FY 2015 Labor HHS Appropriations Bill

Public Health Emergency Preparedness Cooperative Agreement (CDC)
Hospital Preparedness Program (ASPR)

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<th>2013</th>
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<th>2015 President</th>
<th>2015 TFAH</th>
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<tr>
<td>Public Health Emergency Preparedness (CDC)</td>
<td>$608,281,000</td>
<td>$640,000,000</td>
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<td>Hospital Preparedness Program (ASPR)</td>
<td>$358,231,000</td>
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Public Health Emergency Preparedness Cooperative Agreements

**Background:** 2013 was a significant year for public health emergencies. The nation saw outbreaks of previously controlled diseases, major food safety outbreaks, hurricanes, wildfires, and terrorism. The State & Local Preparedness & Response Capability program at the Centers for Disease Control and Prevention (CDC) is the only federal program that supports the work of health departments to prepare for and respond to all types of disasters, including bioterror attacks, natural disasters, and infectious disease outbreaks. The centerpiece of the program is the Public Health Emergency Preparedness (PHEP) Cooperative Agreements. PHEP grants support 15 core public health capabilities identified by CDC, including in the areas of public health laboratory testing, health surveillance and epidemiology, community resilience, countermeasures and mitigation, incident management, information management, and surge management. The grants fund nearly 4,000 state and local public health preparedness staff positions. These funds are useful for everyday public health emergency preparedness activities, such as monitoring public health threats and responding to small-scale emergencies, and for expanding such activities to full-scale disasters and pandemics.

**Impact:** The PHEP has helped the nation make considerable progress since 2001, when health departments had to respond to 9/11 and anthrax on an ad hoc basis. TFAH has found that, in the past decade, these investments have led to significant improvements in planning and coordination, public health laboratory capacity, pharmaceutical and medical equipment distribution, communications, legal protections, and staff training and preparation. However, we have found persistent gaps in areas such as biosurveillance and helping communities become more resilient to cope with and recover from emergencies.

Recent accomplishments of the PHEP program include:
• **Assisting in response to Hurricane Sandy.** Local and county health officials helped set up local and medical-need shelters, ensured food and water safety, and educated the public about mold removal, carbon monoxide poisoning, and safety while doing recovery work. HHS also deployed more than 1,200 personnel, while CDC’s Emergency Operations Center coordinated CDC’s response with state and local health departments, and the Strategic National Stockpile (SNS) deployed personnel and seven Federal Medical Stations.¹

• **Mounting a rapid response to the fungal meningitis outbreak.** CDC support and training enabled health departments from NC, TN, and other states to identify patients at risk for exposure. 99% of at-risk patients were notified in less than a month.²

• **Fighting the West Nile Virus outbreak in Texas.** State and local health departments relied on CDC assistance for mosquito abatement, epidemiology and entomology support, situational awareness and communications.³

Unreliable funding, including declines in CDC preparedness budgets, the sequester and government shutdowns, and cuts at the state and local level, have had a significant impact on preparedness. For example, the shutdown occurred during a foodborne *Salmonella* outbreak and at the beginning of the 2013 flu season, while many CDC epidemiologists and investigators were furloughed. Declines of state public health budgets have led to job losses, reduced services, mandatory furloughs, and elimination of public health programs. During 2012, 48% of local health departments reduced program services, including immunization and emergency

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² CDC, National Snapshot, Jan 2014.

³ CDC, National Snapshot, Jan 2014.
preparedness services.\textsuperscript{4} Annual funding for all of CDC’s preparedness activities is about $1 billion lower in FY2013 than in FY2002.

\textbf{Recommendation:} TFAH recommends $670 million for the Public Health Emergency Preparedness Cooperative Agreements in FY2015. The funding would help states and localities restore some of the core capabilities lost due to significant cuts to the program.

\textbf{Hospital Preparedness Program}

\textbf{Background:} The Hospital Preparedness Program (HPP), administered by the Assistant Secretary for Preparedness and Response (ASPR), provides funding and technical assistance to prepare the health system to respond to and recover from a disaster. The program, which began in response to 9/11, has evolved from one focused on equipment and supplies held by individual hospitals in response to a terrorist event, to a system-wide, all-hazards approach. Instead of individual hospitals purchasing supplies, the new HPP is building the capacity of healthcare coalitions - regional collaborations between healthcare organizations, providers, emergency managers, public sector agencies, and other private partners - to meet the disaster healthcare needs of communities. Through the planning process and cooperation within these coalitions, facilities are learning to leverage resources, such as developing interoperable communications systems, tracking beds, and writing contracts to share assets.

HPP builds capabilities in the areas of health system preparedness, health system recovery, medical surge, emergency operations coordination, fatality management, information sharing, responder safety and health and volunteer management. HPP was recently reauthorized in the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA, P.L. 113-5).

\textbf{Impact:} HPP has made significant progress in preparing the health system for a disaster, and recent events have shown its impact:

- HPP enabled a coordinated response between several hospitals responding to the Boston Marathon bombings.\textsuperscript{5} Hospitals immediately activated emergency operations to prepare to receive traumatic injuries, and of the 264 individuals injured in the bombings, there were no deaths after the three onsite fatalities.
- HPP planning and resources enabled hospitals near West, Texas to implement surge plans to receive patients injured in the fertilizer plant blast.\textsuperscript{6,7} Hospitals moved lower-acuity patients to nearby facilities to prepare for patients, and electronic bed tracking and communication systems were also used as a means to coordinate resources and communicate essential information.\textsuperscript{8}

\textsuperscript{4} NACCHO, \textit{Local Health Department Job Losses and Program Cuts: Findings from the 2013 Profile Study}. 2013.
\textsuperscript{8} HHS Correspondence, May 2013.
• Healthcare coalitions were critical in enabling ongoing medical care in a region of Kentucky where hospitals and mobile units were damaged by tornadoes in 2012.9

• In 2011, 30 percent of Joplin, MO, was destroyed by a tornado, including St. John’s Regional Medical Center. Hospital Preparedness Program planning and resources enabled St. John’s to evacuate, Taney County stood up a mobile medical unit, and neighboring hospitals received hospital evacuees and residents injured by the tornado.10,11

HPP appropriations have decreased from $426 million in FY10 to $255 million in FY2014, including a one third cut in the FY2014 omnibus. Every jurisdiction received cuts in HPP grants from FY12 to FY13, after twenty-one states and D.C. suffered cuts from FY11-FY12. ASPR has not yet announced how FY14 cuts will be allocated, but the significant reduction will likely result in fewer staff, fewer coalitions and less of the nation covered by a coalition, and less prepared coalitions.

**Recommendation:** TFAH recommends $300 million for FY2015 for HPP, an incremental step to rebuild the program from FY2014’s cuts. The move toward funding healthcare coalitions, rather than individual hospitals, has helped grantees better achieve the capabilities required. However, a fewer number of grants means that some regions may be without adequate coverage for disaster events. As additional cuts occur, preparedness activities and the capabilities of HPP coalitions decrease – resulting in a reduced ability to respond effectively. So, not only do budget cuts affect the total number of coalitions that are funded, but also hamper the ability of currently funded coalitions to respond effectively.

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