitro diagnostic (IVDs) tests. Additionally, granting the Department of Health and Human Services (HHS) the ability to contract with public and private entities to aid in public health responses to pandemics and new infectious diseases is a positive step. To be better prepared for future outbreaks, there remains a pressing need for the development of a comprehensive plan to roll out new diagnostic tests swiftly and effectively as they are created. A standardized testing plan to facilitate testing at scale is imperative. It may be prudent to consider dual-track development for new tests, so if one test fails during development, a backup is available. Although quality standards may differ, establishing a set of guiding principles or another framework could prove beneficial. The implementation of such a framework would assist in ensuring the uniformity and quality of future tests developed and rolled out by the CDC.

Good Guidance Practices

Throughout a significant portion of the pandemic response, access to adequate personal protective equipment (PPE) was a frequent problem, due to overwhelming demand and frustratingly short supply. Thousands of emergency physicians, nurses, and other frontline health care workers risk their lives each day to provide care and were forced to reuse what are intended to be single-use protective supplies, threatening the safety of both the health care workforce and patients alike. Many hospitals and other health care entities claimed they had "sufficient" stockpiles of PPE, but that was only because they changed their protocols and required emergency physicians (and others) to utilize a single mask, or other PPE, for an entire shift (or longer) when that mask was designated as a one-time-use product. This very issue was highlighted at a Senate Homeland Security and

Governmental Affairs Committee hearing on June 9, 2020, when it was revealed that the Federal Emergency Management Agency (FEMA) was basing its analysis that it would have a sufficient stockpile of PPE in the fall on the assumption that frontline health care workers would be reusing their N95 masks and surgical gowns. This, of course, significantly increases the risk of contamination and possible infection for both emergency physicians and our patients. The definition of an adequate supply of PPE must be based on the equipment's intended use as a single-use item.

Especially at the beginning of the COVID-19 pandemic, there was a significant amount of confusion around best clinical practices and guidance, leading to different treatment and mitigation protocols and prevention strategies which created inconsistencies in care. To be sure, this is not entirely unexpected or wholly unreasonable in light of a novel virus, and the fact that so much was unknown in the early stages of the response and that guidelines rapidly and frequently changed. However, the CDC's process for updating treatment guidance was confusing and often opaque, and in the ACEP member COVID-19 communications hub where our members were sharing everything they knew and were learning about the disease, many emergency physicians frequently noted difficulty in ascertaining what changes had been made each time the guidance was updated.
Emergency physicians reused N95 respirators, masks, and other equipment because they were in the middle of a public health crisis and had no other option. Some health systems and facilities employed decontamination procedures for filtering facepiece respirators (FFR) like N95 masks, but these methods were not approved by the Centers for Disease Control and Prevention (CDC) and there remains only limited data on their effectiveness (though some methods of decontamination have shown promise, such as ultraviolet germicidal irradiation, vaporous hydrogen peroxide, and moist heat). Some emergency physicians found that certain decontamination methods only worked with particular brands or styles of respirators or masks, or that the procedures may shrink the mask or cause critical parts to become brittle and break. These issues may have harmful secondary effects as well by potentially rendering the equipment less effective (i.e., an ill-fitting mask does not provide the same level of protection) or reducing compliance. The U.S. Food and Drug Administration (FDA) did issue several emergency use authorizations (EUAs) for decontamination processes, but current CDC guidance still notes that there are no manufacturer-authorized methods for decontamination before reuse of these products and that "[o]nly respirator manufacturers can reliably provide guidance on how to decontaminate their specific models of FFRs."

These supply shortages also led to a notable amount of contention and animosity between different hospital services (emergency department vs. inpatient ward vs. critical care units), health care staff, and hospital administrators, as well as health care personnel and the CDC. Multiple incidents occurred in which health care staff were not allowed by hospital administrators to utilize personally-acquired PPE that the hospital could not supply. Furthermore, across the country, various levels of "airborne" vs. "droplet" precautions, protective measures, and cleaning protocols were utilized, sometimes because of the lack of PPE to conform to contemporary guidelines.

There were few health care professionals more acquainted with the fact that our health care system was in crisis, but even still, ACEP found it disconcerting that the CDC's initial recommendations regarding PPE were lower for emergency physicians and other frontline personnel than its own established requirements for what CDC lab workers wear when dealing with the same agent. This went unnoticed by the general public, but it did not by those who have worked in the high-risk infectious disease world and on the front lines of the pandemic response. Additionally, CDC guidance on return-to-work strategies for health care providers who tested positive for COVID-19 was often unclear and confusing and was different than for non-health care providers. There was little in terms of concrete guidance on when emergency physicians and frontline personnel should stay home after COVID-19 exposure or testing positive but without symptoms, and as a result, states, hospitals, and health care systems established their own policies. This led to frustration and confusion among many emergency physicians as many were asked to come to work even if they tested positive, or in some cases, even had mild symptoms.

Despite these difficulties and frustrations, ACEP was able to establish a line of communication with the CDC, and we were grateful for the opportunity to begin having constructive weekly conversations with the CDC to discuss best clinical practices, share experiences from the ground, and hear more about current or upcoming guidance that would affect emergency physicians and our patients. These conversations were productive both in terms of being able to better prepare and educate our members as knowledge, strategies, and treatment evolved, and in being able to help inform the CDC's own strategies based on the firsthand experience and input of emergency physicians. For example, in April 2021 when the CDC updated its strategies for optimizing the supply of N95 respirator masks, this updated guidance reflected changes that came about due to ACEP's ongoing meetings with the CDC.

Additionally, through partnership with the CDC, ACEP put significant resources and experience into developing and maintaining the ACEP COVID-19 Field Guide to support emergency physicians' efforts to treat the disease and provide better, more informed care to patients as new information, guidance, and best practices evolve. While these recommendations do not indicate an exclusive course of treatment or set a standard of medical care, they do provide information on a regularly updated basis that can help supplement the individual's clinical judgment based on the unique circumstances of the case and availability of resources. Guidance such as this was critical to emergency physicians on the frontlines.

For future public health emergencies such as disease outbreaks or other disaster scenarios, resources like the ACEP COVID-19 Field Guide should be actively disseminated by the CDC and communicated to stakeholders on the ground. The CDC should actively continue partnership with relevant stakeholders like physicians, other health care providers, and professional specialty organizations to gather, disseminate, and promote relevant guidelines and protocols for emerging threats, and better leverage the firsthand experience of those on the frontlines of such public health emergencies. These protocols should be based on the latest scientific research and should be clearly updated regularly as new information becomes available. The CDC should also invest in or better utilize existing communication channels that allow for the rapid dissemination of new guidance and clinical practices, including direct communication with specialty organizations (such as ACEP) that can quickly disseminate such information to clinicians.

Data and Surveillance

Among the weaknesses exposed by the COVID-19 pandemic was the continued lack of a sophisticated, integrated system for biosurveillance capabilities and public health data collection and reporting. Given technology that is currently available (and in many cases already in use at system, local, or state levels), it is incomprehensible that much of this data is still not publicly available in real-time or near-real-time. The CDC's National Syndromic Surveillance Program has become a critical tool for identifying and monitoring disease outbreaks and other public health emergencies in real-time. However, there is still room for improvement to enhance its readiness to confront emerging threats, particularly from the perspective of emergency physicians. One way to improve it is by expanding syndromic surveillance to encompass data from non-traditional sources to obtain a more comprehensive understanding of population health trends.

Emergency physicians can provide valuable input on the development of algorithms that integrate this data into the surveillance system to improve situational awareness. For instance, the CDC could utilize the critical data from the Clinical Emergency Data Registry (CEDR), which is the first emergency medicine specialty-wide registry developed by ACEP. CEDR has the capability and functionality to measure EM outcomes; identify practice patterns and trends; improve the quality of acute care; meet and exceed QPP/MIPs quality reporting requirements; and eliminate penalty and/or increase payer revenue. For CDC policymakers, the CEDR registry could provide further understanding around clinical effectiveness, patient safety, care coordination, patient experience, efficiency, and system effectiveness.

While clarifying federal roles and authorities in data collection is important and existing public health systems are in desperate need of modernization, we urge Congress and the CDC to also look to the private sector or other public partners to fully realize the goal of increased biosurveillance capabilities. For example, throughout much of the pandemic, decision-makers turned to the Johns Hopkins University COVID-19 dashboard to get information about the number of tests, reported cases, deaths, and recovered individuals. Many other public and private entities also developed unique and innovative data collection technologies that have helped identify new disease vectors, provide predictive modeling to track the evolution COVID-19 and new variants, or help assess medical supply chains and surge capacity, among others.

In emergency medicine, we believe in the concept of "best practices." Instead of reinventing or creating a government product, there should be more willingness to use what is available through other means and to leverage the new and innovative technologies that have emerged during the pandemic response. Ideally, the CDC could facilitate data sharing across different agencies and organizations by developing standard data sharing agreements and protocols that do not levy additional burdens on those providing care. This would help reduce redundancies in reporting and ensure that public health decisions are based on the most accurate and complete data available. Moreover, the data available internationally should be utilized in making decisions and predicting outbreaks.

ACEP also supports efforts to improve collaboration by the exchanging of public health data and reporting to public health data systems. A truly interoperable, seamless exchange of health data should be standard practice in everyday health care delivery, not just during public health emergencies. The lack of interoperability limits the ability of emergency physicians and public health officials to share information and coordinate response efforts efficiently. The CDC's National Syndromic Surveillance could benefit from a standardized, modular approach that allows it to integrate with other surveillance systems, such as electronic health records and biosurveillance systems, to create a more comprehensive view of public health. We urge legislators and regulators alike to exercise caution in how additional electronic data or information sharing standards are implemented and ensure that they do not impose additional burdens on physicians or further hinder clinical workflows, especially during times of crisis.

Finally, there is a need to improve the speed and accuracy of data reporting and analysis. Emergency physicians need timely, accurate, and actionable information to make informed decisions. The CDC can improve the quality of data by implementing quality control measures and investing in automated data cleaning and processing systems. Additionally, the CDC can enhance the analysis of syndromic surveillance data by implementing advanced analytics and machine learning algorithms that can identify patterns and anomalies in real-time, allowing emergency physicians to respond quickly to emerging threats.

Morbidity and Mortality Weekly Reports Development

The CDC's Morbidity and Mortality Weekly Reports (MMWRs) offer critical insights into the latest national health trends and were invaluable during the early days and throughout the height of the COVID-19 pandemic. These reports were consistently among the most frequently viewed topics on ACEP's website and regularly discussed in ACEP COVID-19 member communications channels.

Access to timely, relevant, accurate, and objective data is essential to the operation of the health care system, and particularly so for emergency physicians. Maintaining objectivity for federal resources such as these is of paramount importance, and, given the wide variety of already-available external sources of data surveillance and analysis, we would urge caution about implementing external or third-party reviews to the development of the MMWRs, or any other layers or protocols that could potentially delay the release of time-sensitive data and information, or, more concerningly, unduly influence the dissemination or conclusions of the reports and undermine their credibility among the public health and scientific communities.

Once again, thank you for the opportunity to share our comments regarding our experiences with the CDC and suggestions for improvements. Should you have any questions or require any further information, please do not hesitate to contact Ryan McBride, ACEP's Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,

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