House Committee on Oversight & Government Reform Hearing:

"The Ebola Crisis: Coordination of a Multi-Agency Response"

Testimony of Jeffrey Levi, PhD
Executive Director, Trust for America's Health

October 24, 2014

Chairman Issa, Ranking Member Cummings and members of the Committee: thank you for the opportunity to offer testimony today. Trust for America's Health (TFAH) is a nonprofit, nonpartisan organization focused on making disease prevention a national priority. I thank the Committee for its attention to this important subject.

For the past 11 years, TFAH has published reports examining the nation's ability to prevent and control infectious disease outbreaks, bioterrorism and disasters. Our *Outbreaks* report, which will be released again in December, compares states on 10 key indicators related to infectious disease detection and response, including vaccination rates, healthcare associated infection prevention, response to foodborne outbreaks, and public health laboratory capacity. Last year's report found that states vary widely in capabilities to protect against infectious disease threats. At TFAH, we believe that where you live should not dictate your level of protection.

I would like to provide context on America's public health and hospital preparedness systems and the implications for epidemic preparedness and response. State and local public health, in conjunction with our healthcare system, are the first line of defense against emerging infections. But first, I must echo the sentiments of public health experts worldwide: the most immediate crisis, and the focus of international response, must be on the affected nations in West Africa. Thousands have died already and thousands more could become infected without additional action. The best way to save lives here and in Africa is to intensify the response in the countries most affected.

In terms of our nation's pandemic preparedness, there are a few points I'd like to emphasize:

1. While on a day to day basis both public health and health care systems are focused on the burden of chronic disease on our society – in terms of lives lost, quality of life, and health care costs – infectious diseases are still a significant threat. From seasonal flu to unusual new bugs to health care associated infections and the growing threat of antimicrobial resistance, nature is teaching us that we can no longer ignore infectious diseases. A strong, coordinated public health and healthcare system will need to fight both chronic and infectious diseases if we are to protect and improve the health of Americans.
2. After a decade of investment in preparedness, we began to let our guard down. We have seen cuts to the Centers for Disease Control's (CDC's) Public Health Emergency Preparedness (PHEP) grants and failure to replenish the Strategic National Stockpile (SNS). On the healthcare side, there have been major cuts in the Hospital Preparedness Program, as well as failure to practice good infection control on a daily basis and failure

to exercise for more serious threats. These investments in the foundational capabilities of public health must be consistent and sustained so that we are not scrambling in the midst of a crisis.

3. Accurate, timely, and clear communication is key. Public health needs to get better at explaining risk to Americans, especially in the midst of an ever-changing crisis. Recommendations may change as our knowledge about a situation changes in the midst of an acute outbreak like Ebola. In addition, we need to understand what the federal government can and cannot do to address public health threats. For example, the CDC can make recommendations and issue guidance, but it is by law not a regulatory body and cannot mandate healthcare worker protections or hospital procedures.
4. Finally, responding to biological threats – whether natural or man-made – requires a cross-government response and White House-level leadership. Appointing an Ebola response coordinator addresses the immediate logistical need. But as the President acknowledged when he decided to name a temporary point person – everyone else at the White House who have been charged with the Ebola response have important competing priorities. It is time the White House had a full-time public health leader charged with assuring a coordinated, government-wide preparedness program, response, and recovery from these crises.

Public Health Emergency Preparedness

America's public health system is made up federal, state and local health departments responsible for preventing, detecting, and responding to outbreaks large and small. We have prepared state and local health departments for emergencies largely through the Public Health Emergency Preparedness (PHEP) cooperative agreement, administered by CDC. PHEP provides grants to 62 states, territories and cities to build state and local readiness for chemical, biological, radiological and nuclear (CBRN) threats.

These grants help build 15 capabilities, including preparedness, recovery, emergency operations coordination, information sharing, laboratory testing, and epidemiology and surveillance. Funding for the program has declined from over $1 billion in FY2006 to $640 million in FY2014. These funds are used for everyday public health emergency activities, such as monitoring public health threats and responding to small-scale outbreaks and localized disasters, and for expanding operations to full-scale disasters and pandemics. The PHEP has helped the nation make considerable progress since 2001, when health departments had to respond to the September 11th and anthrax attacks 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, 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.

In the current Ebola response, health agencies are communicating with hospitals and the public, coordinating related agencies, providing public health laboratory capabilities, and investigating suspected cases and conducting contact tracing.

Emergency preparedness cannot be built overnight. You may be able to stockpile supplies relatively quickly, but you cannot train people and keep them trained after a disease has already become an epidemic. The Association of State and Territorial Health Officials (ASTHO) and National Association of County and City Health Officials (NACCHO) have reported over 50,000 state and local public health job cuts since 2008, and almost all health departments have reported job losses and/or program cuts. NACCHO found that 15 percent of local health departments cut emergency preparedness in 2012 and others have reported additional program cuts in epidemiology and surveillance, food safety, and immunization, all of which impact our preparedness for infectious disease outbreaks.

TFAH recommends restoring funding for the CDC's State and Local Preparedness Capacity to levels authorized in the 2006 Pandemic and All-Hazards Preparedness Act, $824 million. This level would help rebuild the capacity lost through federal, state and local budget cuts and help public health deal with 21st century threats. Just as important, we also recommend consistent, reliable funding. While increases are imperative, providing an infusion of funding one year followed by a drastic cut the next year would mean that health departments will lay off those highly trained public health personnel who are the first responders in an emergency. We must invest in and sustain the core capacities of public health at all levels – including within CDC – to ensure we are ready for the next event.

We also recommend support for the Strategic National Stockpile (SNS), which maintains caches of medical products for use in emergencies and are essential to ensuring that our nation is prepared against threats. These products include vaccines, medicines, and supplies that could be used during an event. The division helps deploy SNS assets and provides technical assistance to public health and healthcare partners in the field. Budget constraints are taking a toll. CDC officials have publicly said that the stockpile will not be sufficiently restocked as a result of budget cuts, which means biotechnology companies may be hesitant to enter the research and development space if they do not believe the products will be procured. In some cases, SNS is the sole purchaser and distributer of certain products, so its role cannot be replaced by the commercial sector. Simply replacing expired items already in the stockpile would exceed the current budget for the program.

Health System Preparedness

The tragic infections of nurses in Dallas has brought attention to the need for strong hospital preparedness and infection control practices. All health facilities need emergency preparedness plans, and staff needs training and exercises to ensure readiness when an emergency strikes.

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 has evolved from one focused more on equipment and supplies held by individual hospitals to a system-wide approach. The new HPP is focused on building the capacity of healthcare coalitions – regional collaborations between healthcare organizations 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 helps build capacity for medical surge, fatality management, information sharing, responder safety and volunteer management.

HPP has declined from a peak of $515 million in FY2004 to $255 million in FY2014. We believe that the healthcare coalition model makes sense for emergency preparedness, as the program is too small to prepare every single hospital and outpatient facility. Not every hospital needs to have the exact same capabilities, but every region of the country should have access to a health system with a baseline level of preparedness for a pandemic or disaster. Significantly, HPP incentivizes and enables coordination and collaboration across health systems and between healthcare and public health. Recent cuts to the program – including a more than $100 million cut in FY2014 – mean that we will see fewer or less prepared healthcare coalitions. Americans would likely be alarmed to learn that, as these budget cuts trickle down, some regions of the country might not have federal assistance for hospital preparedness.

For the current crisis and ongoing health system preparedness, we recommend:

1) Strengthening the Hospital Preparedness Program through increased funding and assistance for healthcare coalitions. We believe funding should be restored to the level authorized in the 2006 Pandemic and All Hazards Preparedness Act, $474 million. This level would help rebuild and expand the program to ensure a baseline level of preparedness nationwide.
2) Every hospital should be prepared with steps to take if an Ebola patient – or patient with any unknown infection – presents, including training emergency room staff and paramedics in proper infection control procedures. It is unrealistic, however, to think that every hospital can be fully prepared to *treat* Ebola, because treatment and hygiene protocols are so specific. The federal government should identify several regional hospitals capable of treating Ebola patients or other emerging threats and ensure safe transport.

For everyday hospital infection control we recommend that:

1) Every acute care hospital should have an infection prevention specialist on staff;

2) Every hospital and outpatient facility should ensure compliance with everyday infection control steps, such as hand washing and full vaccination of staff. CMS and accrediting organizations must ensure health systems comply with best practices.

Conclusion

Ebola is not a new disease, but it is new to us. We have the opportunity to better prepare our public health and healthcare systems for Ebola and a variety of threats. The U.S. must also do its part in the global context. The Global Health program at CDC and U.S. support for WHO are vital to the international response. As you continue oversight of the response, a word of caution: the U.S. will likely see more cases of Ebola. The nature of infectious disease shows us that no level of vigilance can stop a disease at borders. However, we can stop each of these infections from spreading within the U.S. and becoming an outbreak. The fact that Nigeria was just declared Ebola-free this week shows us that the disease can be contained. It will require a strong, coordinated public health and healthcare response, education of those on the front lines, communication with the public, and ongoing investment in infectious disease and emergency preparedness.