



**Public Health Emergency Preparedness Cooperative Agreement  
Centers for Disease Control and Prevention (CDC)  
FY 2022 Labor HHS Appropriations Bill**

	<b>FY2020</b>	<b>FY2021</b>	<b>FY2022 President's Request</b>	<b>FY2022 TFAH</b>
Public Health Emergency Preparedness	\$675,000,000	\$695,000,000	N/A	\$824,000,000

**Background:** The COVID-19 pandemic has illustrated how fragile our nation’s public health infrastructure can be and how vulnerable we are to global threats. While the Public Health Emergency Preparedness (PHEP) cooperative agreement<sup>1</sup> has enabled great strides in our nation’s all-hazards preparedness, the pandemic has renewed the urgency in expanded investment in domestic health security. Yet, appropriations for PHEP have declined by 26 percent since FY2003, or 48 percent when accounting for inflation. Public health is often battling multiple emergencies and outbreaks at the same time. In addition to responding to the pandemic, the public health emergencies of the past year—outbreaks of measles and hepatitis A,<sup>2</sup> extreme heat and power outages, hurricanes, devastating wildfires, and terror attacks—all reinforced the need for every community to be protected from public health threats. The PHEP cooperative agreement at the Centers for Disease Control and Prevention (CDC) is the main federal program that supports the work of health departments in preparing for and responding to all types of disasters, including bioterror attacks, natural disasters, and infectious disease outbreaks. PHEP cooperative agreement supports 62 state, territorial and local recipients in strengthening core public health preparedness capabilities, including in the areas of public health laboratory testing, health surveillance and epidemiology, community resilience, countermeasures and mitigation, incident management, and information management.

**Impact:** The response systems, personnel, and infrastructure that states require to respond to public health emergencies like COVID-19 would not exist in most states without PHEP funding. Since 2002 the PHEP program has saved lives by building and maintaining a nationwide public health emergency management system that enables communities to prepare and rapidly respond to public health threats. The National Health Security Preparedness Index has found that public health preparedness domains trended upward between 2013-2019.<sup>3</sup> The largest investments focused on public health surveillance and epidemiological investigation, laboratory testing, community preparedness and recovery, and medical countermeasures and mitigation. In order to help awardees address gaps, CDC works with the jurisdiction on technical assistance plans, including consultation across CDC. Over 2600 state, local, territorial and federal preparedness and response employees across the country are funded wholly or in

<sup>1</sup> Public Health Emergency Preparedness (PHEP) Cooperative Agreement. In *Centers for Disease Control and Prevention*. <https://www.cdc.gov/cpr/readiness/phep.htm>

<sup>2</sup> “Widespread Person-to-Person Outbreaks of Hepatitis A Across the United States.” In *Centers for Disease Control and Prevention*. <https://www.cdc.gov/hepatitis/outbreaks/2017March-HepatitisA.htm>

<sup>3</sup> National Health Security Preparedness Index 2020 Release Key Findings. NHSPI. [https://nhspi.org/wp-content/uploads/2020/06/NHSPI\\_2020\\_Key\\_Findings.pdf](https://nhspi.org/wp-content/uploads/2020/06/NHSPI_2020_Key_Findings.pdf)

part by CDC's PHEP program.<sup>4</sup>

Federal funding is crucial to maintaining state, local and territorial public health preparedness capacity. Cuts to public health funding from the past two decades have meant that health agencies have been less equipped to sustain the expert workforce and invest in modern data and laboratory technologies that would have made the nation more resilient to COVID-19. While emergency response funding is critical for a major emergency, short-term funding supplements do not allow for sustained preparedness and response infrastructure. An efficient and effective state and local workforce response relies heavily on predictable, ongoing funding support for a network of local expertise, relationships and trust that is carefully built over time through shared responses, training and exercises.

Some examples of recent accomplishments of the PHEP program include:

- The Minnesota Department of Health (MDH) used PHEP funding to develop two mobile/computer apps that can be used to help quickly distribute medication to the public in emergency situations, such as a mass anthrax exposure and an influenza pandemic. The two apps, called POD (Point of Dispensing) PreCheck and POD Locator, were developed to guide citizens through a treatment screening process and will allow the state health department to quickly and accurately distribute medical countermeasure information, like POD locations, to residents.
- In Rhode Island, public health officials drew on medical countermeasure protocols developed with PHEP funding, to successfully receive, stage, and store all assets the state received from the Strategic National Stockpile for the COVID-19 response.
- Technical assistance provided by PHEP subject matter experts has improved the ability of multiple state and local jurisdictions to properly store medical countermeasures, including those requiring strict cold chain management.

**Recommendation:** TFAH recommends \$824 million for the Public Health Emergency Preparedness Cooperative Agreements in FY22, the levels authorized in 2006. This level of funding would:

- Strengthen the nation's readiness to protect the public from future dangers caused by catastrophic emergencies like a pandemic as well as smaller regional emergencies.
- Help restore capacity at health departments impacted by budget cuts and address gaps identified in the PHEP capabilities operational readiness review process, in areas such as risk communications and medical countermeasures distribution.
- Modernize data systems to enhance surveillance systems, data management, and sharing and analysis of disease trends.
- Build the Laboratory Response Network (LRN) and CDC and public health expertise and capacity for radiological and nuclear events. There is currently no public health laboratory capacity outside of CDC for this kind of testing and only limited throughput at CDC's lab.
- Advance biological and chemical laboratory capacity in states to keep up with current technologies and threats.
- Support field staff in additional states, who are highly trained personnel who can help jurisdictions build their disease surveillance and response capability.