



Comments of Trust for America's Health to Committee on Homeland Security on Report by the Majority Staff: *Getting Beyond Getting Ready for Pandemic Influenza*

Trust for America's Health (TFAH), a nonprofit, nonpartisan advocacy organization dedicated to saving lives and making disease prevention a national priority, appreciates the opportunity to comment on the report by the Majority Staff of the House Committee on Homeland Security, *Getting Beyond Getting Ready for Pandemic Influenza*. The report could not be timelier, as we welcome a new Administration and embark on the process of health reform. Experts agree that it is only a matter of time before a global influenza pandemic hits, leaving a devastating trail of human and economic loss. We are pleased to offer the following comments on this report and urge Congress to maintain its vigilance toward this potential disaster.

Establish Effective Leadership and Coordination

Congress, the media, and the public are showing signs of 'pandemic fatigue,' where the warnings are no longer effective, and the nation's economic concerns take precedent over the uncertainty of a pandemic. We urge you and the President to keep this issue at the forefront and hope all of your Congressional colleagues, including those serving on the Committee on Energy & Commerce, will do the same as they move forward with health reform legislation.

In addition to your recommendations for increased coordination at DHS, we believe the President should review the relationship between the office of the Assistant Secretary for Preparedness and Response at the Department of Health and Human Services (HHS), the Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER) at the Centers for Disease Control, and the Office of Health Affairs at the Department of Homeland Security. These roles must be further clarified to prevent duplication of efforts or confusion. Within HHS, ASPR should focus on consistency in policy and coordination among programs, and CDC should continue to be responsible for the public health emergency response. Although there have been attempts to create distinctions between these two offices, confusion remains both in headquarters and in the field. TFAH concurs with the national consensus that DHS should continue to lead the national response, while HHS should be the lead agency for determining policy and planning for the public health aspect of emergencies.

Address and Meet Key Medical Requirements

Planning and building capacity to deal with the surge of patients in a pandemic is the most glaring gap in our state and federal planning efforts. The only state that has undertaken a comprehensive surge plan is California, and that plan still lacks specifics of rationing and altered standards of care. While there has been guidance from the federal government, little incentive has been provided for states to follow California's lead. The only federal program that seeks to build medical readiness, the Hospital Preparedness Program, administered by ASPR, has the right core goals for its grants, but lacks the

funding to allow hospitals to build capacity in a meaningful way. These grants average out to \$80,000 a piece for one year, not enough to hire a preparedness staffer, let alone develop emergency plans and acquire materials. There must be a dedicated funding stream for hospital preparedness.

There must also be consideration of what will happen with uninsured patients during a pandemic. The Public Health Emergency Response Act (S. 3312/H.R. 6569 in 110th Congress), sponsored by Rep. Lois Capps (D-CA) seeks to address this issue by establishing a mechanism ahead of time that would allow the Secretary of HHS to trigger an emergency health benefit in the event of a declared public health emergency. The federal government must also take the lead in developing best practice for altered standards of care, including the legal and ethical issues that providers and facilities will face, then incentivize states to implement these policies. TFAH expects to release a report in the next month which will provide more detail on these hospital preparedness recommendations.

Evaluate and Update Plans

TFAH has echoed the call to update the National Strategy on Pandemic Influenza and its Implementation Plan. These must be evergreen documents. The science continues to evolve as the research and pharmaceutical communities learn more about the viruses and the effects of existing mitigation strategies and develop diagnostic tests, vaccine and antiviral production capacity, and surveillance technologies. The National Strategy must reflect this changing information. Further, the White House and Congress should review how the Strategy has been implemented thus far and which strategies need revising. For example, the Administration may want to review the philosophy of shared responsibility for stockpiling antivirals between the states and the federal government, as 16 states have purchased less than 50 percent of their share of antivirals.¹ Moreover, what antivirals should be stockpiled needs to be reassessed in light of this year's flu variant being resistant to oseltamivir, which is the principal drug being stockpiled. An approach that assumes the need for combination antiviral therapy may be required.

We agree with the report that including stakeholders in the pandemic planning process is a key point that has been missing. State and local health departments have felt excluded from the federal planning process, even though they are asked to be the front line responders if an outbreak occurs. Although HHS has held stakeholder meetings for development of vaccine and antiviral prioritization strategies, the same cannot be said for the National Strategy.

Further, the federal commitment to state pandemic preparedness plans has dwindled from a strictly financial sense – our dependence on states and localities to be the first line of defense has grown, but the state and local dollars are gone. CDC distributed \$600 million that had been appropriated for state and local pandemic preparedness in FY2006, and there is no new money forthcoming. At the same time, the Public Health Emergency Preparedness cooperative agreements that support broad state and local preparedness

¹ Trust for America's Health and Robert Wood Johnson Foundation, *Ready or Not? 2008: Protecting the Public's Health from Diseases, Disasters, and Bioterrorism*. Dec 2008. p. 23.

efforts (also distributed by CDC) have diminished by 25 percent since FY2005.² Employers should also be incorporated into all federal planning efforts, not simply for stockpiling planning, and the federal government should incentivize private sector preparedness. The report recommends requiring continuity of operations plans to qualify for federal funds, which would be an effective model. However, in the event of a pandemic private companies, such as trucking fleets, will be essential for food and supply delivery and likely do not have federal contracts. These companies must have prior relationships with public health departments and disaster response personnel to prepare for a pandemic. Once these sectors are integrated into the planning process, they will have the incentive to determine who are essential personnel, what are considered indispensable services, and obtain prior commitment from essential employees to attend work if they are not sick. The economic impact of a pandemic will be nearly as devastating as the human impact, with estimates that the GDP could drop 5.5 percent.³ One additional concern with private sector planning is that during a recession, there could well be a cutback in resources devoted preparedness. It might be worth asking the DHS to do a rapid assessment of private sector preparedness in light of the economic downturn.

Early Warning and Detection

Your recommendation for increased U.S. support for World Health Organization (WHO) global surveillance efforts coincides with recommendations from TFAH's "Germs Go Global" report. We also agree that integration of all of the biosurveillance efforts at the federal level will be critical to detecting and mitigating the effects of a pandemic. Congress should review upcoming reports that are due this spring/summer from IOM, GAO, and the National Biosurveillance Advisory Subcommittee and take appropriate steps to ensure information is being integrated between DHS, HHS, EPA, USDA and other federal agencies. BioWISE is a good proposal, but Congress would need to ensure the development of a global biosurveillance program would not duplicate other worldwide and domestic efforts by WHO and the U.S. Government. Too much information can be as useless as too little information if there is not proper analysis and filtering of data.

The development of Health IT legislation in Congress is an excellent opportunity to incorporate issues related to the modernization of disease surveillance systems within the U.S. Wide-scale adoption of electronic health records (EHRs) could result in an integrated, consistent source of information that might vastly improve the nation's ability to conduct surveillance, strategically investigate health hazards, rapidly identify new agents and factors contributing to diseases and/or bioterror threats, and develop ways to better control, treat or cure illnesses. EHRs provide an opportunity to collect information about the health of Americans on a systematic, coordinated, and large-scale basis, which could provide insights into the factors that influence the incidence, distribution, and control of diseases and health conditions. Longitudinal datasets could also be created in order to enable researchers to examine how different behavioral, environmental, medical and genetic factors affect health conditions, information that would be extremely

² Ibid. p. 3.

³ Trust for America's Health, *Pandemic Flu and the Potential for U.S. Economic Recession*, March 2007.

beneficial to physicians and researchers, as well as public health professionals. Health IT legislation should include options for interoperable systems, consideration of public health department access to information, and training of public health departments in using new hardware and software. The Committee could work with the Administration in assuring that as new investments in health IT are made as a result of the stimulus package, that attention is paid to the infrastructure and training needs of state and local health departments.

Effective integration of information at the federal level must include investment in state epidemiological and laboratory capacity. Currently 20 states still use web-based manual reporting and 16 are completely paper-based. Current funding for the National Electronic Disease Surveillance System (NEDSS) and Electronic Lab Reporting (ELR) is \$44.5 million. One-time funding of \$47.5 million would allow up to 20 states to address infrastructure projects described in *National Electronic Disease Surveillance System (NEDSS): A Status Report on Implementation*. Funds for electronic lab reporting systems could immediately improve the efficacy and quality of electronic disease surveillance systems. TFAH's "Ready or Not? 2008" report recommends that every health department should be part of a 21st surveillance system that meets national standards and is interoperable between jurisdictions.

We also agree that effective public awareness should be an integral part of future pandemic planning. Ongoing communication is necessary not only to instill proper hygiene habits and encourage personal planning, but also to reduce panic when a pandemic arrives, ensure adherence to social distancing measures, and familiarize the public ahead of time with prioritization of vaccines and antivirals. We believe this effort should use the most effective marketing techniques—including outreach to non-English speaking populations, working through faith-based and community organizations to train families, use of new media such as popular blogs and social networking sites, and development of curricula for children as a means of encouraging families to prepare. State and local health and emergency preparedness departments should invite local stakeholders such as representatives from parent groups (in the model of ReadyMoms Alliance), the Chamber of Commerce, and community organizations to the table in order to build community resiliency.