Trust for America's Health Recommendations for Reauthorization of Pandemic and All-Hazards Preparedness Act, 2018

Trust for America's Health (TFAH) is a nonprofit, nonpartisan advocacy organization dedicated to saving lives by making disease prevention a national priority. TFAH advocates for strong public health defense against natural and manmade threats, including diseases, disasters and terrorism. We offer the following priorities for the impending reauthorization of the Pandemic and All-Hazards Preparedness Act (PAHPA):

- **Preparedness Programs Should Be Nationwide:** The Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) cooperative agreement must continue to fund existing awardees – all states, territories/freely-associated states and four directly-funded large cities. There has been no evidence that drastically changing the programs' formulas would provide any meaningful benefit or that the current formula is flawed. On the contrary, greatly reducing or eliminating funding from some jurisdictions puts other states at risk: those states that border the eliminated state would take on additional burden from the unmet public health and medical needs in neighboring areas. Because disasters can and do occur everywhere, all jurisdictions must be properly resourced in order to have an adequate level of preparedness for all hazards.

- **Preparedness Programs Should Be Authorized at Sufficient Levels:** HPP and PHEP are key to the foundational capabilities of healthcare and public health preparedness, respectively. These programs must be resourced at sufficient levels to ensure every community is prepared for disasters. HPP's highest level of appropriation was $515 million, yet the program has eroded to only $255 million, a vastly insufficient level given the task of preparing the healthcare system for a surge of patients, continuity of operations, and recovery. **HPP should be authorized at least at $474 million**, the level authorized in the PAHPA legislation of 2006. As the Centers for Medicare & Medicaid Services (CMS) emergency preparedness rule goes into effect, Health and Human Services (HHS) expects as many as 50,000 healthcare facilities to seek inclusion in healthcare coalitions. This level would allow rebuilding of the program as it transitions from capacity building to operationalizing healthcare coalitions. **PHEP, currently funded at $660 million, should be authorized at least at $824 million**, the levels authorized in the PAHPA legislation of 2006. Federal funding is crucial to maintaining state, local and territorial public health preparedness capacity. Even small fluctuations in funding – such as the 2016 redirection of $44 million from PHEP for the federal Zika response – have major impacts on workforce, training, and readiness.[1] These cuts cannot be backfilled with short-term funding after an event.

- **Preparedness Programs Should Remain Distinct:** PHEP and HPP should continue to be aligned and coordinated but should be maintained as separate, distinct programs, housed at their respective agencies. The two programs serve a different but complementary purpose: PHEP builds the capacity of state, local and territorial health departments and laboratories to prevent, detect and respond to emergencies, while HPP prepares the healthcare delivery system to provide essential care to patients by ensuring continuity of care during disasters. Both programs are needed to save lives and protect the public from emergency-related illnesses and injuries.

- **Bolster the Hospital Preparedness Program and Healthcare Disaster Response System:** The Hospital Preparedness Program – and healthcare coalitions it supports – should continue to serve as the backbone for preparedness of the healthcare system. In order to make HPP as effective as

[1] ASTHO, NACCHO, APHL & CSTE: *Impact of the Redirection of Public Health Emergency Preparedness (PHEP) Funding from State and Local Health Departments to Support National Zika Response*, May 2016. https://www.naccho.org/uploads/downloadable-resources/Impact-of-the-Redirection-of-PHEP-Funding-to-Support-Zika-Response.pdf

possible, ASPR should ensure performance measures come with transparency, accountability and quality improvement. HPP must focus funding and technical assistance on meeting gaps identified in those measures. In addition, policymakers should create and fund a standing, regionalized network of specialized response hospitals for catastrophic events, similar to the model developed in response to Ebola.[2]

- **Immediate Response Fund:** A pre-approved standing fund of emergency resources that would speed the public health response to disasters is necessary. TFAH affirms the following principles in an immediate response fund for public health emergencies: such a fund should supplement and not supplant existing, base public health and preparedness funds; it should not preclude supplemental emergency funding based on the scope, magnitude and duration of the emergency at hand; and it should come with a mechanism to automatically replenish funds. Such a fund should be used in the short-term for acute emergencies that require a rapid response to saves lives and protect the public. The Secretary of HHS should administer the fund, with Congressional oversight, to ensure relevant agencies receive dollars when needed for response.

- **Support medical countermeasure research, development, stockpiling and distribution:**
  - The Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) should be sufficiently resourced – from initial development through dispensing – to protect the public from severe and emerging national security threats, including naturally occurring and intentional threats.
  - Gaps remain in MCM distribution and dispensing capabilities, especially for disasters that require an immediate medical intervention, such as an anthrax release. If health departments are not able to develop such capacity internally, they must have contingency plans to contract with and train private sector personnel for mass dispensing.
  - Furthermore, HHS should work with providers to develop a standardized template for distributing MCMs to children, people who are home-bound and other specific populations, including informed consent issues.
  - Finally, HHS should monitor and assess MCM use nationally during emergencies.[3]

- **Ease barriers to hiring at federal, state and local level:** In the midst of an emergency, it can be difficult to hire people quickly. HHS agencies should have authority to make immediate job offers to emergency response staff, such as epidemiologists and logisticians, saving time during an emergency.

- **Braiding of grants**: The federal government can facilitate more efficient and effective response efforts by allowing states and grantees the flexibility to braid funding streams that support recovery after an emergency or disaster. Braiding is coordinating funding and financing from various sources to support a single initiative or strategy, at the state, community or program-level. Braided funds remain in separate and distinguishable strands, to allow close tracking and accounting of expenses related to each separate funding source. These funding and resource allocation strategies use multiple existing funding streams to support a single initiative or strategy, such as a coordinated recovery effort in a way that produces greater efficiency and/or effectiveness. This flexibility could have implications in disaster recovery as grantees receive funding across federal agencies or funding lines, yet face gaps in coordinating between grants and meeting unexpected needs that fall through cracks between emergency support functions. Congress could give agencies the needed authority to provide flexibilities for braiding recovery funds from disparate funding streams in the event of a declared public health emergency.

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[2] For more detail, see: *A Framework for Healthcare Disaster Resilience: A View to the Future*, Johns Hopkins Center for Health Security, Feb 2018. http://www.centerforhealthsecurity.org/our-work/pubs_archive/pubs-pdfs/2018/180222-framework-healthcare-disaster-resilience.pdf

[3] *Building a National Capability to Monitor and Assess Medical Countermeasure Use During a Public Health Emergency*, National Academies, Oct 2017. http://nationalacademies.org/hmd/Reports/2017/building-a-national-capability-to-monitor-and-assess-MCM-use-during-a-PHE-proceedings.aspx