

Senate Health, Education, Labor and Pensions (HELP) Committee Hearing:
“Facing 21st Century Public Health Threats: Our Nation’s Preparedness and Response
Capabilities, Part 2”
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Testimony of

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Chairman Alexander, Ranking Member Murray, Senators Burr and Casey, and distinguished Committee members. Thank you for this opportunity to appear before this committee today to discuss an issue of significant importance to the common defense of the country - a strong, agile, and resilient public health and medical preparedness and response system. It is an honor to be here. The thoughts I will be sharing with you today are my own, but I am confident that they are shared by my public health colleagues across the country who strive every day to prepare for and respond to threats of all kinds. These threats may be infectious disease outbreaks like measles, food borne illness, and our annual epidemic of seasonal influenza that can, like this year, unpredictably test our nation’s response readiness and surge capacity. These threats can also be large scale national or global events like an influenza pandemic, Ebola, Zika, the opioid epidemic, or acts of terrorism. Public health also mobilizes during natural disasters such as winter storms, hurricanes, tornados, floods, wildfires, and other extreme weather events that, unfortunately, seldom does a public health jurisdiction of any size go more than a few years without experiencing. Through mechanisms like the Emergency Management Assistance Compact, or EMAC, even unaffected jurisdictions are frequently called upon to assist neighbors.

Public health and medical emergency preparedness, response, and recovery is a responsibility, discipline, and service that we must get right; lives, as well as physical and economic health depend on it. It is something we in public health do every day, it is a matter of local resiliency, as all disasters play out locally, and it is a matter of national security. In the few moments we have together, I would like to share my perspective with you, having been directly involved in planning, implementation, and execution roles at all levels, both in a military and civilian capacity, for over 50 years.

Let me start with a simple question: “What is health and medical emergency preparedness, response, and recovery?” At root, it’s not “stuff” or equipment or plans. It’s people. Shelters don’t staff themselves. A fire truck can’t put out a fire without firefighters, and people, like public health nurses or firefighters, can’t be hired and trained after the alarm sounds. They need to be there, ready to go before the threat ever emerges if they are to be effective in responding to

it.

Preparedness is about the people involved: It is about their interconnected networks. To be truly prepared we need three key things: ONE) Trained people, some with local knowledge, and all connected by relationships built on trust, TWO) Expertise and leadership, at all levels; local, state, and federal and THREE) Communication and shared situational awareness among the responding leaders and experts. Trying to create these three things after an event begins takes the one commodity that is most precious in an emergency: Time. We don't have time to create this network once the event starts.

In a way, the public health and medical emergency preparedness response and recovery network is like a safety net for a performer—it has to be in place before the show starts, anchored, inspected, and in good shape for it to do its job. Many people think equipment or supplies are the net, but if you remember nothing else from my testimony today, please remember this: people, not things, are the net. The relationships, knowledge, and trust created over time are what strengthen the cords, hold them together and keep them adaptable and resilient. The more the cords and nodes on the net degrade or unravel, the less capable the net is for what we need it to do at our most vulnerable times. Things, like durable equipment, medical countermeasures, and communications infrastructure, are essential anchors for the net. Without them, the network of people can't be as effective, but it's the people who are the net.

Our accomplishments and successes in preparedness, response, and recovery over the last 15 years (illustrated in my written remarks) can be directly attributed to the Pandemic and All Hazards Preparedness Act. This Act, both in its initial and first reauthorization form, was transformative relative to public health and healthcare preparedness and has provided the requisite direction, authorities, authorization of resources, and cadence of accountability that have become part of the culture of public health and enable us to do our job in the best way possible.

As you consider PAHPA reauthorization, PHEP and HPP¹ priorities and resources must line up with the demands of an ever-expanding threat environment and give our frontline of defense and safety net the ability, the scale, and the speed it needs to protect the public's health and safety. Congress, and especially this Committee, should be applauded for its continued work on laws like PAHPA that give states, territories, localities, and tribes the resources and tools needed to stay vigilant at this critical post and get the job done when needed. These funds are not duplicative of emergency management and Homeland Security, but complementary and essential. Sometimes, depending on the hazard, public health is the only responder.

What we ultimately need as a nation to ensure a strong safety net is consistent, reliable, and sufficient funding to keep the people, the net—their knowledge, networks, and trust—intact.

¹ Public Health Emergency Preparedness (PHEP) Cooperative Agreement & Hospital Preparedness Program (HPP)

Thank you again for the opportunity to speak with you today about this fundamental issue and for caring about preserving our ability to respond to any hazard or threat for generations to come.

State and territorial public health departments play a critical role in national security and have increased their individual and collective capacity, capabilities, and impact over the last 15 years to manage the consequences of local, regional, and national emergencies more effectively, saving lives and preventing or reducing injury and illness. These accomplishments are due, in large part, to the leadership, strategy and policy provided, and the investments by the federal government in state and local partners, to build and sustain a strong public health and medical preparedness system – both a front-line defense and a safety net. Our accomplishments and successes can be directly attributed to the Pandemic and All Hazards Preparedness Act. This Act, both in its initial and first reauthorization form, was transformational as it pertains to public health and healthcare preparedness and has provided the requisite direction, authorities, and authorization of resources to enable us to do our job in the best way possible.

In Tennessee, our front line of defense and safety net is very adaptable. We have deployed it recently for fires, floods, for winter storms, wind and tornado events, and to provide mutual aid to neighboring states and those as far away as the US Virgin Islands. The list continues with other hazards like Ebola, Zika, measles and mumps outbreaks, foodborne illnesses, the fungal meningitis associated with contaminated compounded injectable drugs which I will come back to in a few moments, and “white powder” incidents. These are real and often different threats requiring flexible and adaptable response capabilities. In each instance, the strength of our system is tested, and each time we assess our performance with a commitment to learn from each and every experience and to make improvements so that our actions will be even stronger the next time.

Among other features, the Pandemic and All Hazards Preparedness Act created and authorized two critically important, aligned and coordinated programs: The Public Health Emergency Preparedness Program administered by the CDC and the Hospital Preparedness Program administered by the HHS Assistant Secretary for Preparedness and Response. These two programs are the bedrock for state and local public health preparedness and response providing essential cooperative agreement funding as well as guidance and technical assistance. They not only enable jurisdictions to plan, train and exercise, but also to purchase laboratory and communications equipment, medical countermeasures, and personal protective equipment for first responders. More importantly, it allows public health departments to hire and retain a skilled workforce and to make a long-term investment in “people” such as epidemiologists, laboratory technicians, nurses, environmental health specialists and other subject matter experts. It is the people, their networks, expertise, and relationships built on trust that are truly the safety net. Eighty-one percent of Tennessee’s Public Health Emergency Preparedness (PHEP) program award goes to personnel costs.

I realize this is not an appropriations committee hearing today but I would be remiss if I did not mention that the aforementioned funding is essential, but not sufficient. The primary source for state and local public health preparedness has been cut by about one-third (from \$940 million in 2002 to \$667 million in 2017) and hospital emergency preparedness funds have been cut in half

(\$514 million in 2003 to \$254 million in 2017). These reductions have degraded the safety net and our resiliency as a nation in the face of these ongoing and increasing threats. This is a high value investment in the health, safety, and security of our homeland, and returning to these earlier levels of funding is a relatively small investment that could reap billions of dollars in savings given the potentially high cost it could take to respond to an unmitigated disaster or pandemic. Having the resources to get it right rapidly at the local level is far more effective and less costly than a poorly coordinated response that would require federal intervention. As you consider PAHPA reauthorization, funding authorization levels for both PHEP and HPP must line up with resource demands of today and into the future to sufficiently handle the ever-expanding threat environment and to give our frontline of defense and safety net the ability, the scale and the speed it needs to protect the public's health.

It is important to understand that public health emergency preparedness and response infrastructure is people. One can think of it in terms of three tiers of public health responders: 1) Emergency preparedness professionals, 2) those who have deep emergency preparedness training but whose daily duties are more in line with traditional public health work, and 3) all other public health professionals like public health nurses who stand ready to assist when needed. Each of these tiers, while they may have differing levels of direct involvement in responding to threats, are all essential to enabling a fully functional net and all must work together when needs arise to support each other.

Using just two examples in my own state of Tennessee, a strong public health response was crucial in saving lives during the 2016 wild fires in Sevier County that impacted the beautiful town of Gatlinburg. In addition to staffing shelters, providing vaccines and care, tracking down and accounting for missing persons, providing for the decedents, assuring food safety, testing water, staffing of local, regional, and state emergency operations centers around the clock, the Tennessee Department of Health (TDH) trailers served as the communications hub for multiple other agencies including the hospital, EMS, and 911 system. We were all part of the same team, and having the proper resources deployed at the right place and time saved lives and property.

During the fungal meningitis outbreak of 2012 that led to 751 cases across 20 states, with 64 total deaths nationwide, the TDH leveraged a PHEP-funded communication system called the Tennessee Countermeasure Response Network to integrate public health in this unprecedented response that included public health and healthcare sectors. It was Tennessee's leadership that pinpointed the source of the outbreak and helped to identify patients at risk. Relationships and trust built between TDH and Tennessee healthcare providers and other public health agencies and, most critically, the relationships between public health nurses and the victims of this terrible event themselves, enabled a swift and coordinated response. The outbreak response was concluded in four months (though the suffering of the victims in some cases continues), and the rapid identification and response eliminated further exposure and cases.

These incidents could have been far worse if it were not for the preparedness efforts of the public health and medical systems. Similarly, I am confident that my colleagues like Dr. John Wiesman in Washington State when responding to the tragic train derailment last December or

Danny Staley in North Carolina recently responding to extreme winter weather, do not want to know how their experiences could have evolved without the critical support from the federal government for public health preparedness efforts. Each of these examples, and I can certainly provide you with many more, demonstrates a return on the investment. That being said, we must also remember that the system built on passionate, compassionate public health professionals can degrade quickly if not maintained and the investment continually renewed.

In closing, allow me to reemphasize the point that the Pandemic and All Hazards Preparedness Act (PAHPA) is the mechanism that undergirds the federal, state, and local governments in these efforts. It is an extremely important and proven piece of legislation that is responsible for transforming public health preparedness over what is approaching two decades and is paramount as it pertains to our ability to protect the public's health from a constant, challenging, and changing threat landscape. Congress, and especially this Committee, should be applauded for its continued work on laws like PAHPA that give states, territories, localities, and tribes the resources and tools needed to get the job done. These funds are not duplicative of emergency management and Homeland Security, but complementary and essential.

As you consider suggestions for the refinement and enhancement of PAHPA, I respectfully submit the following principles to consider:

- Preparedness Programs should be nationwide and extreme care should be given not to change the funding formula or criteria that would result in reduced or eliminated funding to jurisdictions thus compromising their preparedness and response capacity and capability; all states and localities need their neighbors to be as strong as they are,
- As I mentioned previously Preparedness Programs should be authorized at sufficient funding levels to strengthen and maintain support for public health infrastructure and workforce; to retain this highly trained and effective workforce, they need to have some reasonable certainty regarding continuity in the nation's need and wish for their professional activities; these people form the core of the safety net,
- We need a viable Immediate Response Fund allowing for the timely infusion of additional resources to support surge when existing capacity is or will soon be exceeded. This principle is well understood and used routinely by other first responders dealing with natural disasters. A current fund already exists but is not truly funded. The practice community would gladly work with the committee and others to identify those "triggers and guardrails" to be expressed in statute possibly through this reauthorization cycle that will give Congress the necessary comfort and confidence of stewardship to then appropriate reasonable and necessary funds for future use, and
- Strengthen the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) strategy and implementation plan process 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.



Thank you again for your attention today and for caring deeply about our nation's emergency preparedness, response, and recovery system for today and tomorrow.