Statement of Priorities for Reauthorization of Pandemic and All-Hazards Preparedness Act (PAHPA)

On behalf of the undersigned organizations representing public health, healthcare, patients and persons with disabilities, we are pleased to share with you the following shared priorities as Congress begins development and consideration of the 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 communities. Further, funding formulas that lean too heavily on risks from prior natural disasters ignore universal risks, such as an influenza pandemic or other outbreaks, and unpredictable threats such as acts of terrorism and mass shootings. Because disasters can and do occur everywhere in the U.S. states and territories, 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. An efficient and effective state and local workforce response in particular relies heavily on reliable, ongoing funding support for a network of local expertise, relationships and trust that is carefully built over time through shared responses, training and exercises. It can be rapidly degraded but it cannot be rapidly created or brought in through sporadic, ad hoc investments

[1] https://www.naccho.org/uploads/downloadable-resources/Impact-of-the-Redirection-of-PHEP-Funding-to-Support-Zika-Response.pdf

when a crisis strikes.

- **Preparedness Programs Should Remain Distinct:** PHEP and HPP should continue to be aligned and coordinated but should be maintained as separate, distinct programs. 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.

- **Immediate Response Fund:** A pre-approved standing fund of emergency resources that would speed the public health response to disasters is necessary. We affirm 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.

- **Medical Countermeasures (MCMs):** The Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) strategy and implementation plan should be strengthened to require coordination with state and local entities to ensure the products being developed reach the end users in a timely and well-coordinated manner. Several programs created in previous authorizations have been successful and should be maintained, including emergency use authorization, the Strategic National Stockpile and the Shelf-Life Extension Program for state and local stockpiles.

- **Environmental Health:** Environmental health is a branch of public health that examines all the physical, chemical, and biological factors external to a person and incorporates the assessment and control of those environmental factors that can potentially affect health. Environmental Health professionals are extremely important in all-hazard emergency preparedness response, recovery, and mitigation due to their understanding of how disasters impact the environment. Environmental health professionals function in areas of controlling disease-causing vectors, food safety inspections, safeguarding drinking water, preventing chemical and radiation exposure, protecting the public from bioterrorism, and ensuring healthy working and living environments. Environmental health workforce should be included in the national health security strategy and workforce development.

- **Planning for Whole of Community:** HHS should move away from an “at-risk individuals” definition to a more functional approach, including the functional needs of children and persons with disabilities. The current statutory definition of and references to “at-risk individuals” throughout PAHPA are insufficient at improving the preparedness and response of communities

to each of the populations encompassed by that term. HHS (ASPR and CDC) should develop a strategic plan for addressing each of the key sub-population groups, e.g. pregnant women, children, and individuals with access and functional needs. PHEP and HPP must ensure awardees are engaging in meaningful planning and coordination with each of these subpopulations and the institutions that serve them.

- **Advisory Committees and Experts: The National Advisory Committee on Children and Disasters** should be reauthorized and utilized as an important resource for the Secretary of HHS. Federal representatives should be ex officio, non-voting members, and the committee should incorporate additional expertise such as mental and behavioral health and children with special health care needs. **The National Preparedness and Response Science Board** (previously called the National Biodefense Science Board) should also be reauthorized and strengthened to serve as a resource for the Secretary. CDC's **Children's Preparedness Unit** (CPU) should be authorized to ensure the unit becomes permanent. CPU should provide technical assistance to PHEP awardees to assist with their plans and strategies.

Supporting Organizations

American Academy of Pediatrics

American Hospital Association

American Public Health Association

Association of American Medical Colleges

Association of State and Territorial Health Officials

Big Cities Health Coalition

Child Care Aware® of America

Council of State and Territorial Epidemiologists

Infectious Diseases Society of America

Johns Hopkins Center for Health Security

March of Dimes

National Association of County and City Health Officials

National Environmental Health Association

Trust for America's Health