



Dr. Nicole Lurie, MD, MSPH  
Assistant Secretary for Preparedness & Response  
Department of Health and Human Services  
Washington, DC 20201

Re: Trust for America's Health Comments on Biennial Implementation Plan for the *National Health Security Strategy*

August 23, 2010

Dear Dr. Lurie:

On behalf of Trust for America's Health (TFAH), I am pleased to present you with our comments on the draft Biennial Implementation Plan (BIP) for the *National Health Security Strategy* (NHSS). Trust for America's Health is a nonprofit, nonpartisan public health advocacy organization dedicated to saving lives by making disease prevention a national priority.

**Overall Comments:**

We applaud the manner in which the Office of the Assistant Secretary for Preparedness and Response (ASPR) addressed the overall goals of the NHSS. We agree that, given extreme budget constraints, the focus needs to be on building more resilient populations and leveraging capabilities across communities.

While we support nearly all of the objectives within the BIP, there are some areas where additional clarity is needed to help achieve the goals of the NHSS. One concern we have is that many of the objectives and activities do not specify the action to be taken or by whom (for example, "Incentivize communication that focuses on connections between individual and community preparedness" or "Improve monitoring of water and food"). The Implementation Plan, unlike the underlying Strategy, should be as clear as possible, within the constraints of what is known on each topic, as to how each activity will be deployed.

Along these lines, we are also concerned about stakeholder engagement in the design and roll out of the BIP. There is no indication anywhere in the document that ASPR engaged with the state and local agencies, nonprofits, academic and research organizations, or private entities, yet it is clear the success of the plan requires the collaboration and cooperation of this broad group. It would be helpful to include a summary of the stakeholder engagement process, which we believe, would also enhance the credibility of the BIP.

A related question remains as to how nongovernmental partners will be engaged in implementing these activities. Although many leads and partners are listed in Appendix A, in cases where nongovernmental organizations are listed as "Notional Lead" or "Potential Partners" within the Appendix, we encourage you to be explicit as to how these partners will be engaged and by whom. It seems that the BIP is dependent upon the private/academic sector for activities such as workforce development (Objective 2). HHS should clarify how it will incentivize nongovernmental engagement, especially without additional funding.

We are also concerned about the lack of mention of the Affordable Care Act (ACA) throughout the document. ACA has the potential to have a tremendous impact on public health preparedness, such as through increased insurance coverage (which could both improve health and develop the fiscal stability of the health system during a crisis), better access to prevention, funding for public health infrastructure, and grants to create healthier communities. Given the role that the health of a community plays in its resilience, we strongly encourage HHS to leverage the benefits of health reform to improve the nation's ability to prepare for and recover from a disaster.

### **Objective 1: Foster Informed, Empowered Individuals and Communities**

#### **Community Members are Educated about Health Threats:**

**p. 13 line 390-417**

#### **Strong Community Partnerships and Integrated Plans for Health Security Are in Place**

**p. 14 lines 438-452**

How will HHS assess how well local government agencies are partnering with NGOs? We recommend including a measure in cooperative agreements or other survey tools to evaluate the success of this strategy. Perhaps HHS could incorporate a module into an existing survey system, such as CDC's Behavioral Risk Factor Surveillance System, to gauge baseline levels of knowledge about public health threats.

### **Objective 2: Develop and Maintain the Workforce Needed for National Health Security**

#### **Communities Have an Adequate Number of Staff and Volunteers**

**p. 21 lines 637-639**

We agree that there needs to be additional clarity and efforts to overcome obstacles to health care personnel attending work during a disaster. As ASPR identifies strategies to encourage willingness to attend work, we urge you to consider the following activities: clarifying liability protections;<sup>1</sup> improved communication and training of workers;<sup>2</sup> ensuring adequate supplies of personal protective equipment to personnel and their families; and ensuring an adequate supply of medical countermeasures.<sup>3</sup>

#### **Ongoing Recruitment and Retention Efforts Secure the Supply of National Health Security Professionals**

**p. 22 lines 669-675**

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<sup>1</sup> Levi et al, *Ready or Not? 2008: Protecting the Public's Health from Disease, Disasters, and Bioterrorism*. Trust for America's Health, Dec 2008. <http://healthyamericans.org/assets/files/bioterror-report-2008.pdf>

<sup>2</sup> Association of State and Territorial Health Officials. *Assessing Policy Barriers to Effective Public Health Response in the H1N1 Influenza Pandemic. Project Report to the Centers for Disease Control and Prevention*. Arlington, VA: ASTHO, 2010.

<sup>3</sup> Balicer et al, "Characterizing Hospital Workers' Willingness to Report to Duty in an Influenza Pandemic Through Threat- and Efficacy-Based Assessment," *BMC Public Health* 2010, 10:436, Feb 2010. <http://www.biomedcentral.com/1471-2458/10/436>

We encourage an additional sub-bullet here to promote *existing* federal public health workforce recruitment and retention efforts, such as the loan repayment programs and mid-career training grants authorized in health reform. Some of these have already received funding through the Prevention and Public Health Fund authorized by the Affordable Care Act (ACA). ACA also includes provisions to promote a diverse public health and healthcare workforce, which contribute to community resilience. It would also be useful to assess how successful such federal workforce programs have been in attracting public health graduates to governmental public health. We urge ASPR to work with the Health Resources and Services Administration (HRSA) on such an evaluation.

#### **Objective 4: Foster Integrated, Scalable Health Care Delivery Systems**

##### **Routine Medical and Behavioral Health Care, Including Emergency Care, Is Provided Fairly and Efficiently Based on Need, Situation, and Available Resources p. 36 lines 1103-1104**

Although we agree that identifying barriers to adopting electronic health records (EHRs) is an important aspect to achieving a more prepared health care system, this activity should be significantly expanded within the BIP. EHRs hold the potential to assist with rapid communication between providers and with health departments, facilitate rapid identification and treatment of patients after a crisis hits, improve access to medical countermeasures for an infectious disease outbreak, and enable rapid biosurveillance and disease trend tracking over time.<sup>4</sup> First, HHS should consider not just the barriers to health facilities and providers adopting EHRs, but identify and counteract the obstacles public health departments face in being able to receive and use EHR data. Second, ASPR and CDC should work with the Office of the National Coordinator (ONC) to ensure that public health preparedness capabilities are incorporated into the development of EHR meaningful use rules as they are being developed. These factors should include reporting of data to public health departments, usability and uniformity of data collected and reported by clinicians and public health agencies, and communication of public health departments back to clinicians. Finally, meaningful use rules should include better data collection on race, ethnicity, and language, so we can effectively and efficiently address health disparities and increase community resilience.

#### **Objective 5: Ensure Timely and Effective Communication**

##### **Identify and access existing communication networks p. 41 lines 1296-1303 and 1332-1349**

We applaud the implementation plan's recognition that governmental bodies must build on existing social connections in their communities in order to achieve an educated population. We would encourage you to ensure that this activity does not focus solely on risk communications. Communications with the public, non-governmental organizations, and media before a disaster occurs must include day-to-day public health messaging, not just preparedness planning. Messaging also needs to be tailored to specific communities, delivered by trusted, culturally

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<sup>4</sup> Vinter, S., Lieberman, D. and Levi, J. "Public Health Preparedness in a Reforming Health System," *Harvard Law and Policy Review*, Summer 2010, Vol. 4 No. 2. [http://hlpronline.com/wordpress/wp-content/uploads/2010/06/vinter\\_preparedness.pdf](http://hlpronline.com/wordpress/wp-content/uploads/2010/06/vinter_preparedness.pdf)

relevant spokespersons. In this case, one message does not fit all. Once trust is built up between public health and constituencies, the public and media will be more likely to respond to risk communications during a disaster. HHS' marketing programs can provide technical assistance to health departments in both developing a message and building communications networks. As previously mentioned, ACA allocates 5 years of support to aid the development and dissemination of model cultural competence training and education criteria -- this money could be leveraged to address preparedness and community resilience as well.<sup>5</sup>

### **Objective 7: Ensure Prevention or Mitigation of Environmental and Other Emerging Threats to Health**

**p. 52 lines 1626-1645 and p. 55 lines 1739-1740**

We are pleased to see mention of antimicrobial resistance (AMR) within this section, yet the BIP does not reflect the seriousness of this problem. The impending crisis from resistant organisms has such catastrophic potential that the issue should receive its own section within Objective 7, with much more specific objectives and action items. We recommend the Secretary designate a federal official to oversee a government-wide strategic plan, a comprehensive research agenda, and increased coordination among the federal agencies with roles to play in AMR response. We look forward to the updated Public Health Action Plan to Combat Antimicrobial Resistance and hope that this strategy will be coordinated with other efforts, including the forthcoming medical countermeasures strategy being developed by ASPR. We also hope that there will be recognition on the part of the Administration – both through the work of ASPR and through engagement of the National Security Staff at the White House – that AMR is not just a traditional public health threat, but one that has serious bioterrorist potential as well.

#### **Improve Surveillance**

**p. 54 lines 1720-1753**

As state and local health departments detect and report on a growing list of threats to a variety of state and federal agencies, the federal government should build consistency in surveillance strategies, data collection and analysis across surveillance systems. During the H1N1 outbreak, disparities in the types and amount of data collected at different levels of government and jurisdictions made it more difficult to analyze the viral spread and plan the response.<sup>6</sup> In addition to the surveillance strategies included in the BIP, we urge HHS to: 1) conduct an evaluation of all the epidemiology and surveillance systems used during the H1N1 response to determine what worked well and what needs improvement and to evaluate what data was helpful; 2) develop national standards for use and reporting of syndromic surveillance data; and 3) provide greater nationwide consistency in the reporting of data to be used at all levels of government.<sup>7</sup>

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<sup>5</sup> Andrulis DP, Siddiqui NJ, Purtle JP, et al. *Patient Protection and Affordable Care of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*. Washington, DC: Joint Center for Political and Economic Studies, 2010.

<sup>6</sup> ASTHO, 2010.

<sup>7</sup> ASTHO, 2010.

As mentioned above, development of surveillance must also leverage new electronic health records and other health information technology.

**Human health effects of climate change  
p. 51 line 1607 and p. 55 1741-1742**

There is a large and growing body of evidence documenting the adverse human health effects from climate change and the need for a governmental public health response.<sup>8</sup> As such, we believe the report should include a more explicit call for planning and response for the adverse human health effects of climate change.

**Increase ability to develop, deploy, and administer medical countermeasures  
p. 56 lines 1770- 1772**

The H1N1 outbreak illustrated a gap in administering medical countermeasures during an infectious disease outbreak. During the pandemic, vaccine distribution was a key component of the response. Although they were integral throughout the H1N1 response, existing vaccine distribution systems (such as those in place for the Vaccines for Children program) were not included in pandemic planning efforts in most states. Such partnerships, including the use of private sector distribution systems, should be built into the pandemic planning. Health IT also could be leveraged for identifying at-risk individuals for distribution of limited medical countermeasures.

**Objective 10: Ensure that All Systems that Support National Health Security Are Based Upon the Best Available Science, Evaluation, and Quality Improvement Methods**

**Develop and begin executing a work plan for a common core of health security measures and standards  
p. 77 lines 2503-2516**

Although we are encouraged that the BIP includes future plans to assess the progress of implementation, we urge you to use specific interim benchmarks for each objective and activity included in Appendix A. The Cooperative Agreement methodologies do not apply to all objectives of the BIP and may not translate to evaluating federal agencies.

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<sup>8</sup> Levi J, Vinter S, Gratale D, et al. *Health Problems Heat Up: Climate Change and the Public's Health*. Washington DC: Trust for America's Health, October 2009.