

March 29, 2023

The Honorable Bernie Sanders
Chair
Committee on Health, Education, Labor and
Pensions
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy, MD
Ranking Member
Committee on Health, Education, Labor and
Pensions
United States Senate
Washington, DC 20510

The Honorable Bob Casey
United States Senate
Washington, DC 20510

The Honorable Mitt Romney
United States Senate
Washington, DC 20510

Dear Chair Sanders, Ranking Member Cassidy, Senator Casey, and Senator Romney:

On behalf of the National Association of County and City Health Officials (NACCHO) and the nearly 3,000 local health departments across the country, thank you for the opportunity to submit recommendations to inform the reauthorization of programs under the Pandemic and All-Hazards Preparedness Act (PAHPA). Local health departments are on the front lines of preparing for and responding to emergencies in their communities and programs authorized by PAHPA are vital to supporting this work. As you lead the reauthorization of these programs, we appreciate you considering the important role of local health departments in the governmental preparedness and response enterprise. **In response to your request for information, NACCHO respectfully provides the following recommendations.**

Public Health Emergency Coordination and Policy

The responsibilities and authorities of the Secretary of Health and Human Services (HHS) prior to or during a public health emergency (PHE)

Public Health Emergency Fund (PHEF)

NACCHO supports the reauthorization of the PHEF, which should serve as a fast, flexible, and functional method to quickly provide funding to state and local partners during an emergency response. However, the PHEF has not been appropriated or used in decades. NACCHO recommends Congress create a mechanism to require an infusion of funds to the PHEF during a declared public health emergency that can then quickly be deployed to local or state partners for response activities. These funds should supplement, not supplant any existing preparedness and response funding. The experience during COVID-19 and mpox showed that often funding does not arrive quickly enough in a crisis. The PHEF could help serve as a bridge for an immediate response, particularly for local and state partners, until Congress can appropriate additional funds. Furthermore, under current law, HHS must submit to the authorizing and appropriating committees a report at the end of each fiscal year describing how the Fund was used. NACCHO recommends HHS also be required to include in the report information about which entities received funds through the Fund, what activities funds are used for, and any sub-granting of funds.



Temporary Reassignment of Federally Funded Staff

NACCHO supports reauthorizing temporary reassignment of federally funded staff and urges modification to the provision to provide flexibility to also allow local health departments and federal agencies to issue and receive temporary reassignments. Currently only state governors or tribal leaders are authorized to submit temporary reassignment requests to support a PHE. This mechanism enables increased continuity of operations that are vital for a response. In addition, we urge that Congress direct HHS to work with its agencies to establish a "one-stop shop" for SLTT health agencies to submit emergency reassignment requests. Should the federal employee's temporary reassignment need renewal, SLTT health agencies should not need to repeat the entire process each time the public health agency renews an employee.

The authorities, duties, and functions of the Assistant Secretary for Preparedness and Response (ASPR) *ASPR*

NACCHO supports authorizing ASPR as an operating division within HHS to give it more authority over its preparedness and response mission and over its funding for staffing, contracting, and response. NACCHO also recommends the Committee consider how ASPR's authorization can be used to improve coordination among federal agencies and between state and local health departments. National preparedness and response require a coordinated all-of-government approach at the federal level that includes not just HHS, but also other departments that interface with jurisdictions on areas key to preparedness. It is essential that federal agencies have clear preparedness and response roles well in advance of an emergency, and that these roles can be understood at state and local levels for improved coordination, information sharing, and more efficient and streamlined responses.

Strategy for Public Health Preparedness and Response to Address Cybersecurity Threats

Like many sectors of our society, health departments rely increasingly on technology and data to carry out their mission, and threats to cybersecurity present a growing and serious challenge for public health and safety. NACCHO urges federal efforts to enhance cybersecurity to include local and state health departments, including to strengthen cybersecurity infrastructure and prepare for possible threats. Cybersecurity efforts should consider the unique needs of health departments of different jurisdictional levels and sizes (i.e., local, state, and territorial), as well as health departments in both rural and urban settings. Cyberattacks have the potential to compromise individual patient records, as well as whole systems that if compromised would result in a loss of access to vital services that would disproportionately impact people who rely on the public health safety net. Ensuring that health departments are prepared for cyberattacks is critical to the mission of protecting and promoting the health and safety of communities nationwide and we urge you to include public health and health departments in the Department's cybersecurity initiatives.

The National Health Security Strategy (NHSS)

The NHSS is important to setting preparedness and response strategies for the nation's public health system. NACCHO appreciates that the NHSS currently recognizes the importance of developing and sustaining the federal, state, local, and Tribal public health capabilities, and ensuring coordination across the public health enterprise. NACCHO encourages Congress to also direct the NHSS to ensure coordination across sectors including public health, emergency management, and health care, and to consider how to facilitate coordination between federal agencies and preparedness programs such as PHEP, HPP, and FEMA grants.

NHSS describes potential emergency health security threats, and NACCHO supports maintaining as a goal preparedness and response related to zoonotic disease, food, and agriculture. NACCHO

recommends NHSS additionally identify cybersecurity and climate change as threats, and develop preparedness goals to prepare and respond to those threats.

The current NHSS statute requires that in 2022, the NHSS include a national strategy for establishing an effective and prepared public health workforce. The public health workforce remains under-resourced and is suffering burnout after the long COVID-19 response. NACCHO strongly supports maintaining this language for the next NHSS.

Finally, to ensure accountability, NACCHO strongly supports the maintenance of the provision requiring an evaluation of the progress made by federal, state, local, and Tribal entities and encourages Congress to consider additional language to further incentivize adherence to the NHSS.

Medical Countermeasures Development and Deployment

Strategic National Stockpile (SNS)

It is critical that public health stakeholders – including state, local, and Tribal governments – know what to expect in a crisis. The SNS should serve as an asset to state and local governments available in emergencies to deliver medical countermeasures and supplies using point-to-point distribution, and public health stakeholders must know what assets are available and how they will be distributed so they can properly prepare for and respond to public health emergencies. Local health departments still seek clarity on the defined roles between ASPR and CDC in administering the stockpile and providing support for the last mile distribution of resources within the stockpile. There is also a critical need to focus on the last inch of supply distribution that drives demand for these products and has led to competition for limited resources amongst the response partners. Local public health officials need to be engaged in the communication and administration of these planning efforts. NACCHO also urges additional transparency around the contents of the SNS for state and local partners to inform their own preparedness efforts and expectations.

Public Health Emergency Medical Countermeasures Enterprises (PHEMCE)

Input from local health departments must be solicited and incorporated through all aspects of public health emergency preparedness and response, including medical countermeasures. Local health departments provide strategy and direct service on public health matters in their communities and have a unique perspective that complements that of their counterparts at the state and federal level. Taking lessons from the COVID-19 response, the PHEMCE Strategy and Implementation should require that local and state health departments be involved in all phases of the medical countermeasures enterprise including initial investment; research and development for responding to emerging public health threats; and distribution and dispensing of countermeasures. Additionally, distribution and dispensing strategy and implementation must take into account not just the last mile but the last inch. Countermeasures will not be effective if they do not get to the individual level end-consumer. Local health departments are uniquely positioned to ensure countermeasure delivery and acceptance at the individual level and accordingly should be incorporated into planning and implementation efforts.

Support for Jurisdictional Preparedness and Response Capacity

Public Health Emergency Preparedness (PHEP) cooperative-agreement program

PHEP is the core program for building and maintaining local health departments' abilities to prepare for and respond to public health emergencies large and small. These funds are critical for local health departments to support the achievement of our federal preparedness goals. However, the program's

authorization has been reduced since it was originally authorized in 2002 and its buying power further decreased due to inflation. NACCHO strongly recommends PHEP be authorized at \$1 billion, in line with its original authorization level, which could better ensure adequate funding levels of communities of all sizes and rurality. Furthermore, despite current language in statute, local health departments are not uniformly receiving sufficient awards through funded state entities. As such, NACCHO recommends Congress request a study by the Government Accountability Office examining how states determine the appropriate portion of PHEP awards for subdivisions and local health departments including any differences based on governance structure, rural or urban communities, and any other relevant factors, and make recommendations on how federal PHEP funds can be more efficiently used to support system-wide preparedness.

Hospital Preparedness Program (HPP)

HPP provides grants to states and directly funded cities that in turn fund local health departments, healthcare facilities, and other partners to build capabilities and capacities that strengthen the preparedness, response, recovery, and resilience of the public health and healthcare system. HPP supports health department preparedness coordinators to organize coalitions of public health and healthcare providers to plan and prepare for public health emergencies. This coordination is extremely important in response to an emergency where the local health department and the affected healthcare facilities must work together to protect the community. NACCHO recommends reauthorizing HPP at \$500 million, the amount grantees received twenty years ago in FY2003.

Medical Reserve Corps (MRC)

NACCHO supports the reauthorization of the MRC through 2028 at a level of \$22 million to support the ongoing robust country-wide set of volunteer units to assist in emergencies and day-to-day community service. In FY 2021, MRC volunteers contributed over 2.7 million volunteer hours of service from over 600 MRC units to their communities. According to HHS, the total economic value of this contribution, which included the efforts of a variety of medical professionals, is estimated at over \$91 million. MRC units were integral to the COVID-19 response in communities across the country, providing more than 3 million volunteer hours to support activities including community screening and testing operations; COVID-19 vaccination administration; medical surge support; patient case and contact investigations; call center operations; community education and outreach; and logistics support. Congress provided increased resources during the pandemic response which enabled MRC units to undertake these activities that otherwise would not have been possible. An increased authorization level of \$22 million would restore the program to its original authorization level and is critical to maintain the volunteer networks that have been built out during the COVID-19 response. NACCHO supports extending MRC liability coverage so that volunteers are covered during both response and non-response activities, and so that there is universal liability coverage when operating across state lines. Additionally, NACCHO supports the establishment and resourcing of a national volunteer management system that allows for background screening, credential verification of potential volunteers, and provides interoperability to facilitate deployments across local, state, and federal jurisdictions.

Epidemiology and Laboratory Capacity (ELC) Grant Program

ELC provides critical federal support to epidemiologists and laboratory scientists. However, with the exception of six large cities, ELC funding does not go directly to the local level, and local health departments must rely on suballocations by state health departments. Federal funds intended to support both state and federal public health, continue to have variable reach to the local level both in amount and timeliness. NACCHO recommends Congress require that where funds are not sent directly to local jurisdictions, states be made to track and report through CDC how they are suballocating

funding to the local level, including amount, date funds are made available, and how allocation decisions are made. This information should be shared with Congress and the public for accountability and to inform best practices. NACCHO also recommends Congress establish clear expectations limiting additional administrative burdens or requirements states may impose on local jurisdictions attempting to access federal funds. Including provisions such as these in PAHPA will provide needed oversight and transparency to ensure that federal funding is supporting public health priorities at all levels and in all communities, as intended.

Biosurveillance and Public Health Situational Awareness

The governmental public health system's data infrastructure, particularly at the state and local level, is lacking, in part because those needs have not always been accounted for in federal health information technology efforts. Recent investments in the CDC's Data Modernization Initiative, including in COVID-19 response legislation, have been valuable and should be maintained; however, to fully realize the potential of data modernization, public health systems at the local and state level must be modernized as well. NACCHO recommends at least \$7.84 billion over the next five years and sustained annual investments over the next decade to support data modernization throughout all levels of the public health system – federal, state, and local. Such investment is needed to transform public health surveillance into a state of the art, secure, and fully interoperable system. Further, this funding is essential to attract, train, and retain the diverse workforce needed across the governmental public health enterprise to build, implement, and sustain a modern public health data infrastructure.

Under current law, HHS is directed to establish a near real-time electronic nationwide public health situational awareness capability through an interoperable network of systems to facilitate early detection of and rapid response to potentially catastrophic infectious disease outbreaks. This system has not been developed but would be extremely valuable to public health preparedness and response, including at the local level. NACCHO recommends these provisions be reauthorized and implementation supported through appropriate funding and guidance to all levels – federal, state, and local. Furthermore, the system should be interoperable and accessible across all these levels. Local health departments should be able to view data from across the entire system, not just be required to report data upward to state or federal entities.

Vaccine Tracking and Disbursement

The COVID-19 pandemic and mpox outbreaks have shown the importance of incorporating vaccine tracking and distribution beyond pandemic influenza so that federal, state, local, and tribal decisionmakers are informed about a range of infectious diseases. Health departments have long prepared for and practiced their response for emerging infectious diseases, which included plans and exercises for mass vaccinations. Health departments play a critical role as a clinical point for vaccination, but also as an in-community strategist and coordinator to ensure efficient vaccination efforts in their local area. In the case of the COVID-19 vaccine rollout, the federal government established new routes of vaccine delivery that relied heavily on pharmacies and federally qualified health centers (FQHC) as opposed to leveraging pandemic preparedness plans previously developed at the local level to work in tandem with the newly established routes. While pharmacies and FQHCs are important access points; focusing solely on these two settings was not sufficient for broader distribution of the critical vaccinations. It is vital to ensure an array of settings have the capacity to plan, implement, and deploy mass vaccination sites for future outbreaks and emergency response.

Furthermore, health departments with robust immunization information systems experienced an unnecessary burden of navigating new systems through Operation Warp Speed such as the Vaccine

Administration Management System (VAMS,) which created duplicative processes. Finally, local health departments in many areas lacked access and visibility into where COVID-19 vaccines were distributed within their community as they were without uniform access to Tiberius and other data systems. As a result, health departments could not ensure efficient deployment and uptake of vaccines in their communities. Expanding access to vaccine tracking and disbursement information, as well as expanding these to other infectious diseases would empower local health departments to be best positioned to respond to future outbreaks with a known, established process.

Gaps in Current Activities and Capabilities

Adult Vaccine Infrastructure

As we learned from the COVID-19 pandemic, a comprehensive vaccine infrastructure is needed to immunize all Americans from infectious disease threats. Therefore, NACCHO supports authorizing a Vaccines for Adults program that is essential for enhancing and maintaining the infrastructure needed for responding to future pandemics. While the National Vaccine Program or 317 is essential, it is not sufficiently funded to support vaccination for all uninsured adults. Even with the improvements in access to adult vaccines in Medicare Part D, Medicaid, and CHIP authorized in the Inflation Reduction Act, there are still significant gaps in coverage and infrastructure for adults that leave Americans vulnerable to vaccine preventable diseases.

Public Health Data

NACCHO supports inclusion of the Improving Data Accessibility Through Advancements in Public Health Act or Improving DATA in Public Health Act (H.R. 8481, 117th Congress) that promotes coordination between federal agencies to share critical public health data used to prepare for and respond to public health emergencies. The bill also creates standards to improve and secure the transfer of electronic health information and establishes an Advisory Committee to ensure that public health data reporting processes are carried out effectively. Every effort must be made to strengthen public health data systems as an essential component of emergency preparedness.

Seasonal and Pandemic Influenza

NACCHO supports inclusion of the Protecting America from Seasonal and Pandemic Influenza Act (H.R. 9476, 117th Congress) that builds on the National Influenza Vaccine Modernization Strategy and lessons learned from the COVID-19 pandemic, to strengthen the federal government's seasonal and pandemic influenza ecosystem, including flu vaccine innovation, virus detection, and prevention. Seasonal flu kills tens of thousands of Americans – including children – and results in hundreds of thousands of hospitalizations and millions of illnesses and missed workdays. Importantly, we must also prepare for influenza strains with pandemic potential particularly as there is no commercial market for the development of products to prevent, detect, or treat pan flu.

Partnerships

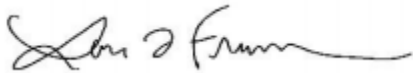
Effective public health response requires action across the governmental public health enterprise at the federal, state, and local levels. Federal funds from CDC support state and local readiness and response, but federal funds intended to support both state and local continue to have variable reach to the local level. To better enable public health emergency readiness and response, Congress should give CDC explicit authority to direct funding to governmental public health agencies. Such authority would improve timeliness of awards intended solely for state and local governments. To truly ensure funds make it to the local level, Congress should empower CDC to expand its grantmaking pool to include as many local jurisdictions as possible, and require that funds flow to locals via their state when direct

allocation is not possible. Any expansion of direct funding authority should also include an analysis of efficiency and efficacy of funding making it to the local level when not directly provided.

Congress can also help partners at the state and local level by cross-walking and streamlining federal grant programs (including HPP, PHEP and those within the Federal Emergency Management Agency) that jurisdictions may rely on during an emergency response. This will require strong federal leadership and multilevel coordination and agreement across numerous federal programs and entities.

Thank you again for the opportunity to provide feedback on behalf of our nation's local health departments. For additional information, please contact Adriane Casalotti, NACCHO's Chief of Government and Public Affairs, at acasalotti@naccho.org. NACCHO looks forward to working with you on improving the preparedness capabilities of our country.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori Tremmel Freeman". The signature is fluid and cursive, with a long horizontal flourish at the end.

Lori Tremmel Freeman, MBA
Chief Executive Officer