March 9, 2022

Dawn O'Connell
Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Ref: 2023-2026 National Health Security Strategy

Dear Assistant Secretary O'Connell:

America’s Essential Hospitals appreciates the leadership of the Department of Health and Human Services (HHS) in confronting COVID-19 and tackling health inequities brought to the fore by the pandemic. As providers continue to invest significant resources into COVID-19 prevention and response, it is critical HHS’ Office of the Assistant Secretary for Preparedness and Response (ASPR) examine the related challenges as well as opportunities presented by the COVID-19 public health emergency (PHE) to help inform development of the 2023–2026 National Health Security Strategy (NHSS). We urge ASPR leaders to think critically about our nation’s response to the COVID-19 pandemic and our preparedness for future public health threats, with particular focus on health equity and the role of essential hospitals.

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including underrepresented people and underserved communities. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation’s uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Essential hospitals provide state-of-the-art, patient-centered care while operating on margins one-third that of other hospitals—2.9 percent on average compared with 8.8 percent for all hospitals nationwide.¹

Essential hospitals’ tight operating margins result in minimal reserves and low cash on hand. The difficulties associated with these narrow margins have been compounded by the strain on hospital finances and staff associated with responding to a pandemic that has entered its third year and continues to impact hospital capacity. Deepening these capacity limitations are health care staffing shortages, particularly among nurses, and high costs associated with hiring and retaining workers. Many essential hospitals have had hundreds of nursing vacancies at any given time during the PHE, and, with the high demand, they are left competing with other hospitals to recruit nurses even on short-term contracts. Further, the COVID-19 pandemic hit the patients and communities served by essential hospitals particularly hard—especially people

of color, who constitute more than half of essential hospitals’ discharges. COVID-19 also is detrimental to those with underlying health conditions; our member hospitals serve a disproportionate number of people facing social risk factors and compounding health issues, putting our members’ patients most at risk.

Many essential hospitals continue to struggle with financial challenges related to the pandemic and will continue to make substantial investments to maintain capacity for treating COVID-19 patients, as well as patients impacted by residual effects of the pandemic. We encourage ASPR to examine the comments below as part of the NHSS development process to ensure essential hospitals are equipped for their central role in the continued response to the COVID-19 pandemic and future public health threats.

1. The NHSS should ensure essential hospitals have the infrastructure—physical, workforce, and digital—to plan for and respond to future emergencies.

Under normal circumstances, essential hospitals meet their mission on slim margins. This often manifests as an inability to modernize hospital facilities or invest in technology upgrades, requiring external support for much-needed improvements. The COVID-19 PHE has highlighted and exacerbated infrastructure needs that existed in essential hospitals before the pandemic, including physical, workforce, and digital infrastructure. These hospitals have faced case surges that overwhelmed their capacity, along with shortages of supplies and personnel.

Further, hospital emergency plans changed day-to-day operations and workflows, and many hospitals were reconfigured to manage patient surge and minimize infection risk to patients and staff, including at alternative care settings. Essential hospitals converted wards to intensive care units, added beds to on-campus space not previously designated for patient care, and erected temporary structures on the premises. While the nimbleness with which essential hospitals adjusted and scaled their treatment capacity in response to COVID-19 illustrates their ability to quickly respond to crises, that ability carries a significant financial cost. The NHSS should address the investments required by essential hospitals to bolster the public health infrastructure and enhance preparedness for future emergencies.

Physical infrastructure improvements should be coupled with investments to bolster digital infrastructure, enabling essential hospitals to leverage telehealth and other capabilities to reach beyond their walls and into the communities where their patients live and work. The key role technology can play in linking patients to access and high-quality care has become increasingly evident amid COVID-19. Flexibilities provided during the PHE have enabled providers to rapidly increase the telehealth presence in their communities. Telehealth expands the reach of specialists and other providers, allowing hospitals to efficiently connect patients to high-quality care, increase access, and improve population health. Essential hospitals on the front lines of the COVID-19 pandemic used technology to connect their providers with patients in a variety of settings. The use of telehealth has been critical in screening potential COVID-19 patients and allowing other patients to maintain continuity of care with their primary and specialty care providers while respecting social distancing mandates. Though furnishing telehealth services doesn’t require the patient’s physical presence within the walls of a hospital, these services nonetheless require significant hospital and staff resources. The NHSS should support the use of telehealth as a mechanism to ensure continued access to care during an emergency.

2 Ibid.
Additionally, it is imperative resources are in place to support health care workers and ensure an adequate workforce can meet the surge of demand for treatment during emergencies. Staffing shortages not only could impact patient care, but also stretch staff’s mental health to the limits and add to the challenges for maintaining a healthy workforce at sufficient levels. Essential hospitals across the country continue to incur high costs in hiring and maintaining staff to respond to COVID-19. As a result of being understaffed, essential hospitals are seeing increased costs associated with hiring bonuses, retention bonuses, and increased salaries to recruit and retain nurses in short supply. The federal government should provide flexible and sufficient resources to meet increased staffing needs during PHEs, natural disasters, and periods of civil unrest.

The United States faces a significant and pervasive workforce shortage, especially in underserved communities. Estimates show there will be a shortage of up to 3.2 million health care workers by 2026, including a 10 percent increase in demand for mental health workers. Health care workers are a vital aspect of our health care system and key to our nation’s emergency preparedness and response strategy. The NHSS should reflect the value of their services and ensure greater workforce stability in times of crises. In the short-term, ASPR should conduct a national study to better understand health care workforce changes and challenges and ensure appropriate resources are committed to effective solutions. More training and residency slots for allied health professionals, nurses, and physicians also must be created and financially supported to address the current workforce shortage and meet the changing demands of tomorrow’s health care system. Further, additional slots should be targeted to meet the needs of underserved communities. Long-term actions include the development of policies that sustain a diverse, inclusive, and cohesive workforce that will reflect the nation’s multicultural communities and address health disparities. The NHSS should address the nation’s current and projected health care workforce shortage.

2. The NHSS should promote culturally appropriate collection of patient race, ethnicity, and language (REL) data and information on other social risk factors in a standardized and useful way to help identify disparities. The strategy should target planning and response activities to achieve equity.

Essential hospitals’ commitment to caring for all people, including marginalized populations, has made them providers of choice for patients of virtually every ethnicity and language. In 2019, more than half of discharges at essential hospitals were people of color. America’s Essential Hospitals and its members continually advance work to improve cultural competency, increase health literacy, and provide communication and language assistance. As providers of care for marginalized and underrepresented communities, essential hospitals deeply understand the need to identify gaps in care quality that exist and to eliminate disparities as a matter of public health. It is critical that health equity is integrated and aligned in the continued response to COVID-19 and in response to future public health threats. We applaud the new administration’s emphasis on health equity and efforts across agencies to evaluate appropriate initiatives to reduce health disparities. These efforts must include actions to identify disparities and ensure emergency planning and response activities are equitable and direct resources to those most in need.

Members of America’s Essential Hospitals understand the value of data and have responded diligently to gather, report, and update information related to COVID-19 throughout the pandemic. The unconscionable rates of COVID-19 infections and deaths among Black, Latino, and other people of color have emphasized the need for collection and analysis of data by race, ethnicity, and preferred spoken and written language of patients. Further, the COVID-19 pandemic has shown pervasive disparities only deepen during times of crisis. A Centers for Disease Control and Prevention (CDC) study of characteristics associated with hospitalization among patients with COVID-19 found a higher rate of hospitalizations among Black people. The agency noted these higher rates “might indicate that Black persons are less likely to be identified in the outpatient setting, potentially reflecting differences in health care access or utilization or other factors not identified through medical record review.” Data are critical to understanding the unique challenges and disparities patients face. While some data collection efforts in federal COVID-19 legislative packages sought to deepen our understanding of these disparities and their root causes, it is clear more can and should be done to ensure all Americans have equitable access to high-quality care—data will be critical to achieving equity.

America’s Essential Hospitals encourages the collection of patient demographic data in a culturally sensitive and linguistically appropriate manner. Limited documentation of REL and social determinants of health (SDOH) data hinders our capacity to understand and adequately address social barriers to positive health outcomes and to direct resources, including tailored public health education, to marginalized communities and others identified to be at high risk for poorer outcomes during a public health threat.

America’s Essential Hospitals supports efforts to improve the collection of SDOH information to better understand how these factors impact outcomes; this work is important in identifying the needs of our nation’s underrepresented patients. However, there are challenges to collecting SDOH data, including the sensitive nature of these conversations, a lack of alignment across screening tools, and a need to link data from medical and nonmedical sources (i.e., community services). When equipped with proper data, essential hospitals can innovate and collaborate with community partners to mitigate health disparities and improve outcomes. **It is critical that the NHSS address challenges in linking data from medical and nonmedical sources and offer guidance on how to capture such data in an actionable way that is informative to a variety of stakeholders during an emergency.**

3. **The NHSS should promote strategies that address SDOH in public health planning and response and support best practices that serve the unique needs of communities.**

CDC defines health equity as “when all members of society enjoy a fair and just opportunity to be as healthy as possible.” Further, the agency states “[p]ublic health policies and programs centered around the specific needs of communities can promote health equity.” Essential hospitals understand that factors driving health equity go well beyond the delivery of hospital care and are highly dependent on the characteristics and needs of a hospital’s patient population and the community it serves.


Our members recognize the effect of upstream social factors and are working to mitigate social determinants of poor health by screening patients for food insecurity, housing instability, and other social needs and referring these patients to community resources. By identifying the needs of their patient population, essential hospitals work tirelessly—and with limited resources—to eliminate disparities and provide cutting-edge care to all, regardless of income or insurance status. However, the COVID-19 pandemic has impeded these efforts and exacerbated the impact of social risk factors on patients served by essential hospitals. For example, essential hospitals providing care to patients experiencing homelessness faced a public health conundrum in helping those patients mitigate the spread of COVID-19. Transmissible diseases can spread quickly among those sleeping in close-quartered shelters and in outdoor encampments without hygiene facilities. However, mitigation strategies, like social distancing or isolation after exposure, are difficult for those without stable housing or who live in congregate settings, like shelters. Identifying this population for vaccination and other public health interventions, such as testing, also presented challenges. The NHSS should include actions to identify and address the underlying social needs that can lead to adverse outcomes during a public health threat.

Throughout the COVID-19 pandemic, innovation and collaboration at the local level provided a more coordinated and targeted response to serve the specific needs of communities. Shared data can uncover trends or illuminate other challenges and opportunities that could be missed in the absence of review by multiple stakeholders with different perspectives. The Healthcare Anchor Network (HAN) is an example of a collaboration that seeks to bring together health systems to share best practices and scale strategies that ultimately improve community health and well-being. HAN members have identified priority areas for the work they are advancing, including addressing upstream SDOH. Essential hospitals often serve as community anchors, with deep ties to the residents; this leads to a unique understanding of the nonclinical influences on patients and population health. When developing the NHSS, we encourage ASPR to examine the role of anchor institutions as critical partners to address issues of SDOH.

As ASPR develops the 2023–2026 NHSS, the challenges and opportunities we outlined are important components to ensure underrepresented people and underserved communities are prioritized in planning and response activities. We look forward to continued engagement and partnership on this topic.

If you have questions, please contact Senior Director of Policy Erin O’Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

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President and CEO