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Legislative Solutions to Bolster Preparedness and Response for All Hazards and Public Health Security Threats
House Energy and Commerce Committee
Subcommittee on Health
June 13, 2023

Chairman Guthrie, Ranking Member Eshoo, and members of the subcommittee, thank you for the opportunity to address you today as the Committee seeks to enhance our nation's preparedness and response to public health emergencies.

I am Dr. Raynard Washington, Public Health Director for Mecklenburg County, North Carolina which includes the city of Charlotte. I am also the Vice Chair of the Big Cities Health Coalition, comprised of 35 health officials who lead the nation's largest metropolitan health departments; together we serve more than 61 million – or about one in five – Americans.

I share my views on the importance of the Pandemic and All Hazard Preparedness Act or PAHPA with the subcommittee through the lens of a public health practitioner for over 15 years at both the federal and local level. I am an epidemiologist by training and have served as the county's health director since December of 2021. I started as the deputy health director in March of 2020 – in fact on my first day of work I went right from county orientation to our emergency operations center to join COVID-19 response activities. Prior to Charlotte, I served as a deputy health commissioner and chief epidemiologist in Philadelphia for 3 years. PAHPA is a critical piece of legislation to governmental public health, our partners in health care, and our communities. Reauthorization of PAHPA is key to ensuring that the infrastructure necessary to prepare and respond to the ever-evolving health threats we encounter at the local level.

Role of Local Public Health Departments in Preparedness and Response
Big city health departments (including county health departments that serve big cities) are on the front lines of preventing and responding to public health emergencies, including natural disasters (such as fires, floods and earthquakes), terrorist attacks, and infectious disease outbreaks and pandemics, like COVID-19 and mpox. Just last week, there was an acute public health response to the Canadian fire smoke in the northeast. Public health departments at the city, county, and state level were able to respond because of the work they have put into maintaining a true all hazards response, which is critical to the nation's health.

Governmental public health departments help to build resilient communities by preparing for, responding to, and supporting residents who are recovering from, public health emergencies. Maintaining coordinated networks and preparing partners on the ground for emergencies before they happen is the only way to respond quickly. This is a unique role of local governmental public health. During the mpox response, for example, local health departments like mine successfully mobilized partnerships with LGBT+ serving organizations and during the

pandemic we partnered with a host of grassroots and nontraditional partners, like corner stores and houses of worship, to achieve our containment goals.

A well-functioning public health system – infrastructure, workforce, disease surveillance, laboratory testing, infection control, and medical countermeasure (MCM) administration – *is* pandemic preparedness and must be well resourced at all levels of government before, during and after emergencies. Diseases don't recognize city, county, or state boundaries, and across the nation, each community is only as prepared as its weakest neighboring community.

Importance of PAHPA and Strong Public Health Infrastructure

Reauthorizing PAHPA is critical to protecting and promoting the public's health and preparing for the next emergency. As we see the resurgence of infectious diseases, like measles and polio, in pockets across the country, it's further evidence that all hazards preparedness must be at the forefront of our nation's public health system. As we move out of the COVID-19 emergency, it is also a timely opportunity to improve the system with the learnings of the last few years.

We need a truly coordinated all of government approach at the federal level that includes not just Health and Human Services, but also the other departments that interface with local and state 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.

At the same time, while federal leadership and resources are needed, a top-down approach to public health is not sufficient. To truly function as a system, public health leaders must be involved at every level of government – local, state, and federal – and information, data, and resources must flow quickly and efficiently to and from each level. Unless and until that happens, we will remain underprepared for the health and health security challenges our nation faces.

PAHPA Authorized Programs

Public Health Emergency Preparedness (PHEP)

The PHEP program was created after September 11, 2001 to provide core funding to strengthen local and state public health departments' capacity and capability to effectively respond to public health emergencies, including terrorist threats, infectious disease outbreaks, natural disasters, and biological, chemical, nuclear, and radiological emergencies. Centers for Disease Control and Prevention (CDC) PHEP grants are provided to 50 states, four localities (Chicago, Los Angeles County, New York City, and Washington, D.C.), and eight territories and freely associated states. Most local health departments do not receive funding directly; rather, dollars are meant to be distributed by and through state health departments.

PHEP is critical to having a response ready workforce at the local level. In Mecklenburg County, our health department preparedness staff has grown from 1 FTE to 3 since the start of COVID-19 due to federal investments. This includes our first ever preparedness manager. These funds allow us to train staff and maintain and implement local response plans for every type of hazard.

Unfortunately, PHEP funding to grantees has been cut by nearly 30 percent over the last two decades, despite the increase in emerging and re-emerging infectious diseases, and weather-related, environmental, and other emergencies and disasters. The continuous barrage of wide-scale public health emergencies, such as the pandemic and mpox, demonstrates the need to reauthorize and reinvest in these programs to rebuild and bolster our country's public health preparedness and response capabilities. As such, PHEP should be reauthorized at $1 billion, which would take into account inflation since the program began and align it with the intended buying power from its 2002 creation of $1.08 billion.

Hospital Preparedness Program (HPP)

Likewise, the Hospital Preparedness Program (HPP) program prepares the nation's health care system to save lives during emergencies and disasters. The Administration for Strategic Preparedness and Response (ASPR) HPP grants are provided to 50 states, four localities (Chicago, Los Angeles County, New York City, and Washington, D.C.), and eight territories and freely associated states. HPP supports regional health care coalitions, like the Metrolina Healthcare Preparedness Coalition in our region, to incentivize health care readiness, assess risks and needs, train the workforce, and maintain preparedness among organizations that might otherwise see each other as competitors. As such, HPP is a vital support – but it has been cut by more than 50% over the last 20 years and remains stretched due to prolonged emergency responses, increased preparedness and response requirements, and annual discretionary funding not keeping pace with inflation. In Mecklenburg County, our health system partners took on a primary role in testing during the early days of COVID, and had to deploy a mobile hospital due to the crushing demand on emergency departments at the height of the pandemic. But like our health departments, this surge required them to stop providing other critical health care services – which patients are now catching up on delayed procedures and appointments. HPP should be reauthorized at $500 million – the amount grantees received twenty years ago in FY 2003.

Epidemiology and Laboratory Capacity (ELC) program

BCHC supports reauthorization of the ELC program that serves as a single vehicle for multiple programmatic initiatives at 50 state health departments, six large BCHC member cities (Chicago, Houston, LA County, New York City, Philadelphia, and Washington, D.C.), Puerto Rico, and the Republic of Palau. ELC provides critical federal support to epidemiologists and laboratory scientists who are instrumental in discovering and responding to various food, water, and vector-borne outbreaks, as well as funding vital improvements in health informatics. Our department, like many across the country, relied heavily on ELC funding we received through

North Carolina, to support our daily COVID-19 response activities, including additional staff capacity to support epidemiology, data reporting, case investigation, contact tracing and testing. Despite ELC's vital role in responding to the pandemic, annual funding levels are not adequate to maintain public health preparedness or address routine challenges.

Strategic National Stockpile (SNS)

The Strategic National Stockpile (SNS) is a critical federal resource in addressing public health emergencies. Deployment of SNS assets is a key capability supported by the PHEP cooperative agreement. CDC works with health departments at the state and local level to develop the capability to receive and distribute countermeasures from the stockpile.

One of the roles of governmental public health is to gather situational awareness for the demand of MCMs during an emergency so states and locals can request and effectively use products from the SNS. This incident command structure is intended to ensure that supply is meeting demand. CDC must retain its responsibilities of technical assistance, subject matter expertise, and support of PHEP MCMs capabilities, with coordination and support from ASPR staff.

Congress should not only provide sufficient funding for the upkeep of the SNS but also increase transparency as to its contents. Recognizing there is a need to exercise some caution regarding what is in the SNS, there is still some level of information that can and should be shared with state and local partners. Congress should require additional reporting on the status of the SNS, including expenditures and expiration dates of goods, on a regular and timely basis.

Public Health Emergency Medical Countermeasures Enterprise (PHEMCE)

The PHEMCE is intended to be an interagency body that oversees decisions on research and development, procurement, and stockpiling of MCMs, as codified in PAHPA. BCHC recommends a permanent seat for state, territorial, local and tribal (STLT) public health officials. STLT health officials are responsible for the last mile -- getting lifesaving medications to people who need them. The requirement to include representation of STLT public health officials on the PHEMCE is essential and will ensure this critical perspective is included in decision-making related to the SNS products and distribution plans from the beginning. The need for a "boots on the ground" perspective regarding MCMs during the COVID-19 response – and mpox – was apparent, and Congress should codify this representation in the PHEMCE.

Integral to the success of the SNS is an effective interagency process for decision-making about the enterprise. HHS must ensure the PHEMCE continues to lead these key determinations, including what items should be purchased for, and held in, the stockpile, as well as what should be held in vendor-managed inventory, if appropriate. The PHEMCE strategy and implementation should also require that local and state health departments be involved in all phases of the MCMs enterprise including in initial investment; research and development of

vaccines, medicines, diagnostics, and equipment for responding to emerging public health threats; and distribution and dispensing of countermeasures.

Additional Considerations for Inclusion in PAHPA

Vaccines for Adults Program

As we learned from the pandemic, a comprehensive vaccine infrastructure is needed to immunize all Americans against infectious disease threats. Congress should authorize a Vaccines for Adults program, which would support access to Advisory Committee on Immunization practices (ACIP)-recommended routine and outbreak vaccines at no cost. Such a program is essential for enhancing and maintaining the infrastructure needed for future pandemic response, while also ensuring access to routine vaccines in non-emergencies. While the existing National Vaccine Program or 317 is a critical support mechanism, it is not sufficiently funded to support vaccination for all uninsured and underinsured adults. Even with the improvements in access to adult vaccines in Medicare Part D, Medicaid, and CHIP, there are still significant gaps in coverage and infrastructure for adults that leave Americans vulnerable to vaccine-preventable diseases, both routine and emergent. During the mpox response, federal support was not provided to our county to support vaccine distribution, and our county picked up the cost. Our progress with COVID-19 was only possible because vaccine cost was not a barrier for our residents. These are just two good examples of why we need a Vaccine for Adults program that can be scaled up in times of need and that has some baseline support of federal resources.

Timely and Accurate Data at the Local Level

Improving Data Accessibility Through Advancements (DATA) in Public Health Act (H.R. 3791) 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.

Further it is essential to strengthening public health situational awareness and disease detection. Our governmental public health system at the federal, state, and local level has systems in place for early detection and using surveillance to respond to health threats. As we saw during the pandemic, these systems need upgrading and modernizing. CDC must collaborate with other HHS operating divisions and partners across the federal government to strengthen public health data systems with better technologies and additional private sector knowledge and expertise.

From the perspective of local health departments, CDC should be given the authority to effectively collect and coordinate public health data necessary to serve its mission. The current framework for collecting and sharing public health data has resulted in fragmented and

inconsistent reporting to CDC, and to state and local public health partners. Expanded data authority for CDC will allow for more complete and timely data sharing to support decisions at the federal, state, and local levels, while reducing burden on providers. For example, authority included in the CARES Act requiring COVID-19 laboratory test reporting during the PHE greatly improved the availability of laboratory data. CDC should have the authority to require reporting of minimum necessary data to serve a range of defined public health and other mission-critical use cases.

Disease X

The *Disease X Act* (H.R. 3832) establishes a program at the Biomedical Advanced Research and Development Authority (BARDA) for developing medical countermeasures for viral threats with pandemic potential. This should be added to BARDA's remit. While we don't know what the next pathogen of pandemic potential will be, we do know which viral families are most likely to cause pandemics. COVID-19 vaccines were able to be developed quickly because of the prior 15 years of federal investment in coronavirus research. It is imperative that we start preparing now for what lies ahead.

Ensuring Funding Reaches Local Communities

Effective public health response depends on action at the federal, state, tribal, local, and territorial levels of government – and each level of government needs to be appropriately resourced in as direct and timely a manner as possible. As stated previously, most local health departments do not receive funding directly; rather, dollars are meant to be distributed by and through state health departments. CDC should continue – and should be encouraged by Congress – to broaden its direct grantmaking pool to include, at a minimum, the 107 jurisdictions funded under the Public Health Infrastructure and Workforce Development Grant Program. This universe of grantees includes the 50 states and Washington, D.C.; eight territories/freely associated states; and 48 local health departments. It is essential that funding for emergency preparedness and response, disease detection, and surveillance reaches those on the ground that are the first to identify and respond to health security threats.

In an emergency, timely allocation of funding is critical to the response. Congress should consider creating or modernizing existing mechanisms to get dollars out quickly to local, state, and federal public health agencies to set up emergency responses in a timely manner to protect health and prevent loss of life. Such funds should be additive, not require jurisdictions or CDC to reallocate existing funds which are primarily used to support the preparedness infrastructure. Such a fund, if resourced, would provide a critical bridge between annual preparedness funding and supplementary appropriations for acute emergencies and emerging threats, as well as support a baseline level of routine preparedness.

Emergency dollars to support a robust response in the intervening time it takes Congress to act are critical. Big cities are often first to respond to crises ranging from hurricanes to outbreaks to floods using whatever resources are available at that moment, with the expectation that the

federal government will contribute to the response. Public health emergencies, like infectious diseases and natural disasters, move at their own pace, which is most often much quicker than traditional funding mechanisms. For example, in the 2016 Zika outbreak it took Congress more than 200 days to respond to an emergency request from the Obama Administration. Although funding was quickly provided to some local jurisdictions through cooperative agreements with states during the early days of the pandemic response, this was not the case for the mpox outbreaks. Funds were made available mostly to state health departments well after the outbreak had peaked and response activities were waning. Local jurisdictions bore almost all the costs of mpox vaccination, which can limit the ability of jurisdictions to respond in a robust and rapid manner. Imagine what could have happened if local, state and other public health agencies actually waited for those resources to mobilize a response.

Thank you again for the opportunity to provide comments on the reauthorization of PAHPA and how to strengthen public health emergency preparedness and response in the future. I look forward to providing additional input and answering any questions you may have about my testimony today.