U.S. Senate Committee on Appropriations Hearing:

"U.S. Government Response: Fighting Ebola and Protecting America"
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November 12, 2014

Chairwoman Mikulski, Ranking Member Shelby and members of the Committee, thank you for the opportunity to offer testimony today on behalf of Trust for America's Health (TFAH). TFAH strongly supports the Administration's request for emergency funding for the domestic and international Ebola responses. From support for the nation's public health infrastructure, medical countermeasures development, and international capacity building, these funds are essential to stemming the epidemic in West Africa and bolstering U.S. readiness for future cases. Contingency funding is also essential to prepare for an ever-changing epidemic. Importantly, because these are one-time, emergency funds, they should not be subject to the caps in the Budget Control Act. I urge you to appropriate these funds as soon as possible.

We support CDC and USAID's missions of building immediate and long-term emergency health capacity in Africa, contributing to overall global health security. These investments in African public health infrastructure, including establishing logistics networks, developing emergency operations centers, building laboratory capacity and training staff on the ground, will significantly impact the region's ability to stem future health threats.

I would like to provide context on America's public health and hospital preparedness systems and their implications for epidemic preparedness and response. State and local public health, in conjunction with our healthcare system, are the first lines of defense against emerging infections. 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 healthcare 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 be complacent about the dangers of infectious diseases. Our annual report, *Outbreaks –Protecting Americans from Infectious Diseases 2013*, found inconsistencies across states in our nation's preparedness for infectious disease threats. A strong, coordinated public health and healthcare system will be needed to fight both chronic and infectious diseases if we are to protect and improve the health of Americans.
2. The Ebola threat has significantly strained local health departments, as a significant portion of their workload for the past few months has focused on preparing for new domestic cases and monitoring at-risk individuals. That means that day-to-day work, such as preventing chronic disease or detecting other outbreaks, may be compromised after

only a handful of domestic cases. We cannot have a reliable public health system if it is constantly scrambling from crisis to crisis without adequate coverage of everyday threats.

3. 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. A reliable funding stream of annual appropriations is needed to ensure implementation of an all-hazards preparedness approach by health departments.
4. 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.

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 to $640 million over the past decade, with additional cuts proposed in FY2015. 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 the healthcare system 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 supports the President's emergency request for CDC response funding, including to support state and local health department and laboratory readiness. We also recommend restoring annual 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 better prepare public health for 21st century threats. Just as important, as mentioned above, we also recommend consistent, reliable funding. While supplemental funds 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 strong ongoing and emergency 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 program 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 – over 500 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. TFAH supports the President's emergency funding request for hospital-based treatment and personal protective equipment (PPE) purchases. In addition, we believe ongoing HPP 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 coalition system 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 unfamiliar infection – presents, including training frontline staff in proper infection control procedures and incorporating health alerts into electronic health records and triage. The Ebola Treatment Centers referenced in the emergency funding request should also be sustained as centers of excellence for future pandemic and emerging infection readiness.

Conclusion

The Ebola outbreak in Africa and transmissions in Dallas must be a wakeup call. We have the opportunity to better prepare our public health and healthcare systems for a variety of threats. 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.