



January 2017

# PUBLIC HEALTH EMERGENCIES

HHS Needs to Better  
Communicate  
Requirements and  
Revise Plans for  
Assessing Impact of  
Personnel  
Reassignment

## Why GAO Did This Study

HHS provides funding to state, local, and territorial entities to help them prepare for and respond to public health emergencies, such as influenza pandemics and other threats. However, states have reported not having sufficient personnel to assist in public health emergencies. The Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA) authorized HHS to allow states and tribes to temporarily reassign personnel funded, in whole or in part, by HHS programs to aid in public health emergency response.

PAHPRA included a provision for GAO to examine the impact of the reassignment authority. However, the authority has not yet been used. Therefore, this report examines the processes HHS has in place to review states' and tribes' requests for temporary reassignment and evaluate the after-action reports states and tribes are to submit after they have used the authority. GAO reviewed HHS guidance and interviewed officials from HHS and five states selected based on their increased risks for public health emergencies and levels of prior federal grant funding received.

## What GAO Recommends

GAO recommends that HHS direct ASPR to (1) conduct outreach to HHS agencies and offices to inform them of ASPR's processes, expectations, and requirements for the reassignment authority; and (2) develop a plan to evaluate after-action reports to assess the authority's impact on emergency response and medical surge. HHS agreed with both recommendations and provided information on how ASPR plans to implement them.

View [GAO-17-187](#). For more information, contact Elizabeth H. Curda at (202) 512-7114 or [curdae@gao.gov](mailto:curdae@gao.gov).

## PUBLIC HEALTH EMERGENCIES

# HHS Needs to Better Communicate Requirements and Revise Plans for Assessing Impact of Personnel Reassignment

## What GAO Found

The Office of the Assistant Secretary for Preparedness and Response (ASPR), within the Department of Health and Human Services (HHS), has primary federal responsibility for overseeing medical and public health preparedness and response and coordinating the reassignment of personnel in a public health emergency. ASPR has developed processes to review and approve states' and tribes' requests for personnel reassignment. Should ASPR receive a request for personnel reassignment, it would convene relevant officials from the HHS agencies and offices from which states were requesting reassignment, with the goal of the agencies and offices considering requests and ASPR communicating reassignment decisions within four days. However, ASPR's efforts to communicate these processes to the HHS agencies and offices that administer programs eligible for personnel reassignment have been limited.

- Program officials—personnel responsible for day-to-day administration of programs eligible for reassignment—from two HHS agencies told GAO that they were generally unaware of the reassignment authority, ASPR's processes and time frames for reviewing and approving requests, or the program officials' expected role in approving requests.
- ASPR officials said that the office did not conduct targeted outreach to HHS agencies and offices to inform them of its processes, requirements, or expectations, noting that these entities should be aware of them through other channels, such as during the vetting of guidance on the use of the reassignment authority through HHS. However, officials from one agency said program officials are typically not directly involved in the vetting process.

Conducting outreach to HHS agencies and offices on ASPR's reassignment requests, review processes, and time frames would be consistent with federal internal control standards for information and communication, and would improve HHS agencies' and offices' awareness of expected roles, thereby preventing potential delays in decision making in the event of a public health emergency.

ASPR has assigned responsibility for reviewing after-action reports to HHS agencies and offices—an expectation program officials were also unaware of—and does not plan to conduct its own evaluations of the reports. HHS requires states and tribes that use the authority to submit after-action reports containing information on how the reassignment assisted their emergency response. In assigning report review responsibility to HHS agencies and offices, ASPR officials said that the HHS agencies and offices will be better able to identify the effect of the reassignments on their programs and take corrective actions as needed. However, ASPR's approach does not address the need to comprehensively assess the impact of reassignment on emergency response across HHS. Conducting its own evaluations of the after-action reports would be consistent with the federal internal control standard for monitoring, and would allow ASPR to determine whether the reassignment authority provides helpful resources for states' public health emergency response, as well as assess the effect of the authority across all participating HHS agencies and offices.

---

# Contents

---

Letter		1
	Background	4
	ASPR's Processes for the Reassignment Authority Were Not Well Communicated, and It Does Not Plan to Assess the Authority's Impact on Emergency Response	6
	Conclusions	13
	Recommendations	13
	Agency Comments and Our Evaluation	14
Appendix I	Examples of the Impact of Federal Preparedness Funding on Medical Surge Capacity and Public Health Response	16
Appendix II	Comments from the Department of Health and Human Services	20
Appendix III	GAO Contact and Staff Acknowledgments	23

---

## Abbreviations

ASPR	Office of the Assistant Secretary for Preparedness and Response
CDC	Centers for Disease Control and Prevention
HHS	Department of Health and Human Services
HPP	Hospital Preparedness Program
HRSA	Health Resources and Services Administration
PAHPRA	Pandemic and All-Hazards Preparedness Reauthorization Act of 2013
PHEP	Public Health Emergency Preparedness program

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



January 9, 2017

Chairman  
Ranking Member  
Committee on Health, Education, Labor and Pensions  
United States Senate

Chairman  
Ranking Member  
Committee on Energy and Commerce  
House of Representatives

The Department of Health and Human Services (HHS) provides funding to state, local, and territorial entities to help them prepare for and respond to public health emergencies, such as influenza pandemics, natural disasters, and other public health threats. After the H1N1 influenza pandemic of 2009, states receiving HHS preparedness funds reported that one barrier to their response efforts was not having sufficient personnel to assist in the response. The Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA) established a new authority allowing the HHS Secretary to authorize state or tribal governments to temporarily reassign—on a voluntary basis—state, local, and tribal public health personnel funded, in whole or in part, by certain federal programs to assist in public health emergency response.<sup>1</sup> In order for a governor or tribal leader to request personnel reassignment, the HHS Secretary must have declared a federal public health emergency that includes areas in the state or tribal area. PAHPRA also requires governors or tribal leaders (or their designees) to submit certain information with the reassignment request. HHS requires states and tribes that use the reassignment authority to subsequently submit reports, known as after-action reports, containing information on, among other things, how the reassignment assisted them in responding to the public health emergency; how, if applicable, medical surge capacity was

---

<sup>1</sup>Pub. L. No. 113-5, § 201, 127 Stat. 161, 170 (codified at 42 U.S.C. § 247d(e)). Personnel subject to reassignment must be funded in whole or in part through programs authorized under the Public Health Service Act (codified at 42 U.S.C., chapt. 6A). The authority also applies to the District of Columbia and U.S. territories through definitions supplied by the Public Health Service Act. For the purposes of this report, we mean “states” to also include the District of Columbia and U.S. territories.

---

improved through reassignment; and the impact the reassignment had on the funded programs from which personnel were reassigned.<sup>2</sup>

PAHPRA includes a provision for GAO to review the impact of the temporary reassignment authority on states' and tribes' public health emergency response. However, to date, no state or tribe has requested to use the reassignment authority.<sup>3</sup> Therefore, this report examines the processes HHS has in place to review states' and tribes' requests to use the temporary reassignment authority and evaluate their after-action reports on the use of this authority.

To determine the processes HHS has in place to review states' and tribes' requests to use the temporary reassignment authority and to evaluate their after-action reports on its use, we reviewed HHS guidance and other relevant documents that provide information on the temporary reassignment authority and compared the processes described in these documents with federal internal control standards.<sup>4</sup> We interviewed officials from HHS's Office of the Assistant Secretary for Preparedness and Response (ASPR) about their plans for reviewing and approving

---

<sup>2</sup>In public health emergencies, such as natural disasters, infectious disease outbreaks, or intentional terrorist attacks that have the potential to result in large numbers of ill or injured individuals, health care facilities and public health departments would need the ability to surge—that is, to have the staff, resources, and equipment in place to adequately care for increased numbers of affected individuals or individuals with unusual or highly specialized needs, including identifying alternate care sites and managing personnel and volunteers.

<sup>3</sup>The most recent federal public health declaration occurred in August 2016 for Puerto Rico, related to the Zika virus, which the HHS Secretary renewed in November 2016. As of the date of this report, Puerto Rico had not requested to use the PAHPRA reassignment authority. ASPR officials told us that the primary need during the declared emergency period is coordination and support between HHS, Puerto Rico, and local public health, and the office had not had any discussions with Puerto Rico regarding the need for personnel reassignment. Prior to the August 2016 Puerto Rico declaration, the last federal public health emergency that the HHS Secretary declared occurred in 2013, before the establishment of the temporary reassignment authority.

<sup>4</sup>GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: Nov. 1, 1999); and *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014). [GAO/AIMD-00-21.3.1](#) was effective through the end of fiscal year 2015 (Sept. 30, 2015). [GAO-14-704G](#) is the 2014 revision of [GAO/AIMD-00-21.3.1](#) and became effective the first day of fiscal year 2016 (Oct. 1, 2015). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

---

reassignment requests and for evaluating after-action reports on the use of the authority. We also interviewed officials from two HHS agencies that administered the largest number of programs eligible for reassignment.<sup>5</sup> Further, we interviewed officials from relevant stakeholder associations, such as the Association of State and Territorial Health Officials and National Indian Health Board, and five selected state departments of health to obtain information on HHS's coordination and communication with them regarding the use of the authority, requirements for submitting reassignment requests and reports on their use of the authority, and the nature and extent of any HHS evaluations of the required reports.<sup>6</sup> In determining which states to select, we considered those states that (1) received the largest amounts of federal grant funding in fiscal year 2015 to prevent terrorism and other catastrophic events, (2) are at higher risk for natural disasters (e.g., hurricanes, tornadoes, and earthquakes) that have the potential to result in public health emergencies, based on their geographic location, and (3) have the largest American Indian and Alaska Native populations (based on 2010 census information). The results of our analysis are intended to be illustrative; they are not generalizable to all state departments of health.

We conducted this performance audit from March 2016 to January 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

---

<sup>5</sup>The two HHS agencies are CDC and the Health Resources and Services Administration (HRSA). We spoke with officials representing a total of 10 funding programs eligible for reassignment—7 eligible CDC programs and 3 eligible HRSA programs.

<sup>6</sup>The Association of State and Territorial Health Officials is a national nonprofit organization that represents public health agencies and their employees in the United States, the U.S. territories, and the District of Columbia. The National Indian Health Board is a nonprofit organization dedicated to strengthening health care for American Indians and Alaska Natives and represents both tribal governments that operate their own health care delivery systems and those that receive health care directly from the Indian Health Service, an agency of HHS. The five states are California, Florida, New York, Texas, and Washington.

---

## Background

Natural disasters and infectious disease outbreaks, such as hurricanes Katrina and Sandy and the 2009 H1N1 influenza pandemic, have raised concerns about the ability of health care systems to “surge”—that is, to have the staff, resources, and equipment in place to adequately care for increased numbers of injured or ill individuals, or individuals with unusual or highly specialized needs. HHS has funded state, local, and territorial entities to help assist them in building their medical and public health emergency preparedness and response capabilities so that they can more effectively address these emergencies. This funding has been provided primarily through Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) program cooperative agreements—administered by HHS’s ASPR and Centers for Disease Control and Prevention (CDC), respectively.<sup>7</sup>

HPP and PHEP generally fund activities to achieve specified preparedness goals.<sup>8</sup> Accordingly, ASPR and CDC officials indicated that this funding is primarily available to support the development of preparedness capabilities and capacity and may be available to support emergency response activities in certain circumstances only. This limitation led to some states’ concerns about the lack of sufficient personnel to assist in the 2009 H1N1 response.

Appendix I provides additional information on the impact of HHS’s cooperative agreement funding on state and local medical surge capacity in public health emergency response.

---

<sup>7</sup>A cooperative agreement is a legal instrument used to provide financial support when substantial interaction is expected between a federal agency and a state, local government, or other recipient carrying out the funded activity. The 62 HPP and PHEP awardees comprise all 50 states, the District of Columbia, three large localities (Chicago, Los Angeles County, and New York City), and eight U.S. territories and freely-associated states—American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, the U.S. Virgin Islands, the Federated State of Micronesia, and the Republics of the Marshall Islands and Palau. For more information on HPP and PHEP, their goals, and progress awardees have made in meeting these goals, see GAO, *National Preparedness: Improvements Needed for Measuring Awardee Performance in Meeting Medical and Public Health Preparedness Goals*, [GAO-13-278](#) (Washington, D.C.: Mar. 22, 2013).

<sup>8</sup>According to the National Indian Health Board, tribes do not receive HPP and PHEP funding directly from HHS but may receive other eligible Public Health Service Act funding. In addition, agents furnishing services on behalf of tribes may receive such funding.

---

HHS also administers programs that provide funding to state and tribal governments that, among other things, allows them to hire public health personnel to carry out certain activities, such as tuberculosis prevention and control activities. These personnel could be eligible for reassignment under PAHPRA in cases where the respective state or tribe was attempting to increase their ability to surge. Specifically, personnel eligible for reassignment under the authority include state, local, and tribal personnel funded in whole or in part through programs authorized under the Public Health Service Act. HHS has identified about 100 Public Health Service Act-authorized programs across the department that are eligible for the reassignment authority—including, for example, CDC’s tuberculosis program and the Health Resources and Services Administration’s (HRSA) Ryan White HIV/AIDS program. Personnel eligible for reassignment may include administrative or leadership staff; environmental health specialists; epidemiologists; medical officers and nurses; safety and health specialists; mental and behavioral health personnel; and technical, logistical, or other support personnel. Public health emergency activities in which these personnel might assist include identifying and transporting patients to health care facilities or alternate care sites, managing mass fatalities, and helping to distribute medical countermeasures from federal and state caches.

---

## Requirements for the Temporary Reassignment Authority

The HHS Secretary delegated responsibility for reviewing and approving state and tribal requests for voluntary temporary reassignment to the HHS agency or office responsible for administering the program from which staff may be reassigned, with HHS’s ASPR responsible for coordinating the review process. If approved, reassignment authorizations are valid for no more than 30 days or until the HHS Secretary determines that the public health emergency no longer exists, whichever comes first.<sup>9</sup>

HHS has issued guidance regarding the circumstances in which the reassignment authority can be used, its requirements, and an overview of federal, state, and tribal responsibilities under the authority. The guidance for the temporary reassignment authority, which was developed by an intradepartmental workgroup led by ASPR, outlines the information states and tribes are required to submit when requesting use of the authority,

---

<sup>9</sup>In cases in which a public health emergency lasts longer than 30 days, the state or tribe may request a personnel reassignment extension for an additional 30 days.



---

such as the number of personnel to be reassigned, the federal program from which they are requesting reassignment, and assurance that the state's or tribe's current public health workforce cannot adequately and appropriately address the emergency without additional personnel. The guidance also notes that states and tribes that use the reassignment authority will be directed to submit after-action reports to ASPR within 120 days of the termination of the authorization. HHS published a notice of availability of the proposed guidance in the *Federal Register* in October 2013, providing a 60-day public comment period.<sup>10</sup> According to ASPR officials, HHS finalized the guidance in August 2015; HHS published the notice of the availability of the final guidance in the *Federal Register* in April 2016.<sup>11</sup> ASPR also posted the guidance on its website.

---

## ASPR's Processes for the Reassignment Authority Were Not Well Communicated, and It Does Not Plan to Assess the Authority's Impact on Emergency Response

HHS's ASPR has developed processes for HHS agencies and offices to review and approve states' and tribes' requests to temporarily reassign federally funded personnel in public health emergencies and to review the after-action reports these entities are required to submit on the effect of the personnel reassignment. ASPR's initial efforts to communicate information about these processes to states, tribes, and HHS agencies and offices were limited, though the office has begun to improve communication efforts to state and tribal public health officials. In addition, rather than conducting its own evaluations, ASPR plans to assign responsibility for reviewing after-action reports to the HHS agencies and offices that administer the programs from which personnel were reassigned, but which are generally not responsible for assessing the impact of the reassignment authority on public health emergency response.

---

## ASPR Has Developed Processes to Review Reassignment Requests and After-Action Reports

ASPR, as the designated HHS coordinator for the reassignment authority, has developed processes for implementing the reassignment authority and reviewing the after-action reports states and tribes are to submit. When states and tribes request to use the reassignment authority, ASPR will coordinate with the relevant HHS agencies and offices that administer the funding programs from which personnel are requested to be

---

<sup>10</sup>78 Fed. Reg. 60283 (Oct. 1, 2013).

<sup>11</sup>81 Fed. Reg. 18865 (Apr. 1, 2016).

---

reassigned to review and approve requests and communicate decisions back to states and tribes.<sup>12</sup> In September 2016, ASPR finalized a written procedure to supplement the April 2016 reassignment guidance. This procedure provides additional information on HHS’s roles, responsibilities, and time frames for reviewing and approving reassignment requests. According to the procedure, ASPR anticipates that HHS’s review and approval process will take as many as four business days: one day for ASPR to forward the request to the relevant HHS agencies and offices, two days for these agencies and offices to review the request and communicate the decision back to ASPR, and one day for ASPR to communicate that decision to the requesting state or tribe. ASPR noted that the review and approval process could be expedited as necessary. For the after-action reports, officials told us that ASPR plans to assign responsibility for their review to the HHS agencies and offices from which personnel are reassigned.

---

## Efforts to Communicate Processes to Stakeholders Have Been Limited

### *States and Tribes*

From the time the reassignment authority was established in 2013 through early 2016, ASPR provided limited information about states’ and tribes’ requirements for submitting reassignment requests and HHS’s processes and anticipated time frames for reviewing and approving them. ASPR’s initial communications provided general information only on the availability of the reassignment authority. In addition to publishing the availability of the 2013 proposed guidance on the reassignment authority in the *Federal Register*, ASPR and CDC jointly developed supplemental information for HPP and PHEP awardees in 2014 that included information about the availability of the reassignment authority, the eligibility of states and tribes to request this authority, and the publication of the proposed guidance. More recently, ASPR officials noted that they included information on personnel reassignment during an exercise at a 2015 preparedness summit convened by the National Association of County and City Health Officials, and presented information about the reassignment authority during a 2015 homeland security conference.

---

<sup>12</sup>ASPR staff within the HHS Secretary’s Operations Center will coordinate requests for temporary reassignment. ASPR officials told us that the office may also activate its Disaster Leadership Group—which ASPR convenes to discuss preparedness and response policy issues with senior HHS officials—to coordinate the reassignment review and approval process.

---

ASPR's initial communication efforts, however, may have not reached a broad audience of states and tribes, or contained up-to-date information. For example, public health officials from all states or tribes may not have attended the 2015 preparedness summit or participated in the exercise. In addition, while some public health officials may attend homeland security conferences, these events are typically targeted to homeland security, law enforcement, and emergency management officials. These officials may be located in separate departments from public health officials, depending on how the state is organized, and are unlikely to be the officials who would be requesting personnel reassignment or submitting after-action reports.<sup>13</sup> ASPR officials told us that the office also provided the attendees at the June 2015 homeland security conference with information contained in the 2013 proposed guidance; however, ASPR subsequently updated the guidance to include certain changes that were issued in the 2016 final guidance. For example, the final guidance contains information about ASPR's process for coordinating and reviewing reassignment requests and approvals, anticipated time frames for doing so, and expectations for HHS agencies to participate in the approval process. The final guidance also increased the amount of time states and tribes have to submit after-action reports from 90 to 120 days after the personnel reassignment period ends, and provides notice that submitting required after-action reports is tied to the award of program funds. ASPR officials told us that the availability of the authority was not dependent on the publication or finalization of the guidance, and that states and tribes would become familiar with processes and requirements as a result of using the authority in actual public health emergencies.

Public health officials from the five states we reviewed were unaware of ASPR's planned processes for reviewing reassignment requests and after-action reports, and most noted that additional direct outreach to provide information or required request forms would be useful. While these officials were generally aware of the reassignment authority provided by PAHPRA, none of them were aware that the reassignment guidance had been finalized in April 2016 until we shared this information

---

<sup>13</sup>For example, all five states we reviewed had separate public health and emergency management departments. In some cases, we met with officials representing both of these state departments, but the public health department officials provided the bulk of the information on their knowledge and awareness of the reassignment authority and on the state's public health emergency response functions.

---

with them in summer 2016. Officials from three of these five states were also not aware of the 2013 proposed guidance, which had established specific requirements for submitting requests and after-action reporting responsibilities. Officials from three states we reviewed said that they generally anticipated having enough personnel to respond to public health emergencies and would likely not need to request further assistance.<sup>14</sup> However, officials from one of these states, as well as officials from the two remaining states in our review, told us that they would potentially use the authority in protracted public health emergencies that were at least several weeks in duration or catastrophic enough to overwhelm state resources. For example, officials from one state believed that the authority would be useful in protracted emergencies even with their estimation that it would take 10 to 14 days both for the state to prepare the reassignment request and for HHS to approve it.

Since the time that we spoke to selected states for this review, ASPR has developed additional information and documents for the reassignment authority and plans to increase its communication efforts. For example, in addition to the September 2016 written procedure to guide HHS's review and approval processes, ASPR finalized a personnel reassignment request template in October 2016 and posted it on the ASPR temporary reassignment website.<sup>15</sup> ASPR officials told us that the office included the reassignment authority and guidance as part of a discussion on grants management at a late October 2016 meeting for state directors of public health preparedness held by the Association of State and Territorial Health Officials. ASPR officials also said that they planned to provide information about the reassignment authority and guidance at the next annual National Association of County and City Health Officials preparedness summit scheduled for April 2017, and during regular meetings that ASPR and CDC hold with HPP and PHEP awardees.

---

<sup>14</sup>These three states had state policies or regulations that established terms for state employee participation in emergency response as a condition of employment, thus providing surge capacity they could use before requesting personnel reassignment from HHS.

<sup>15</sup>See *Guidance for Temporary Reassignment of State and Local Personnel during a Public Health Emergency*, accessed November 2, 2016, <http://www.phe.gov/Preparedness/legal/pahpa/section201/Pages/default.aspx>. In the beginning of November 2016, ASPR also posted information about the reassignment authority and reassignment requests with links to the request template and the written procedure to its blog.

---

### *HHS Agencies and Offices*

ASPR provided limited information to the HHS agencies and offices that administer eligible funding programs about the processes for reviewing and approving requests, reviewing states' and tribes' after-action reports, or specific details about requirements for reassignment requests or after-action reports. The federal internal control standard for information and communication states that effective communication with internal parties is necessary to achieve an entity's objectives.<sup>16</sup> This standard calls for management to communicate information down and across reporting lines to enable personnel to perform key roles in achieving objectives. ASPR officials told us that HHS agencies and offices should be aware of the requirements for reviewing and approving states' and tribes' requests because ASPR vetted the proposed guidance throughout the department. ASPR officials also said that HHS agencies and offices had the opportunity to review the final guidance, which incorporated public comments, during the vetting process that occurred from 2014 to 2016. In August 2016, ASPR finalized language regarding the availability of the reassignment authority for eligible funding programs and requested that HHS disseminate this language to HHS agencies and offices for them to include in their future funding opportunity announcements. In addition, ASPR officials told us that it vetted its September 2016 written procedure through HHS. ASPR plans to continue to provide information about the authority to HPP and PHEP awardees in regular meetings but has no plans to provide additional information to the HHS agencies and offices that administer other programs eligible for reassignment.

HHS program officials who are likely to be asked by ASPR to review and approve temporary reassignment requests and review after-action reports may not be aware of their responsibilities for these activities through such vetting of the guidance, and these officials may not have seen either version of the guidance or the written procedure. For example, HRSA officials we interviewed said that program officials are not directly involved in their agency's vetting process, which usually occurs at the senior management level.<sup>17</sup> ASPR officials told us they would contact relevant

---

<sup>16</sup>GAO/AIMD-00-21.3.1 and GAO-14-704G. The federal internal control standard for information and communication states that management should communicate the necessary quality information to achieve the entity's objectives.

<sup>17</sup>HRSA officials told us that HHS's Office of the General Counsel presented information on the authority to senior HRSA staff in March 2016.

---

HHS grants management staff, including program officials, when they received a reassignment request. However, the agency has not created a roster of specific program officials: those grants management and other staff responsible for day-to-day management of eligible funding programs who would be charged with approving reassignment requests. Instead, ASPR officials said the office would coordinate with the other HHS agencies and offices that may be able to help facilitate the approval process with their agency's grants management staff and program officials. In addition, neither the final guidance nor the written procedure provides direction on how HHS agencies and offices are to review states' and tribes' after-action reports.

Our interviews with officials from selected CDC and HRSA programs confirmed that these officials were not aware of the reassignment authority and the related guidance, ASPR's expectations regarding rapid convening of program officials to make decisions on reassignment requests, or their responsibilities for reviewing after-action reports. While officials from CDC's and HRSA's public health emergency response offices told us that they were aware of the authority and the guidance, they acknowledged that they had not discussed any information regarding the authority with the agencies' program officials.<sup>18</sup> HRSA's emergency coordinator told us that he is generally familiar with the purpose of after-action reports. As such, while HRSA does not have a plan to review the after-action reports, the agency is aware that it can use these reports to determine what effect, if any, personnel reassignment had on meeting the program's original goals, identify any needed corrective actions, and execute those actions, according to this official. However, without more specific outreach on the part of ASPR about decision making for reassignment requests, reporting requirements, and its process for reviewing after-action reports, HHS officials that administer the funding programs may be unaware of their expected roles in reviewing and approving reassignment requests and reviewing after-action reports,

---

<sup>18</sup>CDC public health emergency preparedness and response officials told us that the agency assisted ASPR in developing the processes for reviewing and approving reassignment requests. HRSA's emergency coordinator told us that he participated in HRSA's review of the 2013 proposed guidance—which did not include information about the review process—but had not participated in working through the request, approval, and reporting processes with ASPR.

---

which may negatively affect states' and tribes' public health emergency response.

---

### ASPR Does Not Plan to Evaluate the Impact of the Reassignment Authority on Public Health Emergency Response

ASPR will not be able to fully assess the impact of personnel reassignment on public health emergency response because it does not plan to conduct its own evaluations of states' and tribes' after-action reports. Instead, according to ASPR officials, it plans to assign responsibility for reviewing these reports to the HHS agencies and offices that administer the programs from which personnel were reassigned, because ASPR believes that these other HHS agencies and offices are better able to identify the effect of the reassignment on their funding programs and take corrective action as needed.

However, ASPR is the federal office with primary responsibility for overseeing medical and public health preparedness and response. Therefore, its assigning of sole responsibility for reviewing after-action reports to other HHS agencies and offices is contrary to the federal internal control standard for monitoring, which calls for management to evaluate the results of monitoring activities to identify internal control issues and for the oversight body to conduct evaluations across the organization and take corrective action.<sup>19</sup> Because some of the information that ASPR requires states and tribes to report—specifically, those elements related to the effect of personnel reassignment on emergency response and medical surge capacity—is generally outside the responsibility of the other HHS agencies and offices, this information may not be fully or appropriately monitored and assessed across the department if ASPR does not conduct its own evaluations. Specifically, without evaluating after-action reports to determine the impact on emergency response, ASPR will not be able to comprehensively determine whether the reassignment authority is useful in providing resources for states and tribes to respond to public health emergencies and improve medical surge. ASPR will also be unable to provide technical assistance to states and tribes related to improving their use of the

---

<sup>19</sup>[GAO/AIMD-00-21.3.1](#) and [GAO-14-704G](#). The federal internal control standard for monitoring states that management should evaluate and document internal controls and determine appropriate corrective actions for any deficiencies on a timely basis, including resolution of audit findings.

---

authority, if needed, or seek any necessary changes to the authority or the guidance.<sup>20</sup>

---

## Conclusions

Given the need to respond quickly to public health emergencies that have the potential to overwhelm states' and tribes' medical and public health resources and severely delay the provision of critical medical services for affected individuals, HHS agencies and offices should have a thorough understanding of their responsibilities in reviewing requests to use the temporary reassignment authority. Therefore, HHS and, specifically, ASPR, would benefit from conducting targeted, timely outreach to other HHS agencies and offices to provide information on HHS's processes, expectations, and requirements for using the authority prior to any further federal public health emergency declarations. In addition, given its responsibility for federal medical and public health preparedness and response, ASPR would benefit from conducting its own comprehensive evaluations of states' and tribes' after-action reports on the effect of the authority on public health emergency response, including medical surge.

---

## Recommendations

To help ensure that HHS agencies and offices fully understand the requirements and processes for the temporary reassignment authority, their responsibilities under the authority, and that ASPR is adequately and comprehensively assessing the effect of the authority on public health emergency response and medical surge, we recommend that the Secretary of HHS direct ASPR to take the following two actions:

- ASPR should conduct outreach to HHS agencies and offices that administer programs eligible for the reassignment authority to inform them of their responsibilities and ASPR's expected time frames for reviewing and approving states' and tribes' requests for personnel reassignments, and inform them of their responsibilities and ASPR's expectations for reviewing states' and tribes' after-action reports.
- ASPR should develop a plan to evaluate states' and tribes' after-action reports to assess the impact of the reassignment authority on

---

<sup>20</sup>The temporary reassignment authority will terminate at the end of fiscal year 2018 unless Congress extends it.



---

states' public health emergency response and medical surge and to provide technical assistance as necessary.

---

## Agency Comments and Our Evaluation

We provided a draft of this report to HHS, and its comments are reprinted in appendix II. In its comments, HHS concurred with both of our recommendations. For the first recommendation that ASPR should conduct outreach to HHS agencies and offices that administer the programs eligible for reassignment, HHS told us that ASPR intends to continue to provide information on reassignment procedures through the information posted on its website and sharing language to describe the applicability of the authority to specific grants with HHS agencies and offices that administer the eligible programs. In addition, ASPR plans to continue to provide reassignment information during regular meetings with HPP and PHEP awardees and public health preparedness meetings with relevant stakeholder associations. We encourage ASPR to expand its outreach beyond including reassignment information in eligible funding announcements to include those HHS agencies and offices that administer eligible programs other than HPP and PHEP.

For the second recommendation that ASPR develop a plan to conduct its own evaluations of after-action reports, HHS provided information on ASPR's corrective action process for learning from and improving on past emergency response and told us that ASPR plans to incorporate reviews of states' and tribes' after-action reports into these corrective action reviews in the future, as applicable. In addition, HHS provided technical comments, which we incorporated, as appropriate.

We also provided relevant sections of the draft report to state departments of health for the five states in our review (California, Florida, New York, Texas, and Washington) and incorporated their technical comments, as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services and appropriate congressional committees. In addition, this report is available at no charge on the GAO website at <http://www.gao.gov>.

---

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or [curdae@gao.gov](mailto:curdae@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

A handwritten signature in black ink, reading "Elizabeth H. Curda". The signature is written in a cursive style with a large initial "E" and "C".

Elizabeth H. Curda  
Acting Director, Health Care

---

# Appendix I: Examples of the Impact of Federal Preparedness Funding on Medical Surge Capacity and Public Health Response

---

In mass casualty public health emergencies, such as natural disasters, infectious disease outbreaks, or intentional attacks, health care facilities and public health departments would need the ability to surge—that is, to have the staff, resources, and equipment in place to adequately care for increased numbers of injured or ill individuals or individuals with unusual or highly specialized needs, including identifying alternate care sites and managing personnel and volunteers. The Department of Health and Human Services (HHS) provides funding through Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) program cooperative agreements to assist state and local public health agencies in building their public health emergency preparedness and response capabilities, including for medical surge.<sup>1</sup> To provide examples of the impact that HPP and PHEP funding has had on awardees' medical surge capacity, we reviewed literature, interviewed public health officials from five selected states, and reviewed information from the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) website.<sup>2</sup> Examples from the literature review are from peer-reviewed sources.

---

## Examples from the literature review

We reviewed literature published between 2011 through May 2016 from multiple U.S. sources, including scholarly and peer-reviewed materials; government reports; trade or industry articles; books; conference papers; association, nonprofit, and think tank publications; working papers; and congressional hearings and transcripts. We identified two peer-reviewed articles that provided examples of how HPP or PHEP funds assisted in public health emergency response. In one article, representatives from the North Dakota Department of Health reported on how HHS funding helped it prepare for and respond to river floods in 2009, 2010, and 2011, including in the areas of medical surge, medical material management,

---

<sup>1</sup>We previously reported on the effect that day-to-day emergency department crowding could have on medical surge capacity for injured or ill individuals during mass casualty events. GAO, *National Preparedness: Improvements Needed for Measuring Awardee Performance in Meeting Medical and Public Health Preparedness Goals*, [GAO-13-278](#) (Washington, D.C.: Mar. 22, 2013).

<sup>2</sup>The five states we reviewed were California, Florida, New York, Texas, and Washington. In selecting these states, we considered 2015 grant funding to prevent terrorism and other catastrophic events and geographic location.

and volunteer management.<sup>3</sup> For example, to manage medical surge, North Dakota had previously used HPP and PHEP funding to purchase kits to convert buses into emergency transport vehicles that allowed for wheelchair and stretcher transport, which the state used in its response to the 2011 floods. According to the article, these converted buses were less costly than ambulances used in previous floods. In addition, North Dakota had previously implemented a patient tracking database, which required all hospitals, long-term care facilities, and emergency medical services responders in the state to agree to use a triage and tagging process. The database and triage process provided unique identifiers and transport requirements for each patient, as well as identifying patients requiring priority placement, such as those patients undergoing dialysis. During the 2011 floods, North Dakota used the database to document patients' evacuation to alternate health care facilities and then to discharge (or death). In the area of volunteer management, North Dakota had previously used HPP funding to contract with licensure boards to provide regular and automatic uploads of licensure information from licensure databases, which allowed the state to expand its pool of volunteer health professionals during the 2011 flood response from those volunteers previously registered with the state. In addition, in 2011, North Dakota improved its credentialing process to allow for rapid, provisional credentialing of "spontaneous" medical volunteers—those volunteers who showed up to response sites to assist but were not previously registered in the volunteer database.

Another article described how HPP funding helped various North Carolina organizations, such as North Carolina's Wake County Department of Emergency Medical Services and hospitals in the Raleigh-Durham area, prepare for and respond to an explosion at an industrial plant in June 2009.<sup>4</sup> Under the HPP component of surge planning for burn injuries, the burn surge program developed by North Carolina included providing education for those clinicians working outside of burn centers, planning

---

<sup>3</sup>T. W. Weidrich, J. L. Sickler, B. L. Vossler, and S. P. Pickard, "Critical Systems for Public Health Management of Floods, North Dakota," *Journal of Public Health Management and Practice*, vol. 19, no. 3 (2013).

<sup>4</sup>R. D. Kearns, B. Myers, C. B. Cairns, P. B. Rich, C. S. Hultman, A. G. Charles, S. W. Jones, G. L. Schmits, M. B. Skarote, J. H. Holmes IV, and B. A. Cairns, "Hospital Bioterrorism Planning and Burn Surge," *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science*, vol. 12, no. 1 (2014).

for emergency medical services surge, medical triage, and regional hospital coordination. As a result of this planning, all 68 individuals injured during the explosion were evaluated at the three level I trauma centers and three community hospitals in the Raleigh-Durham area by the end of the day.<sup>5</sup> According to the article, the state's planning efforts contributed to an effective response and positive patient outcomes, including improvements in response times from prior public health emergencies.

---

Examples from interviews with state public health officials

Officials from all five states in our review provided examples of how HPP or PHEP funding assisted in public health emergency response.

- According to officials from the Florida Department of Health, after the June 2016 shooting at the Pulse nightclub in Orlando, Florida, which resulted in 50 fatalities, the department activated its emergency mortuary operations response system, a public-private partnership that had been previously established by HPP and PHEP funding. Officials told us that the department received the request for resources at 8 a.m. on the morning after the shooting and had mortuary response volunteers onsite 90 minutes later to assist with autopsies and victim identification.
- After an explosion at a fertilizer plant in West, Texas, in 2013, the state was able to assemble dozens of ambulances, set up a field hospital, and convene clinicians to treat casualties in a matter of hours through capabilities and systems previously established by HPP and PHEP funding, according to an official from the Texas Department of State Health Services.
- In addition, public health officials from the three other states in our review—California, New York, and Washington—provided information on how HPP and PHEP funding helped support emergency response. Specifically, these states were able to use HPP and PHEP funding to

---

<sup>5</sup>According to the American Trauma Society, trauma center levels (I, II, III, IV, or V) refer to the kinds of resources available in a trauma center and the number of patients admitted yearly. The categorization of trauma center level varies from state to state (including distinctions of adult and pediatric centers). A level I trauma center generally refers to a center that is capable of providing total care for every aspect of injury from prevention through rehabilitation, including 24-hour in-house coverage by general surgeons and prompt availability of care in specialties such as anesthesiology, emergency medicine, and pediatric and critical care, as well as other specialties.

establish systems and purchase resources to coordinate evacuations of health care facilities during wildfires in California and Washington and hurricanes Irene and Sandy in New York; access provider networks to provide timely behavioral health care after the December 2015 mass shooting in San Bernardino, California; and coordinate and manage volunteers to assist with victim identification after a March 2014 landslide decimated a town of 43 people in Washington.<sup>6</sup>

---

Other sources of information

ASPR also collects examples of how HPP funding has enhanced medical and public health emergency response on its website.<sup>7</sup> For example, HPP funding has been used to establish communications systems, systems for tracking and triaging patients, and coalitions of health care facilities to assist in the response to the May 2015 derailment of an Amtrak train in Philadelphia; to purchase interoperable communications equipment to assist in making evacuation decisions during wildfires in Colorado in 2013; and to establish a drive-through seasonal influenza vaccination site in Virginia in October 2015.

---

<sup>6</sup>According to officials from the California Department of Public Health, the state was able to access provider networks for behavioral health care as a result of using HPP and PHEP funding to establish a statewide medical and public health mutual aid system. This system provides a structure for areas affected by emergencies to request and receive resources from other areas.

<sup>7</sup>*HPP In Action: Stories from the Field*, accessed October 24, 2016, <http://www.phe.gov/Preparedness/planning/hpp/events/Pages/default.aspx>.

# Appendix II: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

DEC 15 2016

Elizabeth H. Curda  
Acting Director, Health Care  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Ms. Curda:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*PUBLIC HEALTH EMERGENCIES: HHS Needs to Better Communicate Requirements and Revise Plans for Assessing Impact of Personnel Reassignment*" (GAO-17-187).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in black ink that reads "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: PUBLIC HEALTH EMERGENCIES: HHS NEEDS TO BETTER COMMUNICATE REQUIREMENTS AND REVISE PLANS FOR ASSESSING IMPACT OF PERSONNEL REASSIGNMENT (GAO-17-187)**

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

**Recommendation**

To help ensure that states, tribes and HHS agencies and offices fully understand the requirements and processes for the temporary reassignment authority, their responsibilities under the authority, and that the Office of the Assistant Secretary for Preparedness and Response (ASPR) is adequately and comprehensively assessing the effect of the authority on public health emergency response and medical surge, we recommend that the Secretary of HHS direct ASPR to take the following two actions:

- ASPR should conduct outreach to HHS agencies and offices that administer programs eligible for the reassignment authority to inform them of their responsibilities and ASPR's expected time frames for reviewing and approving states' and tribes' requests for personnel reassignments, and inform them of their responsibilities and ASPR's expectations for reviewing states' and tribes' after-action reports.
- ASPR should develop a plan to evaluate states' and tribes' after-action reports to assess the impact of the reassignment authority on states' public health emergency response and medical surge and to provide technical assistance as necessary.

**HHS Response**

HHS concurs with GAO's recommendations. ASPR has taken steps to conduct outreach to HHS agencies and offices that administer programs eligible for the temporary reassignment authority. For example, ASPR and the HHS Office of Grants and Acquisition Policy and Accountability have prepared language to describe the applicability of the authority to specific grants, and it has been shared with HHS agencies and offices that administer programs eligible for the authority. ASPR also updated its website to be a central source for information on the authority, including guidance documents and the request template where states and tribes can request reassignment. The website is available at: <https://www.phe.gov/Preparedness/legal/pahpa/section201/Pages/default.aspx>. The documents include information on states' and tribes' responsibilities with respect to submitting requests and after-action reporting, as well as the responsibilities of HHS agencies and offices to review and approve requests.

ASPR intends to continuously socialize the temporary reassignment authority and procedures to relevant stakeholders. For example, ASPR plans to provide reassignment information through regular meetings with Hospital Preparedness Program and Public Health Emergency Preparedness awardees and through public health preparedness meetings with relevant stakeholder associations.

Regarding the recommendation that ASPR develop a plan to evaluate states' and tribes' after-action reports to assess the impact of the authority, ASPR prioritizes the implementation of corrective actions and continues to refine procedures and capabilities in order to learn and improve from past responses and mitigate lasting effects of public health and medical emergencies. ASPR incorporates a systematic approach in its corrective action process to ensure



**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: PUBLIC HEALTH EMERGENCIES: HHS NEEDS TO BETTER COMMUNICATE REQUIREMENTS AND REVISE PLANS FOR ASSESSING IMPACT OF PERSONNEL REASSIGNMENT (GAO-17-187)**

that HHS is poised to achieve success in preparedness, response, and recovery from public health and medical incidents.

ASPR also has a formal system in place to capture lessons learned and ultimately leverage them to strengthen the health and emergency response systems in place. Following each response, when appropriate, ASPR conducts professional discussions between HHS response entities and state, local, and interagency partners through participation in interagency committees and through staff level engagements and meetings in order to identify any issues with the response.

ASPR plans to incorporate state and tribal after-action reports on their use of this authority in future corrective action reviews when applicable.

---

# Appendix III: GAO Contact and Staff Acknowledgments

---

---

## GAO Contact:

Elizabeth H. Curda, (202) 512-7114 or [curdae@gao.gov](mailto:curdae@gao.gov).

---

## Staff Acknowledgments:

In addition to the contact named above, Karen Doran, Assistant Director; Shana R. Deitch, Analyst-in-Charge; and Shaunessye D. Curry made key contributions to this report. Also contributing were George Bogart, Sarah Gilliland, and Drew Long.

---

---

## GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

---

## Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (<http://www.gao.gov>). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to <http://www.gao.gov> and select "E-mail Updates."

---

## Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, <http://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

---

## Connect with GAO

Connect with GAO on [Facebook](#), [Flickr](#), [Twitter](#), and [YouTube](#).  
Subscribe to our [RSS Feeds](#) or [E-mail Updates](#). Listen to our [Podcasts](#).  
Visit GAO on the web at [www.gao.gov](http://www.gao.gov).

---

## To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: <http://www.gao.gov/fraudnet/fraudnet.htm>

E-mail: [fraudnet@gao.gov](mailto:fraudnet@gao.gov)

Automated answering system: (800) 424-5454 or (202) 512-7470

---

## Congressional Relations

Katherine Siggerud, Managing Director, [siggerudk@gao.gov](mailto:siggerudk@gao.gov), (202) 512-4400,  
U.S. Government Accountability Office, 441 G Street NW, Room 7125,  
Washington, DC 20548

---

## Public Affairs

Chuck Young, Managing Director, [youngc1@gao.gov](mailto:youngc1@gao.gov), (202) 512-4800  
U.S. Government Accountability Office, 441 G Street NW, Room 7149  
Washington, DC 20548

---

## Strategic Planning and External Liaison

James-Christian Blockwood, Managing Director, [spel@gao.gov](mailto:spel@gao.gov), (202) 512-4707  
U.S. Government Accountability Office, 441 G Street NW, Room 7814,  
Washington, DC 20548



Please Print on Recycled Paper.