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Senate Committee on Health, Education, Labor & Pensions
A Nation Prepared: Strengthening Medical and Public Health Preparedness and Response
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My name is Lowell P. Weicker, and I am President of the Board of Directors of Trust for America's Health (TFAH), a nonprofit, nonpartisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority. I am grateful for the opportunity to submit testimony to the Committee on reauthorization of a groundbreaking piece of legislation, the Pandemic and All-Hazards Preparedness Act (PAHPA).

PAHPA represented a major step in acknowledging and developing the role of America's public health system in preparing for and responding to major emergencies, whether natural or man-made. The reauthorization of PAHPA is an opportunity to build more prepared and resilient communities, able to weather a storm, contain its impact, and return to normal as quickly as possible. I applaud the Committee for demonstrating its commitment to better preparing our nation for disasters.

I have two major points to make in my testimony today:

First, our nation faces continuing natural and man-made threats that require an ongoing commitment to public health preparedness. This is a national security threat – as direct as any we face abroad. The death of Osama Bin-Laden does not erase that threat; there are still very creative terrorists out there and our guard cannot be let down.

Second, we must fund public health preparedness with the same level of commitment as we have made to other national security priorities. This means: (a) we must assure reliable, predictable funding for public health preparedness, in contrast to the 27 percent decline faced over the last several years; (b) we must assure that state and local health departments are given flexibility to use all employees supported with federal funds during an emergency and not be hamstrung by categorical restrictions; (c) and we must fully embrace the spirit of "all hazards" in PAHPA by recognizing that almost every public health program contributes to preparedness. As our health care system modernizes – especially with regard to health information technology – we must be sure public health programs, such as biosurveillance, adapt as well, including by leveraging existing resources in more creative ways.

The public health system has always been integral in our response to natural disasters and terrorist attacks. Public health was on the frontlines of the response to 9-11 and to the anthrax attacks. It is as fundamental to the nation's security as our military and as fundamental to local protection as fire and rescue. Passage of PAHPA codified and expanded the federal

government's support for this role. As a result of this legislation, and the investments that followed, our nation is more prepared than ever. We saw this in the response to the H1N1 outbreak in 2009, when nearly every state and jurisdiction implemented its pandemic influenza plan in response to the H1N1 outbreak, with activities including disease surveillance, ongoing communication updates, carrying out vaccination campaigns and the coordination of response efforts with partners.[1]

In TFAH's 2010 report, *Ready or Not?,* we found that states had made enormous progress since the events of 2001 in planning for and responding to disasters. The Public Health Emergency Preparedness (PHEP) cooperative agreement and Hospital Preparedness Program (HPP), federal, state, and local attention to the role of public health in emergency preparedness, and real-world experiences such as the H1N1 outbreak have helped us bring preparedness to the next level. However, the report also found that the economic crisis is putting almost a decade of gains at serious risk. While emergency H1N1 and stimulus funds may have helped states weather the storm of the pandemic, we cannot continue to fund preparedness on a disaster-by-disaster basis. Our report found that 33 states and D.C. cut public health funding from fiscal years 2008-09 to 2009-10, with 18 of these states cutting funding for the second year in a row. In addition, federal support for public health preparedness was cut by 27 percent between FY2005 and FY2010 (adjusted for inflation). We expect to see major cuts to federal public health preparedness programs in both FY2011 and 2012. These inconsistencies represent the greatest threats to our ability to respond to a public health catastrophe on the level of the Japan earthquake and tsunami.

We believe a modernized, prepared public health system must address several remaining gaps:

- A Workforce Gap: The National Association of County and City Health Officials reports that we have lost roughly 19 percent of the local health department workforce since 2008. This loss of experience has a staggering impact on preparedness, as workers cannot simply be hired and trained once a disaster strikes.
- A Surge Capacity Gap: Surge capacity, the ability of the medical system to care for a massive influx of patients, requires ongoing planning, funding, and coordination across healthcare, public health, first responder, and private sectors.
- A Surveillance Gap: The nation still lacks an integrated, national approach to biosurveillance, which could significantly improve response capabilities for emergencies.
- Gaps in Medical Countermeasure Development: The research and development of vaccines, antivirals, diagnostics, and other countermeasures is years ahead of where we were during the 2001 anthrax outbreak; yet our ability to spur innovation in these limited-use technologies has been hampered by a lack of stable funding and some breakdowns in program administration.

PAHPA reauthorization represents an opportunity to fill some of these critical gaps. As you begin consideration of amending the law, TFAH would like to offer the following recommendations:

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[1] Centers for Disease Control and Prevention, *Public Health Preparedness: Strengthening the Nation's Emergency Response State by State, September 2010.* Available from: http://emergency.cdc.gov/publications/2010phprep/pdf/complete_PHPREP_report.pdf

1. **Strengthen Public Health Preparedness Infrastructure:** The economic recession has led to cuts in public health staffing and eroded the basic capabilities of state and local health departments. Strengthening the public health preparedness workforce and infrastructure is critical to ensuring the health protection of our nation. It also requires adequate funding and human resources to recruit and train personnel, stockpile life saving countermeasures, develop and exercise plans, and identify and engage partners to support the public health mission. The resources required to truly modernize public health systems must be made available to bring public health into the 21st century and improve preparedness.

   The PHEP cooperative agreements and HPP are two key grant programs that support the development and sustainability of state and local public health preparedness infrastructure. Since their inception, these programs have increased the capacity of state and local health departments and health systems to prepare for and respond to a disaster.[2, 3] Our 2010 report found that these funding streams have contributed to major progress in workforce training, epidemiology and laboratory capacity, surveillance, and planning and exercising at the state and local level.

   During the 2009-2010 H1N1 influenza outbreak, state and local health departments were on the front lines responding to the pandemic, though many were limited in their efforts as a result of federal and state budget cuts, particularly those that have occurred over the past five years. These budget crises demonstrated, among other things, the need to build in mechanisms to allow more flexibility in how staff, funded by federal grant programs, are used during emergencies. In the H1N1 influenza response, the ability to re-assign staff from other federally-funded projects in health departments could have improved the financial and human resource efficiencies of that agency's response to the influenza pandemic, especially during the earlier response phases when additional funding was not yet available and jurisdictions needed to mobilize "all hands on deck."
   To address these concerns, we recommend language that would:
   - Establish multi-year grant cycles with greater flexibility in states' retention and use of carry forward and unexpended funds;
   - Create a mechanism to fast track the awarding and programming of emergency supplemental funds into existing grant mechanisms without additional match or maintenance of funding requirements; and
   - Grant authority to the Secretary to allow states to also use personnel that are part of other federal programs in response to a public health emergency (e.g. an "all hands on deck" scenario).
   - We understand that HHS and the Department of Homeland Security (DHS) have begun working to align grant programs that aim to build our nation's emergency preparedness capacity, including PHEP, HPP, and FEMA grants. Currently the PHEP and HPP grants, both of which are often distributed through public health departments, have separate application and reporting requirements, overarching

[2] Centers for Disease Control and Prevention, *Public Health Preparedness: Strengthening the Nation's Emergency Response State by State, Sept 2010.* http://emergency.cdc.gov/publications/2010phprep/index.asp.
[3] Center for Biosecurity, *Hospitals Rising to the Challenge: HPP Evaluation Report*, March 2009. http://www.upmc-biosecurity.org/website/resources/publications/2009/2009-04-16-hppreport.html

goals, and in some cases conflicting performance metrics. We believe the alignment process should include coordinating grant priorities and goals, grant cycles, and streamlining application and reporting mechanisms to achieve maximum efficiency. I urge you to use PAHPA to ensure oversight and proper implementation of this alignment process.

2. **Modernize Biosurveillance:** Situational awareness – knowing what the threats are, and knowing what our capacity to respond is, at any given moment – is critical to responding to any emergency and we need to make sure we are building capacity using 21st century technology and approaches. We have built our disease surveillance system one disease at a time and one crisis at a time, rather than as a unified, interoperable unit. Rather than continuing these silos, we have the opportunity to think across diseases (infectious and chronic) and emergency situations, because health information technology is advancing at a rapid pace and the health care system is becoming electronic.

   It is time for public health to do the same. Imagine a system where a provider inputs data into an electronic health record, the health department is rapidly informed of a cluster of unusual symptoms (indicating an outbreak), and the health department then communicates with the provider and responds quickly with the appropriate intervention. Right now, the ability of health departments to receive and analyze electronic data varies widely from jurisdiction to jurisdiction. Because the federal government is in the process of catalyzing adoption of electronic health records, now is the time to think about how to incorporate public health into the system. PAHPA can help fill this gap:
   - PAHPA should call for a new national strategy, led by HHS and CDC, that would examine means to achieve interoperability and transparency among various surveillance systems.[4] The United States lacks an integrated, national approach to biosurveillance, and there are major variations in how quickly states collect and report data which hamper bioterrorism and disease outbreak response capabilities. The lack of an overarching federal biosurveillance strategy has led to fragmentation, multiple separate surveillance systems, and barriers to relevant agencies prioritizing and synthesizing data.[5, 6] And according to a December 2010 GAO report, HHS had not provided a strategic plan for electronic situational awareness, as required by PAHPA.[7]
   - The national strategy should also call for leveraging of new epidemiological data that may become available as a result of the development of health information technology (IT) and electronic health records (EHRs). There is no overarching coordination between public health surveillance efforts at HHS and the work of

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[4] Nuzzo, Jennifer, Center for Biosecurity of UPMC. "Developing a National Biosurveillance Program," *Biosecurity and Bioterrorism*. Volume 7, Number 1, 2009. http://www.upmc-biosecurity.org/website/resources/publications/2009/biomemo/2009-03-27-develop_natl_biosurveillance.html

[5] Nuzzo, 2009.

[6] Vinter, S. et al, Trust for America's Health, *Ready or Not? 2009: Protecting the Public's Health from Diseases, Disasters, and Bioterrorism*. December, 2009. http://healthyamericans.org/reports/bioterror09/pdf/TFAHReadyorNot200906.pdf

[7] U.S. Government Accountability Office, *Public Health Information Technology: Additional Strategic Planning Needed to Guide HHS's Efforts to Establish Electronic Situational Awareness Capabilities.* http://www.gao.gov/products/GAO-11-99

the Office of the National Coordinator for Health Information Technology (ONC). The ONC should work closely with a designated person at CDC and with state/local/tribal/territorial partners, with PAHPA mandating this synchronization and collaboration. For example, as ONC develops new standards for meaningful use of health IT, it should incorporate the preparedness and biosurveillance implications of such technologies. Interoperability between public health and EHRs could not only help with early detection of an emerging disease outbreak or bioterror attack, but could also help with identification of targeted populations or geographic regions to receive medical countermeasures and tracking the post-dispensing impact of medical interventions.

3. **Improve Vaccine and Pharmaceutical Research, Development, and Manufacturing:** The United States is falling behind in its research and development of medical countermeasures to fight public health threats. As the nation revamps its approach to research and development of vaccines, medicines, diagnostics and equipment to respond to emerging public health threats, policymakers must ensure public health is involved throughout the process, from initial investment through distribution and dispensing. PAHPA can advance the nation's MCM enterprise through the following activities:
    - Congress should consider authorizing President's requests for MCM advancement: building an MCM Strategic Investor to leverage private capital for promising technologies; using unspent H1N1 money to establish Centers for Innovation in Advanced Development and Manufacturing; and developing end-to-end leadership to see products through from initial research through dispensing. However, bill language should request additional detail from HHS on how these programs would be implemented, including multiyear professional judgment budgets for implementation of the PHEMCE strategy.
    - Report language in PAHPA should urge 1) increased coordination between FDA, BARDA, NIH, and CDC from initial investment through dispensing; 2) improved transparency of the development process, including regulatory pathways by FDA and contracting process with BARDA and Bioshield; and 3) MCM strategy should be end-to-end – not just focused on initial investments, but on advance development, procurement, distribution, and surveillance.
    - Improving SNS Management: There should be a plan for stocking the Strategic National Stockpile (SNS) and for ongoing replacement of expiring product, especially vaccines,[8] pediatric doses of antimicrobials, antivirals and other products, and restocking materiel used as a result of the H1N1 outbreak. This plan should also include a professional judgment budget for replacing product expiring over the next several years. The legislation should also call for increased coordination between CDC and BARDA on SNS procurement and management.
    - Authorize extension of the Shelf-Life Extension Program (SLEP) to state stockpiles of medical materiel. Currently, only federally-held stockpiles are eligible for the SLEP, which can be a cost-effective way to maintain state and local supplies.

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[8] Testimony of Robert Kadlec Before House Homeland Security Subcommittee on Emerging Threats, Cybersecurity, and Science and Technology. June 15, 2010. http://hsc.house.gov/SiteDocuments/20100615131640-79968.pdf

4. **Enhance Surge Capacity:** In the event of a major disease outbreak or attack, the public health and health care systems would be severely overstretched. Policymakers must address the ability of the health care system to quickly expand beyond normal services during a major emergency. Investments in research and development, stockpiling, and practice in drills and tabletop exercises will aid in the timely distribution of antivirals and other equipment during an outbreak. PAHPA should facilitate health care preparedness by:
    - Encouraging enhancements in the Hospital Preparedness Program (HPP). The HPP, administered by the Assistant Secretary for Preparedness and Response (ASPR), aims to prepare the nation's health system for the medical and logistical impacts of a disaster. Rather than continuing to fund individual hospitals for preparing for a crisis, HPP has played a role in spurring creation of regional healthcare coalitions, alliances between hospitals, public health, and emergency management.[9] These coalitions allow for a shared burden and reduce surge to any single facility. However, in many regions, this is still a nascent process.[10] Building and developing these coalitions should be an explicit goal of HPP, including expanding coalitions to every city and linking them into a national system.
    - Clarifying crisis standards of care. The federal government should provide a national framework to guide states and local entities in developing crisis standards for use during a mass casualty event. Leaving this process up to the states has not led to enough progress in developing a better understanding of the kind of care that would be available in a disaster.
    - Clarifying federal volunteer liability laws to implement one, blanket liability that applies to all volunteer health professionals and entities volunteering under a nationally-declared public health emergency or disaster. HHS has acknowledged that a patchwork of federal liability laws is confusing and frustrating to providers.[11] There should also be Federal Tort Claims Act protection for Medical Reserve Corps volunteers year-round, as these personnel participate in public health drills and training during times of non-disaster.

Thank you for this opportunity to weigh in as the Committee considers reauthorization of PAHPA. I look forward to your questions.

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[9] Toner, Eric et al, Center for Biosecurity of UPMC. *Hospitals Rising to the Challenge: The First Five Years of the U.S. Hospital Preparedness Program and Priorities Going Forward*, March, 2009. http://www.upmc-biosecurity.org/website/resources/publications/2009/pdf/2009-04-16-hppreport.pdf

[10] Toner, Eric. Expert perspective in *Ready or Not? 2009*. http://healthyamericans.org/assets/files/TFAH2010ReadyorNot%20FINAL.pdf.

[11] DHHS, Office of the General Counsel, "Public Health Emergencies and Federal Health Law." Presentation at 2010 Public Health Preparedness Summit, February 2010. http://www.phprep.org/2010/Agenda/upload/Interactive-145.pdf