



**Healthcare Leadership Council**  
**Public-Private Partnership on Disaster Preparedness**

**September 1, 2020**



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## Background

In late 2019, Deloitte was asked to assess the opinions of the members of the Healthcare Leadership Council (HLC) regarding the role of the private sector in disaster preparedness and response in the United States. Deloitte conducted this work on a pro bono basis to advance the thinking in this critical area. Our approach was two-fold: interview a subset of HLC members to gather their opinions and present the best thinking of Deloitte's internal experts. Deloitte had a preliminary conversation with HLC members at the in-person Patient Safety and Quality task force meeting at the end of January. Before we could begin the project in earnest, the U.S. began preparing and responding to the COVID-19 pandemic. While it made the project immediately relevant, both HLC and Deloitte decided to delay the start due to the potential participants being under significant pressure to organize their company's response to the pandemic.

Once we launched the project, we had originally expected to conduct around a dozen interviews. We ultimately conducted 21 Zoom interviews between June 11 and July 16, 2020. Several of the interviews involved more than one person, so we spoke with 26 people. A roster of all interviewees can be found in the Appendix, as can the questionnaire we used. People were remarkably cooperative and forthcoming with their time. We experienced scheduling issues that prevented connecting with only one prospective participant. The interviews were 30 minutes, and, while we generally covered many topics, we were never able to address all questions with all participants. In some cases, participants volunteered to submit written responses, which were gladly accepted. We did not ask participants to do this, and most did not find it necessary.

## Findings

There was nearly universal agreement around several themes and a diversity of opinion around others. We have summarized the themes here and will expand on several of them in sections to follow.

### Universal Agreement:

- The private sector plays an important role in preparedness and response to local, regional, national, and global-scale emergencies
- The private sector must have its agreed performance measured and be held accountable for those aspects of response for which it is responsible
- Some form of public-private partnership is essential if a state, region, or the country is to successfully handle disasters
- The private sector response to COVID-19, where it was most successful, involved a great deal of collaboration and sharing of heretofore proprietary information between competitors. Each subsector in HLC was proud of having accomplished

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this and believes it should be preserved, with proper guidance and then protection from anti-collusion law and regulation

- Many other assets and approaches developed in response to COVID-19 should be preserved

## Areas of disagreement:

- The exact role of government, at any level, and the boundary between private sector activity and public activity
- The role HLC can play in advancing and operating a public-private partnership

Further, all the interviewees agreed that it might be beneficial to share corporate disaster planning/business continuity plans and documents among the members of HLC in order to identify best practices.

## Public-Private Partnership

There was no doubt among the interviewees that there are areas of function and collaboration best performed by the private sector. The exact nature of these functions varied, depending on the subsector of the industry.

**Delivery systems** created regional collaborations among themselves and competitors to have real time views of capacity during the COVID response. This was driven and led by the private delivery systems themselves. Most health care is delivered naturally along regional, not governmental boundaries. These regions frequently cross local and state governmental boundaries, so partnerships with state and local governments are important, but will vary. There is also very little health care that needs national coordination, so the federal government is not necessarily the best partner during non-emergency times. The right partnership should be led by the delivery systems with government at all three hierarchical levels at the table. Through a delivery system-led partnership, the private sector can match capacity to demand, shift personnel and supplies, and work with local leaders and policymakers to advise on policy decisions and create consistent communications for the public. They can work with federal agencies to surface problems and coordinate between regions. During COVID-19, interviewees in this category described quickly developing regional real-time dashboards, in at least one case complete with predictive analytics that indicated when they would likely run out of beds to inform the governor of when elective procedures might need to be curtailed.

**Supply companies, distributors, and group purchasing organizations (GPOs)** can coordinate and allocate nationally. For this subsector, the right partner is the federal government. This public-private partnership can help convene competitors, give

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guidance to help avoid violation of regulations and laws intended to prevent price fixing and collusion, and augment data streams related to understanding the need/demand for products across the country. Distributors also can coordinate and allocate across the country, partnering again with the federal government to manage allocation ethically and move products efficiently to meet demands. They will need new formulas and data from the federal government to build an ethical allocation scheme, because those decisions are typically based on prior demand. If there is new demand with no prior history (e.g., skilled nursing facilities and long-term care facilities needing large quantities of personal protective equipment (PPE), for example), the federal government can help create guardrails for a new scheme and gather the national data necessary to build a new formula.

**Workforce companies** need to work locally to address complexities of licensure and waivers for some of those requirements. Federal and state governments need to work together to reduce the interstate variability and construct a regulatory framework for the issuance of waivers that all parties understand and agree to and define the triggers by which they are activated or deactivated as a result of a crisis. It is possible to conceive of a framework that allows for the suspension of certain local professional licensure requirements once certain forms of disaster declarations are made. Demands for temporary workforce assistance are always regional and local, but the market is national.

**Medical technology, medical device, and pharmaceutical companies** will also need support as they find ways to allocate products and alter manufacturing lines if there is a sudden increase in demand. Increasing production capacity may require the federal government to invest in redundancy and purchase excess supplies, if necessary. These firms will also need guidance for when they should shift manufacturing capacity from existing products to new products and for when manufacturing capacity outside this subsector may have to be called upon to meet new demand, such as through the Defense Production Act, and understanding the implications for the private sector.

## **Accountability**

There was agreement that the private sector was in the best position to understand what measures of accountability would be both effective and practical to assess health care readiness. However, there was a spectrum of opinion as to how these measurements of accountability should be implemented to evaluate the readiness and contributions of the private sector in both preparedness and response to emergencies. Some feel that government's sole role, at any level, is as convener, and that the private sector should develop the measures and the means for acquiring the data and holding each other accountable. Others believed that, after consultation with private entities, government should develop measures of accountability and collect and analyze the

data. Some had confidence that the private sector could and would develop appropriate measures and behave accountably and felt that the federal government would only reduce efficiency and effectiveness by meddling. Others had no such confidence and felt that, after gathering input from the private sector, the federal government needed to devise and impose measures, gather the data, and perform independent analysis of the data.

## Preserving Effective COVID-19 Innovations

These innovations fell into three categories:

- Regional dashboards
- Industry subsector data sharing and collaboration
- Regulatory waivers

**Dashboards** were built on the fly by several HLC members for their regions. They were able to overcome competition between delivery systems to pool bed capacity, critical care unit capacity, and available ventilators so that a council of hospital leaders and political leaders could appropriately direct patients as inpatient space was required. They were also able to assess inventories of PPE in short supply and work with each other to spread scarce resources to the places where they were needed most. Several leaders noted, when discussing PPE, that FEMA had attempted to interdict their supplies and direct them elsewhere in the country. They suggested that enhanced transparency as to where those supplies ultimately were sent and how they were used is an opportunity for better public-private cooperation for this and future emergencies. This is an area that the federal government, particularly the Department of Homeland Security Federal Emergency Management Agency (FEMA) and the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) need to address. A couple of the regional dashboards we learned of were able to predict future capacity, and this enabled hospital leadership to advise political leadership about the direction of the pandemic. These dashboards should be surfaced, emulated, and distributed to all logical health care regions to be used in an event causing capacity constraints. It would also be useful to develop standard trigger mechanisms for political leaders to use, agreed in advance by hospital leaders, to suspend competition, allow the exposure of this otherwise proprietary information to a regional dashboard. Further, lessons learned from these regional dashboards should be shared with federal leaders as they develop ongoing essential elements of information and national emergency data collection systems that are automated and in real-time.

**Industry data sharing and collaboration** produced rapid, fair, and durable production and distribution schemes for critical equipment and supplies. The same lesson about having triggers for initiating data sharing and collaboration, agreed to in advance and

implemented by political leaders and emergency managers, can be applied here. It is critically important for the federal government to be involved in these decisions at the outset to avoid any perception of industry collusion and price fixing.

**Regulatory waivers**, beyond the fast tracking of pharmaceutical and laboratory test development and deployment, were applied in three areas. The first was in the area of suspending regulatory constraints preventing industry competitors from sharing manufacturing, distribution, and pricing information. This ultimately prevented continuation of the situation in which various delivery systems and state governments were bidding against each other for items in short supply. No one wants that to happen again, so the implementation of a regulatory framework that would allow for this level of cooperation between competing firms is a high priority. Changes would likely need to occur at both the state and federal levels.

The second area where waivers were invaluable was the suspension of state professional licensing requirements, allowing professionals with active, viable licenses in one jurisdiction to practice immediately in another. Making these gains permanent would involve two activities to occur on parallel tracks. First, the federal government, as convener and funder, should aggressively promote the implementation of licensing compacts across all states. Second, the federal government could, with the participation of states, develop a national licensure program, with clinicians applying for and maintaining these licenses in order to be available across state lines during times of emergency. The licenses would only be viable for the duration of the state of emergency.

The third regulatory relief critical to this response were waivers associated with telehealth and telemedicine services. While important and should be a permanent change by both federal and state governments, the professional licensing requirements issue was noted as far more significant. Telehealth and telemedicine alone will not fix the workforce challenges experienced during this response.

## **The Role of HLC**

There was discussion of and no agreement around the role of HLC in furthering this work. All agreed it should advocate for some permanence to helpful waivers and changes in regulation. Some believed it should move further into operating collaboratives and public-private preparedness and response partnerships. This is an area that merits further discussion by HLC.



## Our Perspective

Many members of HLC rose to the occasion as the pandemic unfolded and government struggled to address it. The benefits of an ongoing public-private partnership to address disaster preparedness and response are now clear. The federal government should, in its role as convener, bring together health care sector stakeholders to establish the structure and governance of this partnership going forward. The government must also demand that industry demonstrate how it will be held accountable for the execution of its agreed roles, once the partnership is established. This can be accomplished by convening health care subsector stakeholder groups and charging them with the development of appropriate process and outcomes measures. The judges of the adequacy of these measures for a subsector would be the members of the stakeholder groups of the other subsectors—no one has a greater stake in the performance of one subsector than their suppliers and clients.

This pandemic has also taught us that, when forced to move quickly, the industry can produce high quality processes quickly and then refine them as needed. Accordingly, we believe that building the public-private partnership infrastructure, governance, agreements, needed waivers, and even asset development should be treated as an emergency. Completion of the “project” should be targeted no longer than six months from the start date to capitalize on the lessons learned and experiences from the COVID response and be prepared for subsequent emergencies.

The role of HLC in advancing this agenda is clear to us. The organization should be an advocate for the policy and regulatory framework changes needed to create the public-private partnership, and it should also take a central role in supporting the development of outcomes measures and other forms of accountability for the private sector role in the partnership. It might also have a part to play in establishing a legal entity to house the partnership, but, in the absence of experience as an operating response organization, it probably should not be that entity or the operator of the partnership.

## Closing

Thank you.

It has been a privilege working with the staff of the HLC and talking to its members. We are glad to have been involved in helping to start the conversation and hope that the membership’s interest in advancing the private sector’s readiness posture through creation of a meaningful public-private partnership persists until the tasks have been addressed.



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## Appendix

### Roster of Interviews

Date	Time	Interviewee	Company
6/11/2020	4:30-5:00 pm ET	Barclay Berdan	Texas Health Resources
6/15/2020	1:30-2:00 pm ET	Susan DeVore	Premier, Inc.
6/16/2020	11:00-11:30 am ET	JP Gallagher	NorthShore University HealthSystem
6/16/2020	1:30-2:00 pm ET	Hugh O'Neill	Mallinckrodt Pharmaceuticals
6/17/2020	2:30-3:00 pm ET	Bill Lucia	HMS
6/17/2020	3:30-4:00 pm ET	John Liddicoat	Medtronic
6/22/2020	2:30-3:00 pm ET	Neil de Crescenzo	Change Healthcare
6/23/2020	1:30-2:00 pm ET	Robert Wyllie	Cleveland Clinic
6/23/2020	3:00-3:30 pm ET	Calvin Schmidt	Johnson and Johnson
6/24/2020	12:30-1:00 pm ET	Peter Ross	Senior Helpers
6/24/2020	2:30-3:00 pm ET	Stanton McComb	McKesson
6/25/2020	11:00-11:30 am ET	Rick Redetzke	SSM Health
6/25/2020	11:00-11:30 am ET	Diana Quinn	SSM Health
6/25/2020	11:00-11:30 am ET	John O'Brien	SSM Health
6/29/2020	11:30 am-12:00 pm ET	Joe Impicciche	Ascension
6/29/2020	11:30 am-12:00 pm ET	Craig Cordola	Ascension
6/29/2020	11:30 am-12:00 pm ET	Peter Leibold	Ascension
6/29/2020	1:00-1:30 pm ET	Tom Skelton	Surescripts
6/29/2020	2:00-2:30 pm ET	Judy Faulkner	Epic
6/29/2020	4:00-4:30 pm ET	Tammy Simon	Marshfield Clinic Health System
6/30/2020	11:00-11:30 am ET	Karen Lynch	CVS Health/Aetna Business Unit
7/8/2020	1:00-1:30 pm ET	Barry Arbuckle	MemorialCare
7/8/2020	4:00-4:30 pm ET	Susan Salka	AMN Healthcare
7/9/2020	2:00-2:30 pm ET	Marc Grodman	Genosity
7/16/2020	3:00-3:30 pm ET	Barry Fortner	AmerisourceBergen
7/16/2020	3:00-3:30 pm ET	Rita Norton	AmerisourceBergen

### Interview Questionnaire

## Overall Current State – Questions focus on Prepare and Respond Phases

For COVID-19:

- How has your organization responded to COVID-19?
- How could your company have contributed more to COVID-19? Anything your company could have done differently?
- How could the private life sciences or health care sectors have done more to contribute to the COVID-19 response? Anything the private sector could have done differently?
- How might life sciences and health care sustain the cooperation and collaboration from the COVID-19 response moving forward?
- How could the federal government have improved their response efforts to COVID-19?

Overall, what specific actions can the federal government and the private life sciences and health care sectors do now to organize differently to PREPARE and RESPOND to public health and other emergencies?

Describe how your organization views public health and medical emergency preparedness and response.

How do you PREPARE your organization for:

- Continuity of operations
- Emergency-specific readiness (e.g., addressing patient surge and resource constraints)
- Health and safety of your workforce
- Risk communications with patients or customers

Describe how your organization engages within your industry sector to identify and disseminate leading practices for public health and medical emergencies.

What are the most common gaps in your organization's or your industry's readiness to RESPOND to public health and medical emergencies?

What type of information, resources, or guidance do you seek most often for public health and medical preparedness and response?

- What sources are most valuable to you? Federal resources? State government resources? Industry leader resources?

- How do you use this information (i.e., incorporating resources and guidance into your activities)?
- How do you obtain information on readiness and response (e.g., website, briefings, personal relationships)?

How do you communicate with the federal government or state government leaders about what your organization or your industry sector *needs* in preparation for or during a public health and medical emergency?

How do you communicate with the federal government or state government leaders about what your organization or your industry sector *is doing* in preparation for or during a public health and medical emergency?

Describe how your organization engages your patient/customers, communities/regions, and employees to identify gaps and challenges or disseminate leading practices.

Lastly, what keeps you up at night regarding your organization's, your sector's or the government's ability to manage disaster preparedness and response?

## Where do we go from here? Questions focus on Recover and Thrive Phases

What will it take to achieve nationwide progress toward public health and medical readiness?

Should the private sector set standards for health care readiness and hold each other accountable for achieving readiness metrics?

Using the current COVID-19 domestic health care preparedness and response efforts as an example, we understand that many HLC members sought definitive guidance from the federal government and we also hear that the federal government sought innovations and ideas from the private sector as well. How can HLC members help to bridge the divide between the public and private sectors for readiness for emergencies like COVID-19 to THRIVE in the future?

What are the barriers, if any, for the private sector to take the lead in areas of national health care readiness for public health and medical emergencies?

What steps are your company taking to RECOVER better to stay prepared for a second wave and make permanent lasting change?