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Analysis of the Hospital Preparedness Program

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Abstract

Since its inception in 2002, the Hospital Preparedness Program (HPP) has served as a critical federal initiative with the initial goal of improving chemical, biological, radiological and explosive preparedness then morphed into a general theme of increasing healthcare infrastructure preparedness and response to disasters. These federal funds were used and are used to develop coordinated systems for disaster response, purchase equipment, run drills and exercises, and staff HPP providers.

This analysis examines how states such as Texas, New York, California, Arkansas, Florida, Minnesota, and Nebraska utilize HPP funding to achieve this overarching goal of building regional/state disaster preparedness and response systems for the healthcare sector. The study reviews approaches utilized by these states to develop more resilient healthcare infrastructure and will use open-source data and interviews to review successes, challenges, and lessons learned. Special attention is given to the state of Texas, which has emerged as a model for implementing regional systems of collaboration. The framework Texas uses includes regional coordination, stakeholder engagement, comprehensive training programs, and an emphasis is placed on integrating all aspects of healthcare into preparedness efforts.

This comparative analysis emphasizes the importance of adaptable strategies, cross-sector collaboration, and the need for sustained funding not only for HPP providers but for general preparedness and/or workforce development surrounding preparedness activities. Ultimately Texas's system is utilized as a blueprint for states to build their HPP programs around to enhance preparedness and collaboration. This analysis contributes to the broader discourse on improving disaster preparedness and response capabilities at all levels of government and in the private sector.

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History and Evolution of the Hospital Preparedness Program (HPP)

The terrorist attacks on September 11, 2001, followed by the anthrax incident involving contaminated letters sent through the U.S. Postal Service, triggered a wave of concern over the nation's readiness to manage mass casualty and bioterrorism events. Hospitals experienced a sudden surge in emergency room visits, and law enforcement began reporting potential threats involving chemical, radiological, and nuclear materials. Recognizing the urgent need to strengthen the nation's healthcare system, Congress allocated funding to enhance hospitals preparedness and response capabilities.

To distribute this funding, the Health Resources and Services Administration (HRSA) launched the National Bioterrorism Hospital Preparedness Program (NBHPP). This initiative aimed to bolster the ability of hospitals, emergency medical services, and related healthcare facilities to respond effectively to bioterrorism, mass casualty events, and infectious disease outbreaks. Federal grants were awarded to every state, U.S. territory, and the District of Columbia, as well as directly to three major cities; New York, Los Angeles, and Chicago.

Initial funding began in FY 2022 with $125 million. The following year, in FY 2003, funding increased to $498 million. Each state received a base allocation of $1 million, with additional funds distributed based on population. Annual applications were required, along with documentation demonstrating compliance with NBHPP objectives. Cooperative agreements were executed annually, with specific goals and deliverables aligned with federal preparedness priorities.

States implemented the program in diverse ways. Some passed funds through to hospital associations, individual hospitals, state health departments, or nonprofit agencies. The program's primary focus was on hospital readiness, including expanding surge capacity, acquiring detection equipment for chemical, biological, radiological, and

nuclear (CBRN) threats, and providing specialized training for hospital staff and emergency responders. Hospitals were also required to update their emergency operations plans to address these new threats. By 2004, hospitals across the country had made significant strides in preparedness.

From FY2002 to FY 2004, the NBHPP saw rapid fund increases from $125 million to $498 million. However, in FY 2005, funding began to decline slightly to $471 million, and this downward trend continued in subsequent years, along with changes in program focus. The devasting impacts of Hurricane Katrina in 2005 exposed critical gaps in coordination among healthcare facilities, state, and local governments. In response, Congress passed the Pandemic and All-Hazards Preparedness Act (PAHPA) in 2006, which transferred the NBHPP from HRSA to the newly created office of the Assistant Secretary for Preparedness and Response (ASPR). The program was renamed the Hospital Preparedness Program (HPP) and adopted an “all-hazards” approach to preparedness.

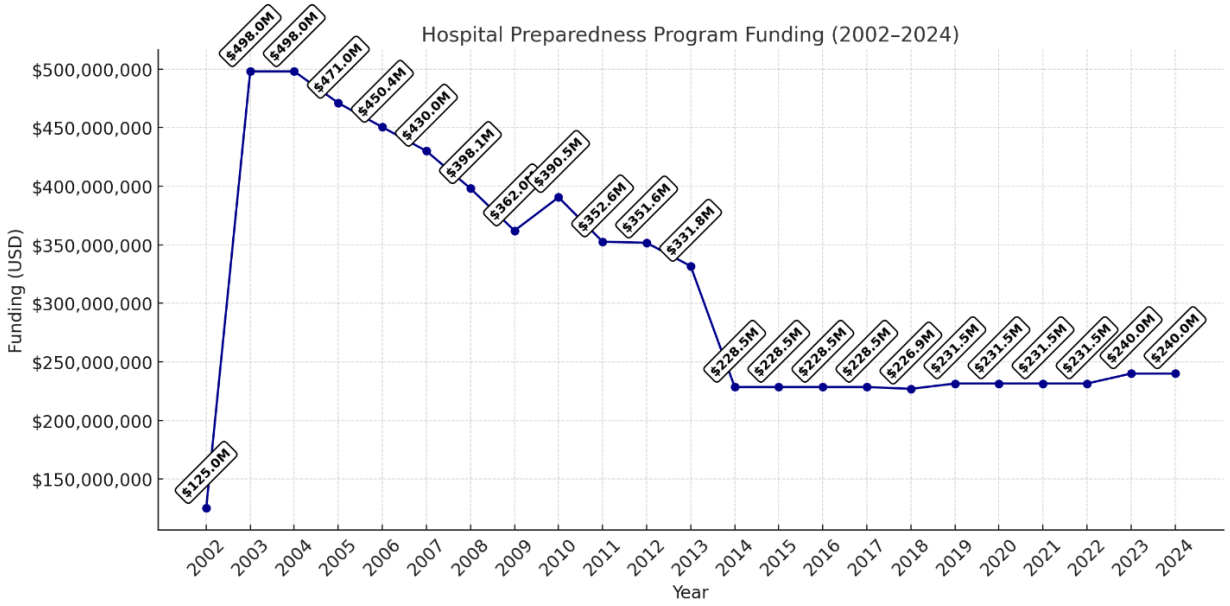
Despite the evident need for greater preparedness in the wake of Hurricane Katrina and other 2005 hurricanes, HPP funding continued to decline: dropping from $471 million to $450 million in FY 2006. The 2006 cooperative agreement marked a strategic shift, emphasizing collaboration among healthcare entities, enhancing interoperable communications, developing state volunteer registries, and planning for mass fatalities and hospital evacuations. Base state allocations reduced from $1 million to $500,000.

From 2006 to 2011, HPP laid the groundwork for a more integrated approach to healthcare readiness. While hospitals had improved their internal capacity and developed partnerships, broader collaboration with public health and emergency management remained limited. The FY 2012 cooperative agreement addressed this by introducing the concept of healthcare coalitions (HCCs), which were multi-sector partnerships aimed at strengthening regional healthcare response. That year, $351 million was allocated to support the formation and development of these HCCs under a new five-year cooperative agreement structure.

Between 2012 and 2017, annual HPP funding decreased by $123 million. During the 2014-2015 Ebola outbreaks, many hospitals struggled to manage the complexities of caring for patients with highly infectious diseases. In response, ASPR provided supplemental HPP funding to increase Ebola readiness; however, base HPP funding remained flat at $288 million through FY 2015-2017.

The introduction of HCCs significantly improved coordination among hospitals, public health agencies, emergency managers, and other stakeholders. States used HPP funding to conduct training, develop regional response plans, and conduct drills. By FY 2019, HPP funding stood at $231 million, coinciding with the onset of the Covid-19 pandemic. HCCs played a vital role in pandemic response, supporting hospitals and helping save lives at the community level. Despite their critical contributions, HPP funding remained unchanged in the years following Covid-19.

In 2025, as part of the broader federal cost reduction initiative, the White House proposed moving ASPR under the Centers for Disease Control and Prevention (CDC). In doing so, the Department of Health and Human Services announced the end of the HPP after 23 years. Funding for FY 2024 fell to $240 million, a steep decline from the programs peak of $498 million in FY 2003 and FY 2004 (ASPR, 2024).



Review of Health Care Coalitions

According to the Centers for Medicare & Medicaid Services (CMS), Health Care Coalitions (HCCs) are networks of healthcare providers (first receivers) and emergency responders (police, fire, EMS) that collaborate to identify challenges and develop solutions to enhance community preparedness (CMS, 2024). The concept of HCCs emerged from a two-year comprehensive analysis of hospital preparedness in the United States. This analysis, conducted from 2002 to mid-2007, revealed that while individual hospital preparedness had improved, there was a critical need for HCCs to coordinate large scale disaster responses, whether natural or manmade. These events often exceeded the capabilities of any single facility or system (Courtney et al., 2009). This analysis provides a comprehensive review of HCCs including: (1) An overview of HCCs, (2) The benefits of coordination within HCCs, and (3) The challenges HCCs face.

Overview of Health Care Coalitions (HCCs)

As of 2001, ASPR reports that there are 318 HCCs across the United States and territories, with 47,836 member organizations (ASPR, 2001). Core partners in HCCs as defined by ASPR are (1) acute care hospitals, (2) emergency medical services (EMS), (3) emergency management agencies, and (4) public health agencies. The breakdown of participation for HCCs nationally is 85% of hospitals belong to an HCC (5,473 total hospitals), 27% of EMS organizations nationwide (4,674 organizations), 56% of emergency management organizations (2,764 organizations), and no data is provided on participation rate for public health agencies (ASPR, 2020). In a general sense the structure of HCCs will vary based on the area but common components exist, such as core capabilities, and governance structure.

Core Capabilities of HCCs. ASPR utilizes the following four core capabilities for HCCs to provide a standardized framework for coalitions to operate in. This ensures a consistent level of preparedness for disaster and emergency situations across the country. The four core capabilities are:

1. *Foundations for healthcare and medical readiness* – which outlines general preparedness goals.
2. *Health care and medical response coordination* – which has the goal of coordination amongst all members in the area during times of emergency.
3. *Continuity of healthcare service delivery* – underscores the need to provide medical care regardless of damage or type of emergency.
4. *Medical surge* – which reinforces the need for coordination during crisis surge response (ASPR 2022). These four core capabilities are consistent across all HCCs.

These four core capabilities are the bases for HCCs bringing the healthcare community in that jurisdiction together to attain a common goal. The means by how this is done may differ from jurisdiction to jurisdiction, meaning some may focus on a series of tabletop exercises, while others build for a full-scale exercise. ASPR provides general guidelines for HCCs to operate within, and the coalition and their governance structure dictate how to achieve a state of readiness for that core capability.

Governance Structure of HCCs. Governance structures of HCCs will vary by jurisdiction, all HCCs operate with a defined leadership framework. For example, North Central Region Healthcare Coalition (NCR) in Colorado (2019) governance structure functions as an advisory board made up of the four core member organizations (Emergency Management, EMS, Hospitals, Public Health), and community partners (behavioral health, ancillary healthcare, and community clinics). The advisory board has two co-chairs, one secretary, and one treasurer, who are all elected for two-year terms (NCR, 2019). This governance model is consistent across many HCCs, with only minor variations. The next section will look at how HCCs coordinate in times of disaster.

Coordination

Numerous examples exist of how HCCs coordinate before, during and after disasters. To add framework to this section we will review coordination efforts by core capabilities.

Coordination – Foundations for healthcare and medical readiness. One of the most prolific disasters that underscored the lack of healthcare and medical readiness was Hurricane Katrina in 2005. Hurricane Katrina initially made landfall between Miami and Fort Lauderdale, Florida as a Category 1 Hurricane before heading to the gulf, regaining strength and reaching a category 4 hurricane making landfall at Plaquemines Parish, Louisiana on August 20, 2005. Hurricane Katrina and the aftermath claimed over 1,800 lives (Britannica, 2025). *The Federal Response to Hurricane Katrina: Lessons Learned* is an extensive review of Hurricane Katrina that identified 17 critical challenges. The common theme that can be seen across these critical challenges was an overall lack of coordination across government and private organizations (United States, 2006). This assessment was confirmed by Howitt and Leonard (2006) which highlighted a lack of preparedness and coordination in medical communication. It is important to note Hurricane Katrina occurred prior to the release of the ASPR assessment of healthcare preparedness where the recommendation of HCCs was made. This is a sharp contrast to Hurricane Harvey in which HCCs had been established for some time, and Texas overall had an established means of coordination and collaboration amongst the healthcare community.

Hurricane Harvey was a category 4 hurricane that made landfall near Rockport, Texas on August 25, 2017, but as the storm moved inland, it stalled over the greater Houston areas for seven days, raining more than 50 inches in some areas (NOAA, 2024). Although the storm impacts many parts of Texas, this analysis will focus on the healthcare coalition that covers the greater Houston area SouthEast Texas Regional Advisory Council (SETAC), and the coordination efforts made. During Hurricane Harvey the Catastrophic Medical Operations Center (CMOC) which is part of the Regional Healthcare Preparedness Coalition, which is ran by SETRAC, helped evacuate 1504 patients from 45 facilities after Hurricane Harvey. It was noted that coordination could

be improved especially with Federal partners (SETRAC, n.d). The impacts of the CMOCs coordination effort are also highlighted by Upton, Kirsch and Harvey (2017) where it is mentioned that SETRAC (HCC for greater Houston) is made up of 25 counties, 277 cities, 9.3 million people, 180 hospitals, 200 EMS agencies, and over 900 nursing homes. The CMOC (essentially a coordination center) was utilized during Hurricane Katrina to assist with evacuees and placed 1100 individuals into healthcare facilities, during Hurricane Rita, Hurricane Ike, and numerous other events such as Hurricane Harvey (Upton et. al., 2017).

Coordination – Health care and medical response coordination. Since December 2019, over 760 million cases of Coronavirus disease (COVID-19) have been reported worldwide, with over 6.9 million deaths (World Health Organization, 2023). In the US, there have been over 103 million cases, with over 1.2 million deaths. Although impacts rippled throughout every sector and industry Davis, et, al. (2022) highlighted the impacts specific to the healthcare sector. Examples of impacts that could been seen from COVID-19 were on the physical environment of healthcare delivery (converting rooms and non-traditional areas for patient care), supply chain disruptions (impacting personal protective equipment), staffing (increased patient-to-nurse ratios), and overall bed availability. Baum, et., al. (2024) found that Medical Operations Coordination Centers (MOCCs) in Minnesota were effective in placing patients during the first 2020 fall surge, but performance of the MOCCs decreased in the second wave as healthcare as an industry was a further decline of resources and bed availability. Between August 1, 2020, and March 31, 2022, the Minnesota MOCC had 5,307 requests and of that they were able to identify 2,008 beds. 1,316 of those requests were canceled and 1,981 requests were unable to be filled. Devereaux, et., al. (2020) describes a similar experience in San Diego County, were the HCC established a resource allocation process to ensure equal distribution of ICS beds, and resources across the HCC.

Coordination – Continuity of healthcare service delivery. Joplin Missouri experienced one of the most devastating tornadoes in the history of the United States. On May 22, 2011, 158 were killed and 1,000 injured when an EF-5 tornado struck Joplin, MO (US Department of Commerce, 2017). According to Mercy (2021) the

tornado struck the hospital resulting in extensive damage and the hospital was evacuated. Patients were triaged, then transported to Springfield MO, and Northwest Arkansas. In terms of continuity of healthcare delivery for one of the main hospitals in this area, within one week a field hospital was established that accommodated 60 beds and saw on average 130 patients per day. The field hospital had an ER and surgical and imaginative capabilities (Mercy, 2025). From field hospital the facility transitioned to a modular facility increasing capabilities and remained this way until 2015 when the new facility was completed (Ferenc, 2015). Another example of a similar, but different story, can be seen in Puerto Rico from Hurricane Maria in 2017. Numerous lessons were learned, but a few of the main takeaways were that a disaster preparedness plan must include comprehensive communication plan, and a two-week supply of food to ensure continuity of healthcare services in the aftermath of a disaster (de Arzola, 2018).

Coordination – Medical Surge. October 2017, in Las Vegas, Nevada, 58 people were killed and 500 injured during a mass shooting at the Route 91 Harvest music festival. This tragedy resulted in a surge of trauma patients to hospitals in the area. Outside of the level 1 trauma center (which is the highest designation a facility can have for trauma) the Desert Spring Hospital, a small medical center closest to the music festival, saw an influx of 105 patients (Welch, 2017). The Nevada Hospital Association (2019) released *A Day Like No Other – Case Study of the Las Vegas Mass Shooting* and amongst the many findings, lessons learned it was identified that the HCC did not have a direct role in the response, but the members felt that the preparedness and planning activities that the HCC oversaw had an impact on the ability of the coalition to respond to this event (Nevada Hospital Association, 2019). This event identifies that although HCCs may not play a role in no-notice surge events, the training they provide prior to any event prepares the hospitals and medical infrastructure to effectively respond to no-notice events. Throughout these sections it was also established that HCCs can play a vital role in surge events but the events where they show to be effective are those that have notice, or are not short lived (examples being hurricanes, and pandemics).

The Main Challenge for HCCs

As discussed earlier, funding for the HPP program and in return healthcare coalition have fluctuated drastically since the inception of the program. In 2003 $515 million was allocated to the HPP program and in 2022, $275.5 million (Barnett et., al, 2022). To add perspective in 2022, the United States Federal government spent approximately $1.5 trillion dollars (Tax Policy Center, 2024) on healthcare, meaning preparedness accounted .0184% of Federal dollars spent on healthcare. This underscore the biggest threat to HCCs, which is funding and the reliance on federal appropriations, for sustainability. This raises a critical question, how can HCCs create a scenario in which they do not rely on the federal appropriations to fund operation? Many HCCs have gone the route of diversifying funding through grants, partnerships, membership fees, establishing non-profit status, charging for certain services outside the scope of the HPP program, or various types of fundraising avenues.

Overall HCCs play a valuable role in disaster preparedness, response, and recovery and this is illustrated by research and reviewing lessons learned of disasters in the United States. Looking back at Hurricane Katrina the lack of coordinated healthcare was highlighted, then addressed by ASPR, and since then HCCs continue to be discussed as a net positive across the county. This is not to say that in some instances areas for improvement or growth are not identified, but the overall concept is supported and needed. The next section will review specific healthcare coalitions in Texas, New York, California, Arkansas, Colorado, Florida, and Minnesota.

A Review of Eight HPP Programs

To assess the operational landscape of the HPP initiatives, an optional survey was distributed to 10 healthcare coalitions or state departments of health and human services. Of these, eight responses were received, resulting in an 80% response rate. The eight responding states and jurisdictions included: (1) California, (2) Colorado, (3) Florida, (4) Minnesota, (5) Nebraska (6) New York City, (7) New York (one of three cities that receives direct funding from ASRP), and (8) Texas. Of the eight responses four were from healthcare coalitions, three from a hospital or hospital system, and one

from a county. It is important to note that the structure and leadership of healthcare coalitions vary by state. In some cases, a hospital or county agency may take a leadership role within the coalition, as governance structures and bylaws dictate coalition management at the state level. The questions that were asked were (note some questions have conditional formatting to show based on the previous response):

1. What State is your HPP provider in?
2. Select what type of organization you work for?
3. Once your state health department receives ASPR funding how is the funding distributed
4. Does your coalition provide financial support to hospitals (strictly dollars, equipment and training does not count for this question)?
5. Is this the same across all healthcare coalitions in your state?
6. What training does your coalition provide (select all that apply)?
7. Is your training conducted by a full- or part-time employee or do you use a contractor?
8. What training does the contractor do?
9. What specific disaster response services does your coalition provide (select all that apply)
10. How does your healthcare coalition help with resource sharing? Can you provide an example?
11. How does your healthcare coalition help with supply management? Can you provide an example?
12. How does your healthcare coalition help with response coordination? Can you provide an example?
13. Please list some of the assistance you have and what they do.
14. Please describe and provide examples of anything typed in the "other" of question 9.
15. What are the biggest challenges your coalition faces?
16. What are the biggest benefits of being part of your coalition?

17. Are there any healthcare coalition(s) in the nation that set at standard to follow that should be replicated in other States or nationwide as it relates to preparedness and response activities?

The following analysis highlights key insights from the questions, revealing some similarities and some differences in perspectives and approaches.

The survey responses reflect a diverse and complex landscape in how states and healthcare coalition manage federal funding received through ASPR. Funding distribution varies significantly across states. In some cases, state health departments directly manage and distribute these funds, while in others, coalitions received subawards through the state. A few jurisdictions, such as New York City, have unique arrangements where city level departments are the direct recipients and managers of the funds. This inconsistency has the potential to impact on the flexibility and responsiveness of preparedness activities.

One of the core issues examined in the survey is whether coalitions provide direct financial support to hospitals. The responses show a split. While some coalitions do offer monetary assistance, others strictly support hospitals through resources such as equipment or training. This distinction is important because financial support can directly impact a hospital's ability to maintain readiness, especially in underserved or rural areas.

Another area of disparity is the use of external contracts. Some coalitions hire private companies for training and operational support, citing benefits such as specialized expertise and scalability. Others rely on internal staff or partners within the coalition network. This inconsistency suggests that coalitions maturity and available resources may heavily influence whether outsourcing is seen as viable or necessary.

When it comes to disaster response, coalitions primarily provide coordination, information sharing, and logistical support rather than hands-on field operations. The most cited services include situation awareness updates, response coordination, and

resource mobilization. Full-scale operational services such as patient transport or deployment of mobile units were rarely mentioned, indicating that most coalition focus on support functions rather than direct response capabilities.

Resource sharing and supply chain management were highlighted as critical coalition functions. Several respondents emphasized the importance of memorandums or understanding (MOUs) and mutual aid agreements, which allow healthcare facilities to share scarce resources during a crisis. Examples included emergency sharing of medical gas and decontamination equipment. Still, not all coalition reported strong frameworks in these areas indicating potential gaps in preparedness.

In the realm of coordination, many coalitions play a key role in emergency response through participation in Emergency Support Function (ESF) 8 – Public Health and Medical Services, activities. They assist with information flow between agencies, coordinate with state health departments, and sometimes operate joint emergency operations centers. These activities are particularly valued during regional events requiring unified response strategies.

Coalition owned assets vary widely in scope and sophistication. Some reported having decontamination tents, bariatric cots, or mass casualty shower systems, while others mentioned basic logistical supplies. These assets are crucial during a disaster, but their availability depends heavily on past funding allocations and the strategic priorities of that coalition.

Despite the benefits, coalition faces significant challenges. Funding stability remains the top concern, with several respondents warning that loss of federal support would effectively dismantle coalition operations. Other challenges include low participation, especially in states where coalition engagement is voluntary, and overly centralized governance structures that stifle local initiative and responsiveness.

Nonetheless, coalitions remain valued for the relationships they foster and the collaborative planning they facilitate. Many respondents noted that being part of a coalition enhances situational awareness, enables joint exercises, and strengthens

regional partnerships. These intangible benefits such as trust and communication often translate into effective emergency response during real world events.

Finally, when asked about exemplary coalition most respondents championed their own organizations, emphasizing that effective preparedness must be tailored to local realities. They highlighted the unique challenges and contexts faced by different regions, arguing that strategies which work well in one area may not be suitable in another. As a result, the respondents cautioned against adopting a one size fits all approach, advocating instead for flexible, locally informed models that reflect the specific needs, resources, and risk of each community.

Current State & Potential Implications

As of May 22, 2025, the House of Representatives passed the “One Big Beautiful Bill Act” with a vote of 215-214, advancing the bill to the Senate for further consideration (Zanona & Ferris, 2025). While the bill contains a wide range of policy and funding provisions, one line item holds particular significance for this analysis and that is the complete elimination of all $240 million in HPP funding (Bosch, 2025).

If the HPP is completed eliminated from the federal budget, as proposed, the survey responses are indicative of the consequences for healthcare preparedness being significant and far-reaching. Across the responses, several key themes emerge that collectively highlight the program’s foundational role in sustaining local and regional readiness efforts.

First and foremost, based on these survey results, HPP funding is the core resource enabling coalition to function. Several explicitly noted that without federal funding, their coalitions “would go away”, indicating a direct dependence on HPP for operational continuity. This includes the ability to maintain staff, facilitate communication among member organizations, and support essential functions such as planning, training, and coordination. For coalition that already operate with limited financial support, a funding cut would likely lead to complete dissolution.

Moreover, coalition repeatedly identified financial support both direct and indirect, as critical to their ability to engage hospitals and other partners. While some coalitions do not provide financial aid in the form of dollars, many offer equipment, training, and logistical resources that are made possible through HPP grants. The absence of such support would strip hospitals of key incentives and capability to participate in preparedness initiatives, likely reducing engagement and degrading response capabilities.

Respondents also described how coalitions play a vital role in disaster response coordination, resource sharing, and maintaining situational awareness. Without HPP, coalitions would struggle to maintain or update mutual aid agreements, deploy sharing resources like decontamination tents or specialized cots, and coordinate across regions during emergencies. Several responses highlighted the importance of having structured mechanisms to share information and resources particularly in crises. The elimination of HPP would severely disrupt these coordinated systems, resulting in more fragmented and less effective response.

Importantly, many coalitions use HPP funds to conduct exercises, maintain readiness assets, and build the relationships necessary for coordinated action. One respondent noted that the primary value of their coalition lies in “relationship building and being a good partner,” which directly contributes to rapid and trusted coordination during emergencies. Loss of HPP support would undermine this relational infrastructure, which cannot be quickly or easily rebuilt.

In summary, based on the survey responses, the elimination of the HPP program from the federal budget would be catastrophic for many states, as the HPP program is the linchpin of U.S. healthcare preparedness. Eliminating it would dismantle coalitions, reduce engagement, erode inter-organizational coordination, as healthcare coalitions serve as the forum for this. The result would be a healthcare delivery system that is less equipped and prepared to handle disasters.

Recommendations / Way Forward

As the future of the HPP remains uncertain, the need to ensure the long-term viability of HCCs has become increasingly urgent. These coalitions are essential to coordinate disaster response and overall resilience, yet many remain financially dependent on a single source of federal funding. In the face of potential funding elimination, HCCs must evolve by pursuing sustainable, diversified funding models and adopting systems that ensure consistent performance and accountability. At the same time, the general public's lack of awareness about the existence and importance of HCCs presents a significant barrier to both support and sustainability. To address these challenges this section presents three core recommendations: (1) developing alternative funding mechanisms that reduce reliance on federal appropriations, (2) establishing a national framework for best practices, governance, and dynamic performance metrics, and (3) increasing public visibility through strategic outreach and education. Together, these strategies provide a roadmap for strengthening the role, impact, and resilience of HCCs in an increasingly complex prepared environment.

Alternative Funding Sources for Sustainability

Earlier in this discussion, the question was raised, how can HCCs create a sustainable financial model that ensures independence from federally appropriated? While many HCCs have made efforts to diversify their funding streams through grants, private sector partnerships, membership dues, establishing non-profit status, utilizing a fee for service model for services outside the scope of the HPP program, or other traditional fundraising avenues. These mechanisms, while valuable, often lack the consistency and scalability needed to fully support coalition operations in the absence of federal funding. These traditional approaches tend to vary widely in effectiveness depending on region, administrative capacity, and organizational structures.

A more innovative and potentially transformative solution is proposed by Barnett et al. (2022), which would require policy level change; aligning financial incentives with coalition participation through modifications to Medicare reimbursement. Specifically, healthcare systems that actively contribute to coalition activities such as hosting

exercises, sharing resources, or leading preparedness planning could be rewarded with enhanced Medicare payments. Additionally, tax incentives could be offered to private entities and healthcare providers that invest in or support coalition infrastructure.

This model offers two major advantages. First, it shifts preparedness from a federally subsidized program to a shared responsibility model that incentivizes local ownership. Second, it could foster stronger, more engaged coalitions with sustainable funding mechanisms that are embedded within the healthcare delivery and reimbursement system. By tying preparedness to financial incentives, HCCs would gain a more predictable and performance-based funding stream, reducing vulnerability to budget cuts and enhancing long term sustainability.

Identifying Best Practices with Integrated Dynamic Performance Metrics

Although survey responses from HPP providers stated that a one size fits all models is impractical for HCCs, given that governance, structure, and operational functions must reflect local needs, there remains a clear and urgent need for the establishment of a nationally recognized industry standard. This standard should define a minimum baseline for all healthcare coalition, including requirements for core training offerings, exercise frequence, use of contractual support, and define roles in disaster response. Importantly, adopting a standardized best practice framework does not mean eliminating flexibility. Rather, it ensures that all coalitions adhere to a consistent foundation for governance, structure, and performance while maintaining the ability to adapt to their unique regional contexts.

As a second recommendation, a dynamic performance evaluation system should be implemented to complement the traditional static, annual review of performance. This system would support more frequent assessments ideally monthly to ensure that coalitions are continuously meeting readiness benchmarks and be compared to similar sized coalitions. Rather than introducing additional administrative burdens, this approach should leverage technology to automate the tracking of performance metrics, integrating directly with operational workflows (i.e. number of training courses held each month. This metric is being tracked but could be utilized with other metrics to give a

monthly score for the coalition, which then would be compared to similar sized coalitions).

Together, the implementation of a national standard and the shift toward dynamic, technology driven performance evaluation would reinforce coalition accountability, promote operational excellence, and ensure that preparedness remains a continuous and prioritized function within the healthcare system. These enhancements would help keep coalitions aligned with their core mission and better positioned to respond effectively to evolving threats.

Highlighting the Purpose: Why are HCCs Needed

This last recommendation is likely the least supported in terms of literature to support the claim that the public simply does not know what a healthcare coalition is or why it is important. Two examples can initially be provided before discussing the recommendation with the first being from the National Association of County and City Health Officials (NACCHO) who calls out the vital importance of HCCs and their role, but on the same note says that the work is not visible to the general public which contributes to the lack of understanding of HCCs to people (NACCHO, 2017). The second is when reviewing the U.S. Department of Health and Human Services website information can be found on HCCs but the information is designed for healthcare providers first responders and not designed for the public. The same could be said for ASPRs site, great information exists but not geared for educating the public of the role of an HCC, why they are important, and why they exist.

This gap in public understanding underscores the need for HCCs to proactively engage in community education. Coalition should work with partner organizations to develop and disseminate communications that clearly explain their purpose, activities, and value to local communities. Increasing public awareness not only strengthens community support but may also improve coalition sustainability by expanding fundraising opportunities. It is difficult to secure donations from individuals or

businesses outside the healthcare and emergency response sectors if people and businesses are unaware of what HCCs are or how they contribute to community response, resilience, and recovery.

Closing

For more than two decades, the HPP has been the cornerstone of the nation's healthcare. Readiness efforts. From its inception in the aftermath of 9/11 and the anthrax attacks, through multiple public health emergencies and disasters, HPP has enabled hospitals, health. departments, and emergency responders to build critical capabilities. The formation of HCCs under HPP strengthened collaboration across agencies and sectors, improved communication and training, and ensured that communities were better prepared to respond to mass casualty incidents, infectious disease outbreaks, and natural disasters.

Today, the future of the HPP stands at a crossroads. The proposed elimination of HPP funding would dismantle the very coalitions and systems that have proven essential during crises like Hurricane Harvey and the Covid-19 pandemic. Survey responses and historical analysis. demonstrate that HPP funding is not just supplemental, it is foundational. Without it, many, if not all coalitions would cease to function, and healthcare entities, especially in rural areas which would lose the critical coordination infrastructure that enables effective emergency response, planning, and preparedness efforts.

As disasters continue to become larger, more frequent, and more complex, the need for sustained investment in healthcare preparedness has never been more urgent. Federal policymakers must recognize that readiness is not a one-time achievement but an ongoing commitment. At the same time, HCCs must adapt by diversifying funding, adopting performance-based metrics, and increasing public engagement. Preserving and modernizing the HPP is essential not only for disaster response but for long term readiness of the U.S. healthcare delivery system.

Author Biographies

Adam Lee currently is the Director of Emergency Management and Organizational Resilience for Memorial Hermann Health System, where he is responsible for leading the Emergency Management, Business Continuity, and Resilience programs across all Memorial Hermann Owned and Operated Sites. Adam also is an Adjunct Professor with Sam Houston State University and sits at the Institute of Homeland Security Institute at Sam Houston State's Advisory Committee for Healthcare, the Advisory Committee for the Association of Business Continuity's Special Interest Group on healthcare, and the Greater Houston Partnerships Resilience Workgroup. Prior to joining Memorial Hermann Adam worked for the SouthEast Texas Regional Advisory Council (SETRAC) and the City of League City. Adam's academic credentials consist of a master's in business administration (MBA), Master of Science (MS), Certified Emergency Manager (CEM), Master Continuity Practitioner (MCP) and is a Six Sigma Green Belt. Adam had also published in both peer-reviewed and professional journals.

Fidel J Calvillo is the Emergency Management Operations Coordinator – Special Populations for the SouthEast Texas Regional Advisory Council. Mr. Calvillo currently holds a position as the Emergency Management Operations Coordinator – Special Populations for the SouthEast Texas Regional Advisory Council (SETRAC). As the Emergency Management Coordinator, he is part of a team responsible for the implementation of the Hospital Preparedness Program for 25 counties with a combined population of over 8 million people, 180 hospitals, over 1,000 nursing homes/assisted living facilities and numerous EMS agencies.

With over twenty (20) years of experience in working in disaster preparedness and response in emergency management, public health preparedness, and healthcare preparedness has developed a wealth of knowledge with over dozens of response activations. Mr. Calvillo's largest disaster response was hurricane Harvey assigned at the Catastrophic Medical Operations Center with the responsibility of overseeing information management, brokering requests for assistance and supplies, coordinating patient movement, and providing situational awareness across emergency response disciplines within a 25 County Region. Mr. Calvillo's last regional activation to support the SETRAC Region was for Hurricane Beryl.

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