



TFAH PAHPA Reauthorization Recommendations

1. **Fully Fund Preparedness and Infrastructure:** The resources required to truly modernize public health systems must be made available to bring public health into 21st century and improve preparedness. The Public Health Emergency Preparedness grants should be updated to include:
 - Giving the Secretary enhanced flexibility during an emergency to waive some categorical requirements for state and local health department personnel funded under other federal funding programs and the authority to waive maintenance of effort requirements during a declared disaster.
 - Multiyear grant cycles to allow for long term planning by state and local jurisdictions, rather than one year funding awards.
2. **Increase Workforce Capacity:** The United States has 50,000 fewer public health workers than it did 20 years ago - and one-third of current workers are eligible to retire within five years. PAHPA can also help with recruitment and training of the preparedness workforce by:
 - Including report language calling for funding to train and retain the 21st century public health workforce, including the Public Health Workforce Loan Repayment Program and Epidemiology-Laboratory Capacity Grants. This workforce should be cross-trained to prepare for and respond to public health emergencies.
3. **Modernize Biosurveillance:** 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. PAHPA can help fill this gap through these steps:
 - The federal government should enhance national disease surveillance systems to include uniform national standards and compatibility with emerging Health Information Technology and Electronic Health Records standards.
 - According to the GAO, HHS failed to provide a strategic plan for electronic situational awareness, as required by PAHPA 2006.¹ PAHPA should again mandate development of a National Biosurveillance Strategic Plan, with HHS leading the public health surveillance enterprise. TFAH agrees that 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.^{2, 3} To that end, we

¹ GAO, "Public Health Information Technology: Additional Strategic Planning Needed to Guide HHS's Efforts to Establish Electronic Situational Awareness Capabilities," December 17, 2010.

<http://www.gao.gov/products/GAO-11-99>

² Nuzzo, Jennifer, Center for Biosecurity. "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

³ 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>

recommend language requiring the newly developed strategy to examine means to achieve interoperability and transparency among various surveillance systems.⁴ The national strategy should also leverage new epidemiological data that may become available as a result of the development of health information technology and electronic health records and other advancements included in the Affordable Care Act. There is no overarching coordination between public health surveillance efforts at HHS, the Office of the National Coordinator, and other ACA advancements, and PAHPA should call for this synchronization.

4. **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. 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,⁵ pediatric doses of antimicrobials and antivirals, 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 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.
5. **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. Congress should facilitate health care preparedness by:

⁴ Nuzzo, 2009.

⁵ 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>

- Encouraging enhancements in the Hospital Preparedness Program – Healthcare coalitions should be expanded to every city and linked nationally.⁶ Some questions for assessment: how extensive have regional coalitions been? How well have public health, emergency management, health system been working together? How has reach extended into ambulatory care, non-acute hospital, and individual provider community?
- Designating a disaster coordinator for each facility.
- 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.
- 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.⁷ 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.

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⁶ Toner, Eric. <http://healthyamericans.org/assets/files/TFAH2010ReadyorNot%20FINAL.pdf>.

⁷ 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>