

May 4, 2018

The Honorable Lamar Alexander
Chairman
Senate Health, Education, Labor
and Pensions Committee
428 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Patty Murray
Ranking Member
Senate Health, Education, Labor
and Pensions Committee
648 Hart Senate Office Building
Washington, DC 20510

The Honorable Richard Burr
United States Senate
217 Russell Senate Office Building
Washington, DC 20510

The Honorable Robert Casey
United States Senate
393 Russell Senate Office Building
Washington, DC 20510

Dear Senators Alexander, Murray, Burr, and Casey:

On behalf of the National Association of County and City Health Officials (NACCHO), I am writing to provide comment on the draft *Pandemic and All-Hazards Preparedness and Advancing Innovation Act* (PAHPAI). NACCHO is the voice of the nearly 3,000 local health departments across the country that prepare communities for disasters, respond if emergencies occur, and lend support throughout the recovery process. We thank you for your leadership on this legislation that is essential to protecting our nation.

In recent years, the nation has faced a myriad of emerging infectious diseases, including Zika, Ebola, H1N1 flu, severe acute respiratory syndrome (SARS), and Middle East Respiratory Syndrome (MERS), in addition to multi-state food-borne illness outbreaks, devastating floods and other natural disasters, and terrorist attacks. Local health departments play an essential role in ensuring that people and their communities are prepared for, protected from and are resilient to threats to health that result from disasters and emergencies. Since all disasters are felt locally, local health departments have and will continue to play a critical part of every community's first response to emergencies. Local health departments regularly host trainings and exercises to prepare staff and healthcare coalition partners for public health emergencies, build consistent and ongoing communication between partners, clearly define response roles, and anticipate challenges before an emergency occurs. And when disasters arise, local health departments are the "boots on the ground" responding to and helping communities recover.

The programs authorized by the *Pandemic All-Hazards Preparedness Act* are vital to local health departments. Therefore, we provide the following comments on the discussion draft:

Sec. 101. National Health Security Strategy.

The goal of the National Health Security Strategy (NHSS) and implementation plan is to coordinate a national strategy and provide strategic direction towards increasing national health security at every level of government and all sectors both public and private. NACCHO supports a National Health



Security Strategy that provides for a coordinated federal agency strategy.

NACCHO supports the inclusion of a description of the status of the public health workforce in the NHSS. Trained county and city health department employees are on-call 24 hours a day, seven days a week to implement carefully developed and exercised plans in response to all hazards events which will help their communities recover from emergencies. They ensure health security by investigating disease outbreaks, distributing medicines, conducting drills to prepare workers and residents, facilitating preparation of the health care system, educating the public on how to protect themselves, and issuing emergency guidance among many other critical activities.

NACCHO supports the inclusion in the NHSS of a description of potential public health threats and the process for preparing to respond to such threats.

NACCHO supports the inclusion in the preparedness goals of zoonotic disease, food, and agriculture and global health security. We support a One Health approach to national security.

Sec. 201. Improving benchmarks and standards for preparedness and response.

The section requires the evaluation of existing performance measures, benchmarks, and standards for the Public Health Emergency Preparedness (PHEP) program and the Hospital Preparedness Program (HPP). The existing performance measures for PHEP and HPP are in their infancy and therefore it is critical that funding not be tied to achieving benchmarks rather making progress towards the benchmarks. We recommend the performance measure development process be a joint collaboration between local, state, and federal jurisdictions.

Sec. 202. Amendments to preparedness and response programs.

This section clarifies that the PHEP Cooperative Agreements be administered by the Centers for Disease Control and Prevention (CDC). PHEP and HPP are critical but separate programs and should remain as such. NACCHO emphatically supports this provision as critical public health preparedness and scientific expertise lies at CDC and furthermore state and local health departments have long-standing relationships with CDC. Public health preparedness is a federal, state, and local responsibility that often involves coordination across a variety of other CDC programs depending on the hazard. Maintaining the state, local, tribal, and territorial health department collaborative relationship with CDC is essential to protecting our communities.

NACCHO supports the reauthorization of the PHEP grants through 2023. By authorizing the PHEP Cooperative Agreement, PAHPA has enabled local health departments to hire personnel, develop and exercise critical response plans, and stockpile medicines and supplies. Since 2002, PHEP has provided more than \$11 billion to health departments enabling them to effectively respond to a range of public health threats, including infectious diseases, natural disasters, and biological, chemical, nuclear, and radiological events.

However, there have been dramatic decreases in funding for PHEP since its inception. The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (BT Act), P.L. 107-188, which initially established PHEP and HPP in 2002, authorized \$1.08 billion for PHEP and \$520 million for HPP. Subsequently PAHPA (which replaced the BT Act) authorization levels for PHEP dropped to \$824 million in FY2007 and \$642 million for each fiscal year from 2014 through 2018. As authorization levels dropped, so did appropriations. At its highest point in 2003, Congress appropriated nearly \$1 billion for PHEP. After austere cuts, PHEP appropriations have been stagnant at \$660 million for the past several

years, with a slight increase to \$670 million in FY2018. These drastic cuts reduce local health department capacity to prepare for all-hazards and consequently impact the ability of communities throughout the nation to be resilient when disasters strike. Therefore, NACCHO recommends the program be authorized at \$824 million, which is the level authorized in 2006.

CDC should continue allocating a base amount of funds to each existing PHEP awardee to enable all jurisdictions to maintain a minimum level of preparedness as well as preserve direct funding for certain political subdivisions consistent with 42 U.S.C 247d-3a(h)(4)(A).

NACCHO also strongly supports the reauthorization of HPP through 2023. More than \$5 billion has been provided to HPP to enable health care systems to save lives during emergencies that exceed the day-to-day capacity of health and emergency response systems. The distinct and complimentary HPP has supported a preparedness healthcare system through support for development of medical surge capacity and healthcare coalitions. HPP has helped to improve emergency communication and coordination among hospitals, ancillary medical facilities and health officials; facilitate patient tracking in mass casualty events; sustain operations during an event; track medical resources and assets including available hospital beds; and establish systems to reunite family members following an event.

HPP appropriations have been cut in half from a maximum investment of \$515 million in fiscal year 2004 to only \$255 million in fiscal year 2014. Funding has since stayed level at \$255 million annually, with a slight increase to \$265 million in FY2018. Despite the progress made with early investments, austerity has taken its toll. Funding cuts have resulted in staffing reductions, forced staff to fill multiple roles and hindered the ability to maintain existing or build new partnerships between public health and the healthcare sector. Therefore, NACCHO supports authorizing HPP at a minimum of \$474 million to ensure on-going robust country-wide health system preparedness infrastructure.

A base amount of funds should continue to be allocated by ASPR to each existing HPP awardee to enable all jurisdictions to maintain a minimum level of preparedness to support national health security. Additionally, direct funding for certain political subdivisions should be preserved in accordance with 42 U.S.C. 247d-3b.

Sec. 203. Regional public health emergency preparedness and response systems.

Section 203 requires the Assistant Secretary for Preparedness and Response to develop guidelines for regional healthcare and public health facilities to respond to varying threats. This section needs clarification that the regional response system guidelines are focused on health system preparedness. The section requires PHEP grantees to report on implementation efforts aimed at meeting the capability guidelines. This should be the responsibility of HPP, in coordination with the PHEP grantees.

While a new regional model is an intriguing prospect, ensuring that any “new” system does not erode the HPP health care coalition model is paramount. Healthcare coalitions, as developed through HPP, are already central in this space, and if sufficient funding were appropriated, could expand to become regional centers during incidents of great magnitude. NACCHO is also concerned that the draft prioritizes awarding HPP grants to entities that will enhance coordination among one or more facilities in a regional public health emergency system. All states and directly funded cities should have a minimum level of support through HPP.

All guidelines should require the input and review of state and local public health, healthcare, hospitals and other subject matter experts. State and local public health agencies, in particular, act as the neutral

arbiter in a very competitive healthcare environment which requires complex coordination among first responders, public health and a vast array of healthcare partners. It is critical that public health play this coordination role to ensure that the needs of the entire jurisdiction are considered. As such, public health is a key stakeholder in the development, review and implementation of a regional public health and healthcare response system.

The proposed timeline will make gathering this input challenging. The establishment of new guidelines for a regional system should be done with a thoughtful and prudent approach, allowing for multiple rounds of feedback from stakeholders. We propose modifying the timeline to allow for better engagement and offer more time for the implementation and evaluation of these guidelines.

Similarly, the GAO report to Congress should require input and review of state and local public health agencies prior to its issuance to Congress.

In identifying and developing guidelines (c)(1) consult and engage health care facilities, add “long term care, home based care”

Sec. 204 Public Health Situational Awareness and Biosurveillance Capabilities

A robust and integrated biosurveillance system is critical to ensuring the nation has the capacity to rapidly detect and respond to disease outbreaks and acts of bioterrorism to protect the nation’s health security. Surveillance systems collect and aggregate health data from multiple sources in real time, providing valuable information that local health departments use to analyze, interpret and verify any incident of public health concern.

NACCHO encourages continued efforts to support cooperation among federal, state, local and tribal agencies to develop a biosurveillance strategy implementation plan that will examine means of achieving timely interoperability and transparency among various surveillance systems. Specifically, the implementation plan should:

- Encourage federal and state governments to support development of local health department infrastructure, staff, and training for biosurveillance.
- Require an integrated biosurveillance infrastructure strategy,
- Define best use cases of data, determine which data is most useful and ensure access to data in a timely manner.
- Support local health department involvement in and implementation of biosurveillance systems.
- Call for leveraging of new epidemiological data that may become available as a result of the development of health information technology (IT), electronic health records and other advancements.
- Establish protections in dual-use agreements to balance access to important data while ensuring proper safeguards are in place to protect the rights of patients.

NACCHO appreciates the inclusion of biosurveillance and the need for an interoperable system for communications and surveillance to quickly identify and track public health threats. Under the section on Standards, NACCHO recommends further defining what is meant by “voluntary consensus-based standards entities.” This definition should be broad enough to encompass entities that are developing public health as well as health care focused standards for interoperability.

NACCHO thanks the Committee for including state, local, tribal and territorial public health officials as experts to be consulted and included in the public meeting under this section. Without the input of these stakeholders, the input provided to the Secretary and other policymakers may be incomplete and unworkable at the local level.

NACCHO thanks the Committee for continuing to recognize the expertise of the National Biodefense Science Board (renamed National Preparedness and Response Science Board.) This Board has representation from across the field of emergency preparedness, including local health department representation and provides valuable input to HHS.

The draft includes technical assistance to be provided to states or to a consortium of states. NACCHO recommends a mechanism to ensure concurrence with local health departments to ensure funding decisions take into consideration local variables and needs regarding data exchange and interoperability.

NACCHO thanks the Committee for adding “immunization information systems” in subsection (b)(1)(B).

Under (2) COORDINATION AND CONSULTATION, (C) paragraph (3)(iv)(I), the draft includes “immunization information *programs*.” NACCHO recommends the Committee modify this addition to say “immunization information *systems*” to reflect the current nomenclature. Immunization information systems are an integral part of vaccine ordering, management, distribution and tracking activities within state, local and tribal immunization programs.

NACCHO thanks the Committee for including “immunization programs” in (8) SITUATIONAL AWARENESS AND BIOSURVEILLANCE AS A NATIONAL SECURITY PRIORITY (5)(A)(ii).

NACCHO recommends the Committee consider inserting under (d) State And Regional Systems To Enhance Situational Awareness In Public Health Emergencies -- (3)(B) Use of Funds, “including immunization information systems” after “information technology systems.”

Sec. 205. Strengthening and supporting the public health emergency bridge fund.

NACCHO supports altering the existing public health emergency fund (PHEF) to make it fast, flexible and functional. However, without creating a mechanism to fund and replenish the PHEF, it is likely to remain unfunded and rendered effectively useless. A pre-approved standing fund of emergency resources that would speed the public health response to disasters is necessary. We urge the Committee to create a mechanism to fund and replenish the PHEF and work with Appropriations Committees to ensure PHEF receives new funding. NACCHO is opposed to any funding mechanism that cuts or repurposes existing funding.

NACCHO agrees that this fund should serve as a bridge between underlying preparedness funds and supplemental emergency funds. We ask that language be added that clarifies such intent: “*Funds appropriated under this section shall be used as a bridge between preparedness and supplemental emergency appropriations and should not supplant other federal, state, and local public funds provided for activities under this Act, nor should they supplant emergency supplemental appropriations as needed.*”

It should be clear that the PHEF is an immediate response fund, not a source of funding for long-term, ongoing health threats. NACCHO recommends the addition of language to the “In General” paragraph

(42 U.S.C §247d (b)(1)) or a separate “Purposes” section to clarify that the intent of the PHEF is to be used in the short-term for the acute, immediate response to emerging public health emergencies that require a rapid response to save lives and protect the public.

NACCHO supports the inclusion of appropriate uses for the PHEF. We ask that paragraph (2) USES, subsection A be amended to also allow the funding for state, local, tribal and territorial entities to be for *“making grants, providing awards for expenses, entering into contracts, and/or conducting supporting investigations into the cause, treatment or prevention of a public health emergency or potential public health emergency.”*

PHEF resources, once triggered, must be rapidly allocated to states and local jurisdictions with maximum flexibility and minimal administrative burden through existing channels. We urge the Committee to add language to this section directing the Secretary to explore and ensure that there are means for funds to be distributed from the PHEF in an expedited fashion. Recently, the CDC issued a [Public Health Crisis Notice of Funding Opportunity](#) to more quickly disburse funds in the event of a public health emergency. The Secretary could be directed to create similar mechanisms as appropriate for other Uses listed in Section 205.

There should be specified additional triggers for accessing the fund, such as the discretion of the Secretary combined with other factors, *e.g.*, whether the World Health Organization has declared a public health emergency of international concern, or whether an executive of a state, or a city directly funded by PHEP and HPP, has declared a public health emergency or equivalent.

NACCHO strongly supports the amended language to ensure that public health emergency funds are used to supplement and not supplant other funds provided for in this act.

Sec. 206. Improving preparedness for and response to all-hazards by public health emergency volunteers.

NACCHO supports the reauthorization of the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and efforts to address the waiving of licensing requirements for volunteers to provide medical services in a public health emergency. We support the explicit inclusion of the Medical Reserve Corps in ESAR-VHP.

Sec. 301. Strengthening and assessing the emergency response workforce.

NACCHO supports the reauthorization of the Medical Reserve Corps (MRC) through 2023. NACCHO recommends the MRC be authorized at \$22 million to ensure on-going robust country-wide set of volunteer units to assist in emergencies and day-to-day community service. An investment in this program allows for the necessary recruitment, proper registration, retention and training efforts needed to maintain this capability.

The MRC program is a national, community-based corps of medical and non-medical volunteers that strengthen public health, emergency response, and community resiliency. MRC volunteers contribute to building a strong public health system, capable of responding to any emergency, be it manmade, a weather-related natural disaster, or an emerging infectious illness, to better able to respond to emergencies. MRC units support and supplement existing emergency and public health resources in the community. These volunteers are a critical emergency response resource to address public health challenges more quickly and efficiently. In a one year period between June 2015 and May 2016, MRC units logged more than 375,000 volunteer hours. MRC volunteers provided critical support and

expertise in response to recent emergencies, including Hurricane Harvey and the California wildfires in 2017.

Funding for the MRC program continues to dwindle as it is currently funded at \$6 million, a cut of \$5 million or 45% since FY2010. Without this funding, communities will be at greater risk in emergency situations, without the necessary human resources for emergency response. Staff will be pulled from other public health functions, which can endanger the health and safety of the public.

Sec. 302. Health system infrastructure to improve preparedness and response.

NACCHO appreciates that this provision requires the ASPR to include logistical support from federal, state, local, tribal, and territorial public health officials to identify the infrastructure entities capable of preparing for, responding to, or mitigating the effect of a public health emergency.

NACCHO recommends the Committee include language with the Strategic National Stockpile requirements that establish formal mechanisms to solicit and consider input from state, territorial, local, tribal, and public health officials.

Sec. 305. Reauthorizing the National Advisory Committee on Children and Disasters.

NACCHO supports the reauthorization of the National Advisory Committee on Children and Disasters.

Sec. 402. Public Health Emergency Medical Countermeasures Enterprise.

NACCHO supports the codification of the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE). The PHEMCE Strategy and Implementation should require that state and local health departments be involved in all phases of the medical countermeasures (MCM) enterprise including in initial investment; research and development of vaccines, medicines, diagnostics and equipment for responding to emerging public health threats; and distribution and dispensing of countermeasures.

NACCHO recommends the Committee include in (b) Members- State and local public health should have a permanent place in the PHEMCE membership to ensure that all decisions that will affect state and local health functions are vetted by public health authorities. Membership should include a state public health authority and a local public health authority.

Sec. 403. Strategic National Stockpile.

NACCHO recommends strengthening medical countermeasure planning and response capacity by requiring HHS to promptly notify jurisdictions of changes in Strategic National Stockpile (SNS) composition and other factors that impact the ability of jurisdictions to rapidly dispense lifesaving medication.

NACCHO supports the consultation with CDC and others for effective supply-chain management of the stockpile. SNS decisions must be made with a realistic understanding of supply-chain management capabilities of state and local health departments, which CDC and health departments can provide.

Sec. 404. Preparing for pandemic influenza, antimicrobial resistance, and other significant threats.

NACCHO appreciates the Committee's acknowledgment of the risks associated with antimicrobial resistance. Antibiotics underpin modern medicine. Antibiotic resistance is not a disease state. Rather, it is a biological process that threatens a medical response to Chemical, Biological, Radiological, and Nuclear (CBRN) threats or naturally occurring disease. Given the importance of antibiotics to the infrastructure of our response capabilities please consider the following:

- Specifically referencing antibiotic resistance as a threat in the text of the provision.
- Tie the need for antibiotics to emerging infectious diseases and other naturally occurring disease as well as to CBRN threats.
- Specify that the Biomedical Advanced Research and Development Authority (BARDA) should be supporting both pre-clinical and clinical development of antibiotics.
- A dedicated authorization of appropriations for these activities of \$500 million.

Section 404: Preparing for Pandemic Influenza, Antimicrobial Resistance, and Other Significant Threats.

NACCHO appreciates the Committee's acknowledgement that pandemic influenza, antimicrobial resistance and other emerging infectious diseases are under the umbrella of BARDA's mission. Recent years have demonstrated that infectious diseases represent a significant a threat to our national security as a natural disaster or terror attack. We urge the Committee to authorize additional appropriations for these new strategic initiatives.

Sec. 504. BARDA and the BioShield Special Reserve Fund.

NACCHO recommends BARDA be authorized at \$700 million annually and at least \$5.6 billion over 10 years for the Special Reserve Fund. BARDA has been highly successful in bringing products to fruition for which there has been little commercial market. Yet the challenges facing the nation are greater than ever, including emerging infectious disease and other global threats.

Section 701 Reauthorizations and Technical Changes.

NACCHO supports the continuation of the temporary reassignment of state and local personnel through 2023.

Thank you for your work to strengthen and enhance our nation's preparedness and response system and we appreciate the opportunity to share our views in response to this discussion draft. We look forward to continuing to work with you as this legislation moves forward. Please do not hesitate to contact Laura Hanen, Chief of Government Affairs at 202.507.4255 or lhane@naccho.org should you have any questions or need additional clarification on our comments.

Sincerely,



Lori Tremmel Freeman, MBA
Chief Executive Officer