

“Examining the Reauthorization of the Pandemic All-Hazards Preparedness Act”

**Statement of
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I would like to thank the House Energy and Commerce Health Subcommittee for inviting me to testify today on behalf of local health departments across the country that are tasked with preparing for and responding to public health emergencies in their communities. My name is Dr. Umair Shah, and I am the Executive Director for Harris County Public Health (HCPH) and the Local Health Authority for Harris County, Texas. Harris County is the third most populous county in the United States with 4.7 million people and is home to the nation’s 4th largest city, Houston. I am also here today as the President of NACCHO, the National Association of County and City Health Officials. NACCHO is the voice of the nearly 3,000 local health departments (LHDs) across the country that prepare communities for disasters, respond when emergencies occur, and lend support throughout the entire recovery process.

I want to thank the Committee for taking steps to reauthorize the “Pandemic All-Hazards Preparedness Act” which is critical to public health and health care preparedness. Public health emergency preparedness is truly national health security. Local health departments play an essential role in ensuring that people and their communities are prepared for, protected from, and are resilient to threats to health that result from all forms of disasters and emergencies. Since all disasters begin and end locally, local health departments must always be prepared to assume our role as first responders to any public health emergency. To this end, local health departments regularly host trainings and exercises to prepare staff and numerous community partners – including those in the healthcare system – for public health emergencies, to build consistent and ongoing communication amongst partners, clearly define response roles, and anticipate challenges before an emergency occurs. And when disasters arise, local health departments coast-to-coast are the “boots on the ground” responding to and helping communities recover.

Just this past year, our nation has seen a variety of large-scale emergencies and events that remind us just how important public health emergency preparedness truly is, especially at the local level. From a busy and incredibly challenging hurricane season including Hurricanes Harvey, Irma, Maria, and Nate; to wildfires in northern and southern California; to unfortunate and large-scale acts of violence perpetuated in Nevada, New York, California, Texas, Florida, and elsewhere; to an incredibly difficult influenza season of 2017-2018; one thing is certain: emergencies can and will be lurking around the next corner. And it is



our ability to prepare for, respond to, and recover from these emergencies that is expected by the American people.

I can attest to this first hand. As you will recall, in August 2017, the Texas Gulf Coast was hard hit by Hurricane Harvey. In Harris County alone, a total of 1 trillion gallons of water fell across the county's 1,800 square miles (the size of the state of Rhode Island) over a 4-day period where many areas received over 40 inches of rain with a total peak accumulation of over 51.88 inches (making Harvey the wettest hurricane on record in the contiguous United States). Harvey caused unprecedented widespread flooding, representing Harris County's third 500-year flood event in just three years. Yet according to the National Flood Insurance Program, only 15% of homes in Harris County were covered by flood insurance. Over 200,000 homes and apartment buildings were damaged, and tens of thousands of people had to evacuate; regrettably, there were 36 fatalities in Harris County.

Hurricane Harvey was but one emergency in a long line of others for our community. Dating back to 2001, Tropical Storm (TS) Allison severely damaged several buildings and hospitals in Texas Medical Center, the world's largest medical center. TS Allison was followed by the large-scale responses to Hurricane Katrina with 27,000 evacuees being sheltered at the Astrodome and then the community-wide evacuation in advance of Hurricane Rita in 2005; direct impact from Hurricane Ike in 2008 when 90% of the community was without power for days to weeks; and then the devastating floods of the last few years. These natural disasters were coupled with responses to the nation's first BioWatch hit in 2003; novel H1n1 pandemic response in 2009-10; Ebola and Zika responses of 2015 and 2016, respectively, to name but a few. Certainly, Hurricane Harvey response of 2017 culminated in all that our community learned through these disasters of yesterday.

While Hurricane Harvey was incredibly impactful for our community and our residents, there were numerous other communities impacted all across Texas – both large and small. I am proud of the work that Texas LHDs put in to respond to what occurred in their communities. In fact, the Texas Association of City & County Health Officials (TACCHO) – an associated affiliate of NACCHO representing approximately 45 LHDs across Texas – played a role in coordinating work in various LHDs across Texas. But though things were busy enough in Texas, communities across the United States faced their own unique challenges with the myriad emergencies that came their way this past year. A common thread seen across these catastrophic events was that people of all economic backgrounds found themselves stripped of their homes and life-long possessions; hospitals faced personnel, supply, and medicine shortages; many residents were found suffering from the traumatic events resulting in ongoing mental health issues; and older and disabled populations as well as children and those with functional needs were found to be especially vulnerable. In emergencies like these, local health departments, healthcare providers, emergency responders, emergency management, and the whole of local government all work together in a unified response to exact immediate action and minimize loss of life and property.

In the case of Hurricane Harvey, our public health response was integral to the overall incident command structure and response activated by the Harris County Office of Homeland Security & Emergency Management led by Harris County Judge Ed Emmett and Harris County Commissioners Court. Tens of thousands of people took refuge in a community shelter somewhere, including the 10,000 people



cumulatively who stayed at the NRG Center, the mega-shelter set up by Harris County. The other mega-shelter, the George R. Brown Convention Center, was set-up by the City of Houston (supported by our public health partner, the Houston Health Department) and provided shelter for an additional 10,000 persons. Additionally, within 24 hours and in partnership with healthcare system partners, HCPH set up a Functional Needs Medical Refuge unit (FNMR) at NRG Center. Though mass sheltering gets the attention, public health has response roles behind the scenes throughout a community's response.

HCPH activated its emergency management plan and reassigned departmental assets and resources to disaster relief efforts across the broader community. HCPH monitored for communicable diseases in other community "pop-up" shelters, simultaneously while deploying a fleet of mobile response RV units across over 30 events within just six weeks of Harvey's landfall. When our community was not mobile, we became mobile for it – bringing "public health to the public" and ensuring residents had access to basic provisions such as food and water, immunizations (flu and tetanus), veterinary/animal services, health and safety education, and clinical services.

Additional response activities included: working with 9,000 local businesses to ensure food was safe to eat, drinking water inspections, assessments of area environmental, toxicology and chemical risks, "door-to-door" surveys using the Centers for Disease Control and Prevention's Community Assessment for Public Health Emergency Response (CASPER) tool, as well as enhanced county-wide mosquito control efforts (including aerial spraying) in collaboration with the Texas Department of State Health Services (DSHS) and the U.S. Air Force. It was truly an "all-public health" response to a singular, massive event.

Indeed, no one was spared from the impact of Hurricane Harvey. Our own staff members – as those of many local health departments in the region impacted by Harvey – were personally devastated by losing homes, having water and flood damage, children displaced from schools and loved ones impacted throughout the community. Yet despite it all – and true the nature of public health professionals across this noble field nationally – our staff members still came to work, came early, worked late, did not go home, and worked days and weeks on end, to serve the needs of our devastated community. I would be remiss if I did not recognize three individuals in particular who helped lead our department's response: Mr. Les Becker, our Deputy Director/Director of Operations, Mr. Michael "Mac" McClendon, Director of the HCPH Office of Public Health Preparedness and Response (OPHPR), and his OPHPR Deputy, Mrs. Jennifer Kiger, who was 8 ½ months pregnant but still responded to what our community needed. When asked to go home, Mrs. Kiger refused and stated emphatically, 'this is my community and I want to be here to serve it'. I am incredibly humbled by the dedication of our HCPH team and the nationwide network of public health professionals who act as first responders and yet often are not recognized as such.

Passion and dedication aside, it is clear that without resources from the Centers for Disease Control and Prevention (CDC) and the Assistant Secretary for Preparedness and Response (ASPR) during Hurricane Harvey, our preparedness, response, and recovery efforts and impacts would have been far less robust. This was not just from the acute response phase that went into play during the event but the years of planning in advance of events such as Hurricane Harvey. **In order to meet preparedness and response needs of communities such as ours, CDC and ASPR must have adequate support and authorization levels along with commensurate funding** to ensure local health departments are equipped to prepare and



respond to the variety of local disasters, whether natural, man-made, pandemic, bioterrorism, or otherwise.

Summarizing the often-invisible nature of public health, I would ask you to consider public health as the offensive line of a football team protecting the quarterback. Most everyone knows who Nick Foles is on the Super Bowl-winning Philadelphia Eagles is, but can they name any member of the offensive line of that Eagles Championship team? Very doubtful. In the case of football, when any football team has a successful year, does that mean that they will be putting in a second string offensive line the next year? No, they will by and large keep that offensive line strong in the hopes of being successful and winning again. In public health, unfortunately, the opposite happens as we do not continue to invest in the invisible offensive line for a community's health, security and well-being. Since FY2003 when the Public Health Emergency Preparedness (PHEP) program was appropriated at \$1 billion, we have since seen a precipitous decline in funding year after year, and it is the concern of local health departments that soon cracks will show and forces will penetrate and overwhelm the offensive line that protects the public's health.

The programs authorized by the *Pandemic All-Hazards Preparedness Act* are vital to local health departments. The proposed bill "Pandemic and All-Hazards Preparedness Act of 2018" authored by Representative Susan Brooks (R-IN) is an important step in ensuring local health departments can protect the health and safety of their communities in the event of an emergency. I firmly believe that the funding PAHPA has provided saved lives in each major 2017 disaster, as well as small and other large-scale emergencies over the years in local communities across our country. NACCHO's recommendations on the provisions in the draft "Pandemic and All-Hazards Preparedness Reauthorization Act of 2018" are as follows:

Public Health Emergency Preparedness (PHEP)

NACCHO strongly supports the reauthorization of the Public Health Emergency Preparedness Program (PHEP) grants through 2023. By authorizing the PHEP Cooperative Agreement, PAHPA has enabled local health departments to hire personnel, develop and exercise critical response plans, and stockpile medicines and supplies. Since 2002, PHEP has provided more than \$11 billion to health departments enabling them to effectively respond to a range of public health threats, including infectious diseases, natural disasters, and biological, chemical, nuclear, and radiological events. It is important to note that 55% of local health departments rely solely on PHEP funding to support their preparedness activities.

However, as noted previously, there have been dramatic decreases in funding for PHEP since its inception. The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (BT Act), P.L. 107-188, which initially established PHEP and HPP in 2002 authorized \$1.08 billion for PHEP and \$520 million for HPP. Subsequently PAHPA (which replaced the BT Act) authorization levels for PHEP dropped to \$824 million in FY2007 and \$642 million for each fiscal year from 2014 through 2018. As authorization levels dropped, so did appropriations. At its highest point in 2003, Congress appropriated nearly \$1 billion for PHEP. After austere cuts, PHEP appropriations have been stagnant at \$660 million for the past several years, with a slight increase to \$670 million in FY2018.

These drastic cuts reduce local health department capacity to prepare for all-hazards and consequently impact the ability of communities throughout the nation to be resilient when disasters strike. Many local



health departments, such as HCPH, have been able to reallocate resources from other areas to cover the gaps created by the continual cuts to PHEP funding levels and even this is a stop-gap strategy that is not sustainable. Unfortunately, not all health departments can even do this as many do not have the luxury to “borrow from Peter to pay Paul.” This creates an inequitable environment for public health preparedness, disproportionately impacting smaller jurisdictions such as those in rural and frontier areas. Therefore, **NACCHO recommends the Committee increase the authorization level from \$670 million to \$824 million, which is the level authorized in 2006.**

Hospital Preparedness Program (HPP)

NACCHO strongly supports the reauthorization of the Hospital Preparedness Program (HPP) through 2023. HPP and PHEP are complementary programs with different purposes. While PHEP supports local health departments and their response to public health threats and helps to build resilient communities; HPP enables health care systems to save lives during emergencies that exceed day-to-day capacity of health and emergency response systems. Both programs work hand-in-hand for overall community response in the midst of an emergency or disaster.

More than \$5 billion has been provided to HPP to expand capabilities that will allow healthcare systems to meet acute needs and more rapidly expand capacity when there is a surge in the demand for medical care and emergency services in the aftermath of a disaster. As such, HPP is a distinct and complementary program that supports the broader public health and emergency response system as a whole. HPP has helped to improve emergency communication and coordination among hospitals, ancillary medical facilities and public health officials; facilitate patient tracking in mass casualty events, such as the horrific concert mass-shooting in Las Vegas in 2017; sustain operations in the midst of an event; track medical resources and assets including available hospital beds; and establish systems to reunite family members following an event.

HPP funding has been cut in half from a maximum investment of \$515 million in FY2004 to only \$264 million in FY2018. Funding has since stayed relatively level annually since being cut by a third in FY2014. Despite the progress made with early investments, austerity has taken its toll. Funding cuts have resulted in staffing reductions, forced staff to fill multiple roles and hindered the ability to maintain existing or build new partnerships between public health and the healthcare sector. Therefore, **NACCHO urges the Committee to increase the authorization for HPP from \$264 million to \$474 million** to ensure that ASPR can support the on-going robust country-wide health system preparedness infrastructure that is equally necessary. Even in response to Hurricane Harvey, HCPH worked closely with our HPP regional partners through the healthcare coalition convening partner, the Southeast Texas Regional Advisory Center (SETRAC), to respond to health and medical needs of the residents of Harris County as well as 24 other surrounding counties. SETRAC coordinated a wide arrange of medical activities including 1,544 patient movements, 24 hospital evacuations, and 20 nursing home evacuations. Their regional healthcare preparedness coalition also assisted in efforts to ensure that patients on dialysis, for example, who were trapped in their homes or relocated to evacuation centers could continue to receive treatment.

Medical Reserve Corps

The Medical Reserve Corps (MRC) program is a national, community-based corps of medical and non-medical volunteers that strengthen public health, emergency response, and community resiliency. MRC



volunteers contribute to building a strong public health system, capable of responding to any emergency, be it manmade, a weather-related natural disaster, or an emerging infectious illness, to better respond to emergencies. MRC units support and supplement existing emergency and public health resources in the community. These volunteers are critical emergency response resources to address public health challenges more quickly and efficiently. These trained volunteers are members of the community they work to protect.

Local MRC's were vital to the Hurricanes Harvey, Maria, Irma, and Nate responses as well as other emergencies throughout our country such as the wildfires on the West Coast. For the hurricanes, in total, 100 MRC units were dispatched in local communities with over 5,000 volunteers, totaling 106,354 hours of volunteer service for an estimated total economic value of almost \$4 million.

Funding for the MRC program continues to dwindle as it is currently funded at \$6 million, a cut of \$5 million or 45% since FY2010. The bill cuts the authorization for MRC from \$11 million to \$6 million. Without this funding, communities will be at greater risk in emergency situations, without the necessary human resources for emergency response. Staff will be pulled from other public health functions, which can endanger the health and safety of the public. **NACCHO urges the Committee to maintain the authorization level for MRC under current law.**

Public Health Emergency Fund

A standing rapid response fund to provide bridge funding between base preparedness funding and supplemental appropriations for acute emergencies and emerging threats is necessary. NACCHO appreciates that the bill strengthens existing authorities for the Public Health Emergency Fund (PHEF). However, there is concern about the 1% transfer authority to infuse the fund when a public health emergency is declared. The transfer authority will take vital dollars away from other public health programs in the midst of a funding cycle. Furthermore, there are timing challenges if a disaster occurs at the end of the federal fiscal year when most funding will have been obligated and distributed. In addition, as we experienced in 2017, there can be multiple public health emergencies in a given year and these can be even spread over far-reaching geographies across the United States (consider Harvey in Texas and Irma in Florida while wildfires were burning in California, as an example).

NACCHO and Harris County can both attest to the impact of cuts in the midst of a fiscal year to pay for an emergency. In 2016 during the Zika response, in the absence of supplemental funding, CDC redirected \$44 million in Public Health Emergency Preparedness funds from state and local health departments. NACCHO surveyed local health departments on the impact of the cuts to their preparedness programs and found that the cuts were disruptive impacting planning, staffing, exercising, and coordination with partners. In the case of Ebola in 2015, more broad "all-hazards" funding for public health emergency response was instead funneled to Ebola response activities. While this may have been necessary given the context at that time, it must be remembered that while our nation may be dealing with a specific accentuated response for a single threat at any one time, the reality is that multiple emergencies can occur at once. Thus, taking away from overall preparedness and response funding to handle a potential singular emergency such as Ebola is a strategy with significant limitations.



Further, it is imperative that emergency fund dollars be used to jumpstart the response to emergency events such as the Zika outbreak in 2016 or Ebola in 2015. Due to the cost of recent public health emergencies – especially those requiring development of new medical countermeasures – the PHEF, as proposed to be funded through transfer authority, will likely be insufficient to pay for the entire response. The PHEF as proposed would not eliminate the need for supplemental funding for large scale emergencies. Nor does it eliminate the need for robust funding for ongoing preparedness. **NACCHO believes strongly that it is essential Congress appropriate funds for the PHEF without transferring money away from existing public health and preparedness resources.**

Public Health Emergency Medical Countermeasure Enterprise

NACCHO supports the codification of the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE). The PHEMCE Strategy and Implementation should require that state and local health departments be involved in all phases of the medical countermeasures (MCM) 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.

NACCHO recommends that state and local public health departments have a permanent place in the PHEMCE membership to ensure that all decisions that will affect state and local health functions are vetted by public health authorities. Membership should include a state public health authority and a local public health authority.

Strategic National Stockpile (SNS)

Current funding, support, and expertise provided to state and local health departments for the SNS must be maintained regardless of the infrastructure or location of the SNS – it is too vital to this country’s ability to respond in the midst of a variety of large-scale emergencies. However, there are potential vulnerabilities to this with the proposed transfer of authority for the SNS from CDC to ASPR at the beginning of FY2019. **NACCHO believes there should be language that assures the maintenance of appropriate coordination and support for state and local public health departments.** Under no circumstance can public health response capabilities be lost in the sea of other health care system response capability needs. This cannot and must not happen. As proposed, operational and logistical functions that would be transferred to ASPR would essentially be separated from programmatic and support functions already in place at the CDC. If not handled well, such a transfer may introduce added complexity, poor coordination and less expediency as it pertains to the national, state and local operational readiness to distribute and dispense medical countermeasures from the stockpile where the healthcare-public health interface is critical.

BARDA and the BioShield Special Reserve Fund

NACCHO supports the authorization level of BARDA and the BioShield Special Reserve Fund and at no less than \$710 million annually for BARDA and \$7.1 billion over 10 years for the Fund. BARDA has been highly successful in bringing vaccines, drugs, and diagnostic to fruition for which there has been little commercial market. Since 2007, there have been 34 products approved or licensed. Yet the challenges facing the nation are greater than ever, including emerging infectious diseases and other global threats. The recent reemergence of Ebola in the Democratic Republic of Congo underscores the importance of this capability in real-time today.



Pandemic Influenza and Emerging Infectious Diseases

NACCHO appreciates the Committee’s acknowledgement that pandemic influenza and other emerging infectious diseases are under the umbrella of BARDA’s mission. Recent years have demonstrated that infectious diseases from around the globe are a threat to our national health security. Truly global health and domestic health are tied ever more so than before. Recent global health threats such as the novel H1N1 pandemic, Ebola, and Zika, as well as others that are climate and environmental in nature, have shown us just this. A true “One Health” notion of ensuring human health, animal health, entomology (insects) and environmental health, is leveraged and absolutely critical to robust multi-sectoral response. This was underscored in the CDC’s 2018 *Vital Signs* report that highlights the tripling of vector-type infectious diseases – often zoonotic in origin – in the U.S. from 2004-2016. Such threats remind us of how important collaboration across the One Health spectrum truly is and provides a glimpse of public health of tomorrow. With these threats in mind, **NACCHO supports the Committee’s authorization of additional appropriations for these new strategic initiatives.**

Cybersecurity

NACCHO appreciates that the bill highlights the importance of cybersecurity as part of national health security. As people use electronic health data more widely and increasingly rely on networked computer technology to deliver efficient healthcare and public health services, the need to protect public health information and public health infrastructure increases. A successful cyber-attack on public health information infrastructure would severely reduce both public health emergency responses and non-emergency public health functions. It could paralyze and indeed shut down our combined public health and healthcare systems at a moment’s notice. That said, however, NACCHO would urge the Committee to be cautious in expanding the scope of PAHPA without the authorization of commensurate resources to carry out new activities and initiatives.

Summary

In summary, I want to highlight the need for Congress to see dollars spent in public health as a true investment and this absolutely applies to the area of public health emergency preparedness and response. Further, funding for CDC and ASPR must not just be maintained but enhanced and used in a way to leverage these dollars to build adequate capacity at the state and local levels throughout the United States. Local health departments like Harris County Public Health are working “24-7” to save lives and address the preparedness needs of the community to respond to disasters. A ten percent, for example, cut in funding does not coincide with a ten percent decrease in responsibilities or expectations from our respective communities. These responsibilities and these expectations cannot be underscored enough for the health and security of our nation’s communities. The Pandemic All-Hazards Preparedness Act of 2018 will definitely provide support for activities that would help local health departments in their preparedness and response efforts.

As communities across the country recover from last year’s devastating events, both natural and manmade, coastal communities in Florida and North Carolina have already experienced adverse impacts of Subtropical Storm Alberto, just prior to the start of the 2018 hurricane season, and a busy hurricane season is already anticipated throughout this summer and fall. In our own neighborhood, we witnessed a mass casualty event at a local high school in Santa Fe, Texas – joining the list of other impacted



communities that have seen such horrific and terrifying events play out in their schools. While LHDs will continue to prepare and respond to future emergencies at the local level, equally we need increased federal support to continue doing this work effectively and efficiently. It is truly a long-term investment in our communities.

Our community knows this all too well. If Hurricane Harvey was just the only emergency we had to deal with that would have been bad enough. However, Harvey was on the heels of multiple storms and emergencies over a decade plus that have impacted Harris County. It is clear our community has seen an emergency or two and we – like other communities – have shown that proper investment in public health and healthcare delivery is absolutely necessary for a community’s safety, vitality, and well-being and that we can learn from previous events. Case in point, due to the significant investment in public health and healthcare infrastructure in our community from TS Allison forward, a storm as devastating as Hurricane Harvey caused only 10% of our area’s 120 some hospitals, long-term acute care, and nursing homes to be inoperable or requiring evacuation. Lessons can be learned. Investments can pay off.

Closing

In closing, we urge Congress not only to support the PAHPA Reauthorization but also to direct efforts toward building healthy and resilient communities through appropriate and meaningful enhancements to proactive public health system capacity, including in areas of community preparedness, laboratory testing, surveillance and epidemiological investigation, emergency operations coordination, public health awareness infrastructure, and others alike. Investments in smart, forward-facing technologies and information systems are equally critical to the success of response capabilities and must also be remembered.

Such efforts will not only help communities recover faster from an emergency but will reduce the impact of that very emergency. The more resilient a community is, the better it is able to resist, respond, and recover from a disaster. The strong and incredibly important work of local health departments – the invisible offensive line of our communities – across the country should not be kept hidden but made more visible so all of us can recognize the absolute value proposition of what public health brings to the table, just like our partners in law enforcement, fire, EMS, and emergency management. With optimal and necessary support from the federal government, state and local public health partners can continue to perform the incredibly critical work that they do on a daily basis even if it remains invisible to the vast majority.

On behalf of HCPH, NACCHO, and the nearly 3,000 LHDs across the country, I appreciate again the opportunity to testify today. We join you in working toward strengthening and enhancing our nation’s preparedness and response systems and look forward to continuing to work with you on this legislation as it moves forward. Thank you for all you do in building safe, healthy, and protected communities where we live, learn, work, worship, and play, across this great nation of ours.

Thank you.

