

March 1, 2011

Chairman Tom Harkin  
U.S. Senate HELP Committee  
Washington, DC 20510

Senator Richard Burr  
U.S. Senate HELP Committee  
Washington, DC 20510

Dear Chairman Harkin and Senator Burr:

On behalf of the undersigned organizations, we are pleased to provide you with some of our top recommendations, presented in four specific tracks, for reauthorization of the Pandemic and All-Hazards Preparedness Act (PAHPA). Our groups represent public health, provider and health advocacy organizations. We believe the reauthorization of PAHPA is a key opportunity to strengthen and enhance the provisions put in place at its inception to build more prepared and resilient communities in the face of disasters and other public health emergencies be they infectious disease outbreaks, acts of bioterrorism, or natural disasters. These recommendations are proffered in the spirit and context of enhancing an already well constructed and effective statute with the benefit of reflecting on and drawing upon the experiences and lessons learned over the last five years. It is also recognized that the undersigned organizations, as well as others, likely will share with you other specific recommendations for consideration that are relevant to the mission and role of their respective members and germane to this matter.

Our recommendations include:

- **Strengthen Public Health Preparedness Infrastructure** – Strengthening public health preparedness infrastructure is critical to ensuring the health protection of our nation and building resilient communities. It also requires adequate funding and human resources to recruit and train personnel, stockpile supplies and life saving countermeasures, support research to address gaps in the evidence base, and identify and engage partners to support the public health mission. The Public Health Emergency Preparedness (PHEP) cooperative agreement, Hospital Preparedness Program (HPP), and Preparedness and Emergency Response Research and Learning Centers are 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.<sup>1</sup> They could be strengthened through changes in their administration, especially during disasters.
  - 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 utilized during emergencies. **In the H1N1 influenza response, the ability to re-assign staff from other 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**

---

<sup>1</sup> See: 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>.

- response phases when additional funding was not yet available and jurisdictions needed to mobilize “all hands on deck.”** We urge you to give the HHS Secretary the authority to waive some categorical requirements of non-preparedness grants during a public health emergency so that federally funded personnel in any public health program can be mobilized to respond to an emergency at the discretion of the state or local health official. Specifically, we recommend language that would:
- Establish multi-year grant cycles with greater flexibility in states’ retention and use of carry forward and unobligated 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 funds and resources (e.g. personnel) that are part of other (categorical) federal programs in response to a public health emergency (e.g. an “all hands on deck” scenario).
- Currently the PHEP and HPP grants, both of which are often distributed through public health departments, have separate application and reporting requirements, overarching goals, and in some cases conflicting performance metrics. The reauthorization of PAHPA would provide an opportunity for greater alignment of these two grant mechanisms and further, reduce the burden on local and state public health personnel who are required to prepare, monitor, and report on these grant activities.
- **Develop an Integrated Biosurveillance Infrastructure Strategy**– A robust and integrated biosurveillance system is critical to ensuring the nation has the capacity to rapidly detect and respond to disease outbreak and acts of bioterrorism to protect the nation’s health security. The United States currently lacks such a system.
    - According to a December 2010 GAO report, HHS had not provided a strategic plan for electronic situational awareness, as required by PAHPA.<sup>2</sup> The Centers for Disease Control and Prevention (CDC) did just release a “National Biosurveillance Strategy for Human Health (January 2011) and has a State/Local/Tribal/Territory Subcommittee providing input to its National Biosurveillance Committee; these efforts should continue under PAHPA. CDC should continue to lead the public health surveillance enterprise. 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.<sup>3, 4</sup> To that end, we

---

<sup>2</sup> 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>

<sup>3</sup> 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](http://www.upmc-biosecurity.org/website/resources/publications/2009/biomemo/2009-03-27-develop_natl_biosurveillance.html)

<sup>4</sup> 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.<sup>5</sup>
- 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), electronic health records and other advancements included in the Affordable Care Act (ACA). There is no overarching coordination between public health surveillance efforts at HHS, the work of the Office of the National Coordinator (ONC), and implementation of ACA. The Office of the National Coordinator for Health Information Technology (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.
- **Medical Countermeasures (MCM) and Public Health** – 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.
    - Report language in PAHPA should urge 1) increased coordination between FDA, BARDA, NIH, CDC, and representatives for the state and local public health system 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, administration, and surveillance.
    - PAHPA should call for a review and strategic, long-term plan for stocking and restocking medical materiel in the Strategic National Stockpile (SNS) to ensure adequate supplies of countermeasures, specifically a) products for special populations, especially children, and b) to replace expiring products and products used during the H1N1 outbreak.
    - Legislation should establish authorities and mechanisms to extend the Shelf-Life Extension Program to stockpiles held by state and local jurisdictions. Currently, only federally-held stockpiles are eligible for this program.
  - **Strengthen Surge Capacity** – In the event of a mass casualty event, the health care system would be severely compromised limiting the capacity to provide acute life saving measures. The formation of public health and health care coalitions are vital resources in preventing or mitigating potential surge. Policymakers must address the ability of the health care system to quickly expand beyond normal services during a major emergency.
    - PAHPA should enhance the Hospital Preparedness Program by expanding health care coalitions, and building a national framework that links the coalitions.<sup>6</sup> The program should also address the following questions: how extensive and successful have regional coalitions been? How well have the emergency management and public health systems worked together? How has the program

---

<sup>5</sup> Nuzzo, 2009.

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

extended its reach into ambulatory care, non-acute hospital, pediatric, and individual provider communities?

Thank you for this opportunity to weigh in as the Committee considers reauthorization of PAHPA. Should you have any questions, please contact any of our organizations, or questions can be directed through Dara Lieberman at Trust for America's Health at 202-223-9870 ext. 20 or [dliberman@tfah.org](mailto:dliberman@tfah.org).

Sincerely,

American Public Health Association  
Association of Public Health Laboratories  
Association of Schools of Public Health  
Association of State and Territorial Health Officials  
Center for Biosecurity of UPMC  
Council of State and Territorial Epidemiologists  
National Association of County and City Health Officials  
Trust for America's Health