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PUBLIC HEALTH

Leading Practices Could Help Guide HHS Reform Efforts to Address Risk and Improve Preparedness

Statement of Mary Denigan-Macauley, Director, Health Care

Accessible Version

GAO-23-106872

Chair Griffith, Ranking Member Castor, and Members of the Subcommittee:

I appreciate the opportunity to be here today to discuss efforts to reform the Department of Health and Human Services (HHS) within the context of the designation of HHS's leadership and coordination of public health emergencies in GAO's High-Risk List.

In January 2022, we added HHS's leadership and coordination of our nation's preparedness for, and response to, public health emergencies—including extreme weather events, infectious disease outbreaks and pandemics, and intentional acts—to our High-Risk List. We have determined this is an area in need of transformation. Improving HHS's leadership and coordination in this area will better prepare the nation for future emergencies and help mitigate their devastating public health and economic effects.

My statement today provides information from our prior work on HHS's leadership and coordination of public health emergencies and describes leading practices for agency reform efforts. This statement is based on the work that led us to designate this area as high risk, as well as our June 2018 report on agency reform leading practices.[1]

We conducted our work in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions in this product.

[1]See GAO, *New High-Risk Designation: HHS and Public Health Emergencies* appendix in *COVID-19: Significant Improvements Are Needed for Overseeing Relief Funds and Leading Responses to Public Health Emergencies*, GAO-22-105291 (Washington, D.C.: Jan. 27, 2022), *High-Risk Series: Efforts Made to Achieve Progress Need to Be Maintained and Expanded to Fully Address All Areas*, GAO-23-106203 (Washington, D.C.: Apr. 20, 2023), and *Government Reorganization: Key Questions to Assess Agency Reform Efforts,* GAO-18-427 (Washington, D.C.: June 13, 2018).

HHS Leadership and Coordination of Public Health Emergencies

Our recent high-risk designation is based on a body of work that found persistent deficiencies for more than a decade in HHS's ability to perform its leadership role. These deficiencies hindered the nation's response to the COVID-19 pandemic and to a variety of other past emergencies, including other infectious diseases—such as the H1N1 influenza pandemic, Zika, and Ebola—and extreme weather events, such as hurricanes. Specifically, HHS's efforts have fallen short in five key areas of an effective national response:

- **Clear roles and responsibilities**. The unprecedented scale of the COVID-19 pandemic, and the whole-of-nation response required to address it, highlighted the critical importance of clearly defining the roles and responsibilities for the wide range of federal departments and other key partners involved when preparing for pandemics and addressing unforeseen emergencies. Unclear roles and responsibilities persisted at HHS and affected response efforts. For example, we found that when HHS helped repatriate U.S. citizens from abroad and quarantine them domestically at the beginning of the COVID-19 pandemic to prevent the spread of the virus, significant confusion ensued due to a lack of clarity as to which HHS agency was in charge.[2] As a result, HHS put repatriates, its own personnel, and nearby communities at risk.
- **Complete and consistent data**. Data are critical to inform the response to a public health emergency. However, the data HHS relied on during the COVID-19 pandemic were incomplete and inconsistent, highlighting longstanding concerns in this area. Moreover, we found in 2010, 2017, and again in 2022 that, although required by statute since 2006, HHS had made little progress in implementing a nationwide public health situational awareness capability through an interoperable network of systems to help ensure timely and complete

[2]GAO, *COVID-19: HHS Should Clarify Agency Roles for Emergency Return of U.S. Citizens during a Pandemic*, GAO-21-334 (Washington, D.C.: Apr. 19, 2021).

collection of public health data to aid a response.[3] Under the existing process—which HHS had to rely on during the COVID-19 pandemic—public health data are collected by thousands of disparate health departments, health care providers, and laboratories, as well as multiple federal agencies.

- **Clear and consistent communication**. In the midst of a public health emergency, clear and consistent communication—among all levels of government, with health care providers, and to the public—is paramount. Our work over the years, including most recently during the COVID-19 pandemic, has found that HHS has provided unclear and inconsistent communication during critical incidents. For example, this was problematic during the H1N1 response when we found that selected state officials reported being overwhelmed by the large volume of, and sometimes inconsistent, information received from HHS and the Department of Homeland Security.[4]
- **Transparency and accountability**. When agencies need to quickly disseminate funding and information during public health emergencies, transparency and accountability are especially critical to help ensure program integrity and build public trust. However, we have found deficiencies in this area both prior to and during the COVID-19 pandemic. For example, within HHS, the Centers for Disease Control and Prevention (CDC) changed its COVID-19 testing guidelines several times over the course of the pandemic with little explanation of the scientific rationale behind the changes.[5] This resulted in confusion among the providers and public health stakeholder groups implementing the guidelines and risked the erosion of trust in the federal government.
- **Key partners' capabilities and limitations**. We found in September 2019 that, in general, the agency within HHS tasked with leading

[3]GAO, *COVID-19: Pandemic Lessons Highlight Need for Public Health Situational Awareness Network*, GAO-22-104600 (Washington, D.C.: June 23, 2022); *Public Health Information Technology: HHS Has Made Little Progress toward Implementing Enhanced Situational Awareness Network Capabilities*, GAO-17-377 (Washington, D.C.: Sept. 6, 2017); and *Public Health Information Technology: Additional Strategic Planning Needed to Guide HHS's Efforts to Establish Electronic Situational Awareness Capabilities*, GAO-11-99 (Washington, D.C.: Dec. 17, 2010).

[4]GAO, *Influenza Pandemic: Lessons from the H1N1 Pandemic Should Be Incorporated into Future Planning*, GAO-11-632 (Washington, D.C.: June 27, 2011).

[5]GAO, *COVID-19 Testing Guidance* enclosure in GAO, *COVID-19: Urgent Actions Needed to Better Ensure an Effective Federal Response*, GAO-21-191 (Washington, D.C.: Nov. 30, 2020).

preparedness and response activities on behalf of the Secretary—the Administration for Strategic Preparedness and Response (ASPR)—had limited capacity. Specifically, its personnel and supplies could support a response to two simultaneous events that occurred in different areas in the continental U.S. for 30 days, according to officials.[6] Beyond that, ASPR relies on other response partners, but does not have a complete understanding of the capabilities and limitations of those partners, which creates a vulnerability.

Furthermore, we have concerns that ASPR lacks the capability to fully execute its responsibilities. In April 2022, we found that ASPR had not undertaken key workforce planning steps to support the mission and goals of the new office it created to address medical product supply vulnerabilities highlighted during the pandemic.[7] Additionally, in June 2020, we found that ASPR had aligned the size of its emergency responder workforce with the agency's strategic goals and objectives to a limited extent, affecting ASPR's ability to ensure that the size of the workforce could support its mission.[8]

We have made 155 recommendations to HHS to help address the aforementioned deficiencies and others we have identified in this area since 2007. As of April 2023, 91 of these recommendations remained unimplemented. We maintain that implementing these remaining recommendations will strengthen HHS's leadership and coordination of public health emergencies.

In our April 2023 update on this high-risk area, we reported that two HHS agencies that play key preparedness and response roles—ASPR and CDC—are undergoing reforms. Specifically, in July 2022, HHS announced that it had elevated ASPR to a stand-alone agency alongside other HHS agencies, such as CDC. According to an HHS statement, this change will ultimately allow ASPR to mobilize a coordinated national emergency response more effectively and efficiently. In August 2022, CDC announced programmatic, scientific, and operational improvements

[6]GAO, *Disaster Response: HHS Should Address Deficiencies Highlighted by Recent Hurricanes in the U.S. Virgin Islands and Puerto Rico*, GAO-19-592 (Washington, D.C.: Sept. 20, 2019).

[7]See the *Public Health Industrial Base Expansion* enclosure in GAO, *COVID-19: Current and Future Federal Preparedness Requires Fixes to Improve Health Data and Address Improper Payments*, GAO-22-105397 (Washington, D.C.: Apr. 27, 2022).

[8]GAO, *Public Health Preparedness: HHS Should Take Actions to Ensure It Has an Adequate Number of Effectively Trained Emergency Responders*, GAO-20-525 (Washington, D.C.: June 18, 2020).

to better support the agency's public health response during emergencies and in normal operations. These agencies have taken some actions since their initial announcements, which we will continue to monitor. For example, in February 2023, ASPR announced a new organizational structure that, according to ASPR, accounts for the agency's expanded mission and new capabilities, among other considerations.

Leading Agency Reform Practices

We have identified leading practices for successful agency reforms, by which agencies could address deficiencies such as those that led us to include HHS's leadership and coordination of public health emergencies on our High-Risk List.[9] These leading practices indicate that agencies can successfully change if they have (1) clear goals, (2) follow a process to develop proposed reforms, (3) allocate implementation resources, and (4) consider workforce needs during and after the reform. See table 1 for examples of key questions that Congress can use to assess agencies' proposals for and implementation of reform efforts, in these four broad categories.

Table 1: Leading Agency Reform Practices

Leading practice category	Examples of key questions to assess agency reform efforts
Goals and outcomes	To what extent has the agency established clear outcome-oriented goals and performance measures for the proposed reforms?
Process for developing reforms	To what extent has the agency addressed areas of fragmentation, overlap, and duplication—including the ones GAO identified—in developing its reform proposals?
Implementing the reforms	Has the agency developed an implementation plan with key milestones and deliverables to track implementation progress?
Strategically managing the federal workforce	To what extent has the agency conducted strategic workforce planning to determine whether it will have the needed resources and capacity, including the skills and competencies, in place for the proposed reforms or reorganization?

Source: GAO. | GAO-23-106872

For example, one key question to assess agency reform efforts is the extent to which the agency conducts strategic workforce planning to determine whether it will have the needed resources and capacity in place for the proposed reforms or reorganization. This planning includes determining the critical skills and competencies needed to achieve an agency's current and future programmatic results, and developing

[9]GAO-18-427.

strategies to address gaps in the number of staff and their skills and competencies to meet those results.[10]

We shared these leading practices with HHS in January 2023 to use as it implements its planned reforms. These leading practices, along with the prerequisite of sustained leadership commitment, are essential to helping ensure the country is better prepared for future public health emergencies. Leadership commitment is the critical element for initiating and sustaining progress and making the types of management and operational improvements required to narrow or remove high-risk areas.

In closing, it is too soon to tell if HHS's efforts at reform will address the deficiencies we have identified in our high-risk designation. However, to the extent HHS chooses to follow these leading agency reform practices, they will help the department in its efforts to improve its leadership and coordination of future public health emergencies. The practices can also assist Congress as it oversees HHS's implementation of these reforms.

Chair Griffith, Ranking Member Castor, and Members of the Subcommittee, this concludes my statement. I would be pleased to respond to any questions you may have.

GAO Contacts and Staff Acknowledgments

For further information about this statement, please contact Mary Denigan-Macauley at (202) 512-7114 or deniganmacauleym@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. In addition to the contacts named above, key contributors to this statement were Deirdre G. Brown (Assistant Director), Kaitlin Farquharson, Sarah Resavy, and Cathleen Whitmore. Additional support was provided by Erin B. Pearson, Lillian Riehl Schultze, and Sarah Veale.

[10]GAO, *Human Capital: Key Principles for Effective Strategic Workforce Planning*, GAO-04-39 (Washington, D.C.: Dec. 11, 2003).

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