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Yale New Haven Health System

Center for Emergency
Preparedness and
Disaster Response

IMPACTS OF FEDERAL FUNDING REDUCTIONS ON PUBLIC HEALTH AND HOSPITAL EMERGENCY PREPAREDNESS INITIATIVES

Contents

Public Health Emergency Preparedness and Hospital Preparedness Program Cooperative Agreements Have Strengthened Public Health and Hospital Preparedness and Response

The Public health and healthcare sectors are the underpinnings of emergency preparedness (EP) and response in the nation. Since the enactment of the Public Health Security and Bioterrorism Preparedness and Response Act (often referred to as the Bioterrorism Act or BT Act), in 2002, their importance has continued to grow in all areas of emergency readiness: planning and readiness assessment, infectious disease surveillance and detection, vaccination and mass dispensing of medical counter measures, epidemiological investigations, communications of health risks, health information-sharing, education and training, and drills and exercises, to name a few.[1]

Investments in time, workforce, and money at the federal, state and local levels have resulted in dramatically enhanced EP capabilities across the country, as compared to those that existed before the September 11th, 2001 terrorist attacks. Two federally sponsored programs, *Public Health Emergency Preparedness (PHEP)* and the *Hospital Preparedness Program (HPP)* (formerly, the National Bioterrorism Hospital Preparedness Program), administered by the Centers for Disease Control and Prevention and the Office of the Assistant Secretary for Preparedness and Response (ASPR), respectively, financially support the development and sustainment of EP capabilities.[2] PHEP and HPP provide the resources needed to ensure that local communities respond effectively to infectious disease outbreaks, natural disasters, and chemical, biological, radiological/nuclear and burn/trauma events. A report published in 2011 by Trust for America's Health underscored the significant progress made by states with regards to preparedness and response capabilities because of protracted investments in the PHEP and HPP.[3] The report found that in 2010, relative to 2003:

- The number of states with pandemic influenza plans had increased from 13 to 50;[3,4]
- The number of states with plans to receive and dispense medical counter measures from the Strategic National Stockpile increased from 2 to 50;[3,4]
- Laboratory Response Network capacity was maintained or augmented in 49 states, up from 10 states;[3,4]
- Three quarters of hospitals participating in the HPP attained 90% of the Program's objectives;[3,4] and

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[1] Centers for Disease Control and Prevention; Office of Public Health and Response. 2011. Public Health Preparedness Capabilities: National standards for state and local planning. Available at: http://www.cdc.gov/phpr/capabilities/dslr_capabilities_july.pdf

[2] Centers for Disease Control and Prevention. 2014. HHS grants bolster health care and public health disaster preparedness. Available at: http://www.cdc.gov/media/releases/2014/p0701-HHS-grants.html

[3] Trust for America's Health. Ready or Not? 2011: Protecting the public's health from diseases, disasters, and bioterrorism. Washington, DC: TFAH; 2011. Available at: http://healthyamericans.org/assets/files/TFAH2011ReadyorNot_09.pdf

[4] Gursky EA, Bice G. 2011. Assessing a decade of public health preparedness: Progress on the precipice? Biosecur Bioterror. 10:55-65.

- State departments of public health had formed partnerships with emergency management agencies in order to streamline response activities during an emergency[3,4]

Recent examples of preparedness and response dividends yielded by investments in PHEP and HPP include:

- Deployment federal medical stations for Hurricane Sandy, in 2012;[5,6]
- Education and training of health departments to identify patients at risk for exposure during the fungal meningitis outbreaks in TN and NC, in 2012;[5,6]
- Maintenance of situational awareness across response agencies during the West Nile outbreak in TX, in 2012; [5,6]
- Harmonization of emergency responses among hospitals during the Boston Marathon bombings, in 2013;[5,6]
- Creation of surge capacity in hospitals receiving injured patients from the fertilizer plant explosion in TX; activation of healthcare coalitions to ensure continued medical care in tornadostricken regions of KY, in 2012;[5,6] and
- Evacuation of St. John's Regional Medical Center and coordination of area hospitals to receive patient transfers and other injured victims of the tornado in Joplin, MO, in 2011[5,6]

These actions have contributed to saving lives of people affected by these events.[7]

Congressional Funding and Appropriations for PHEP and HPP Have Decreased Since Their Implementation

Despite many demonstrated achievements, PHEP and HPP have been subject to persistent budget cuts. Since 2002, emergency preparedness funding for state and local public health departments, and hospitals, provided by PHEP, and HPP cooperative agreements, respectively, has consistently declined, and has done so more radically, more distressingly, in recent years (see **Figures 1** and **2** and **Table 1**).

In fiscal year 2013, states received $988 million dollars for PHEP and HPP initiatives, down from 1.046 billion dollars, the previous year. This represents a 58 million dollars reduction in funding relative to that awarded to states by the US Department of Health and Human Services, in 2012. In 2014, while funding from PHEP increased by 33 million dollars as compared to funding in 2013, the HPP was defunded by 104

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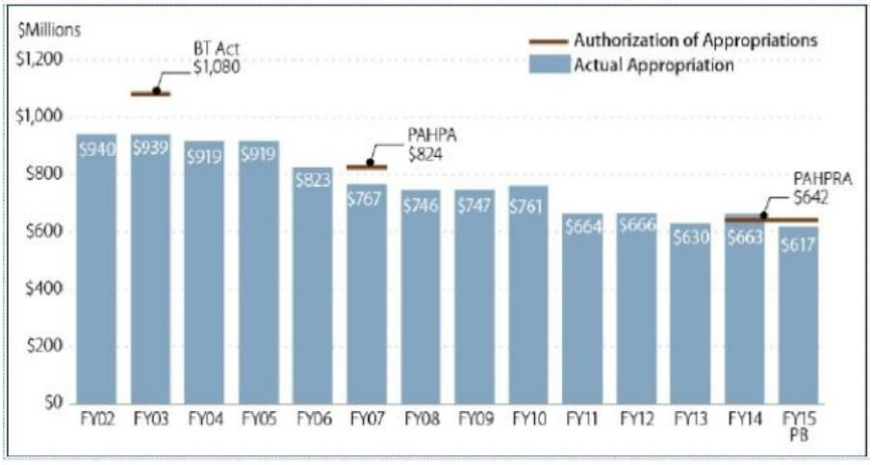
[5] Trust for America's Health. FY 2015 Labor HHS Appropriations Bill. Available at: http://healthyamericans.org/health-issues/wp-content/uploads/2014/03/FY2015-PHEP-HPP.pdf

[6] Department of Health and Human Services; Centers for Disease Control and Prevention. 2014. 2013 – 2014 National snapshot of public health preparedness. Available at: http://www.cdc.gov/phpr/pubslinks/2013/documents/2013_Preparedness_Report.pdf

[7] American Hospital Association. 2014. Hospital Emergency Preparedness and Response. Available at: http://www.aha.org/content/14/ip- hospemerprepared.pdf

million dollars from its previous year's budget (**Figure 2** and **Table 1**). This cut to the HPP is the most drastic to date and equals approximately a 30% decrease in the nation's principal program aimed at bolstering hospital preparedness for emergency and disaster events.

FIGURE 1: Appropriations for Public Health Emergency Preparedness (PHEP), FY2002 – FY2015[8]



BT Act - Public Health Security and Bioterrorism Preparedness and Response Act;
PAHPA - Pandemic and All Hazards Preparedness Act;
PAHPRA - Pandemic and All-Hazards Preparedness Reauthorization Act **PB –** President's budget

FIGURE 2: Appropriations for Hospital Preparedness Program (HPP), FY2002 – FY2015

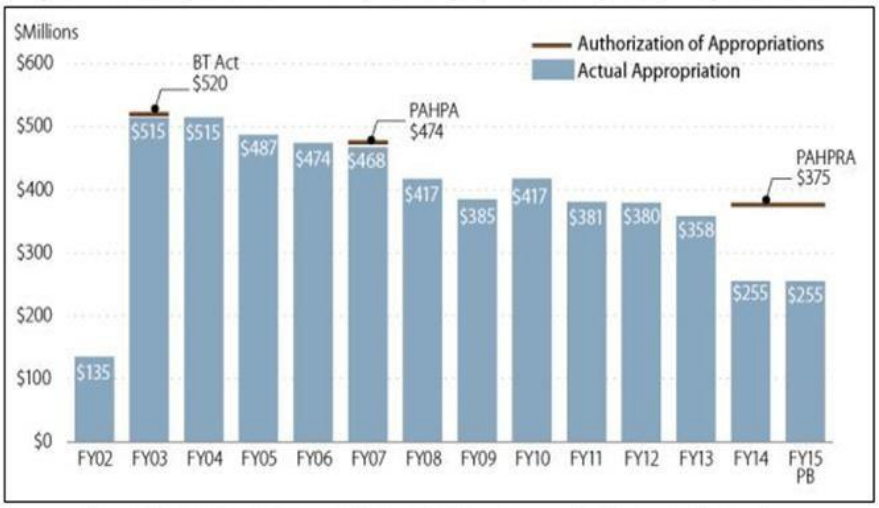


TABLE 1: Federal funding for PHEP and HPP for FY 2013 - 2015

	2013	2014	2015 (President's Budget)
PHEP	$630,281,000	$663,000,000	$617,000,000
HPP	$358,231000	$254,555000	$255,000,000

[8] Lister, SA; Congressional Research Services. (2014). Memorandum: Funding History for Public Health and Hospital Preparedness Grants to States. Document 7-5700. Available at: https://www.scribd.com/doc/242986545/CRS-Report-on-HPP-and-PHEP-Appropriations

Overall, twelve years after the enactment of the Public Health Security and Bioterrorism Preparedness and Response Act, the budget for the nation's emergency preparedness initiatives has decreased by 1 billion dollars.

This reduction in financial support has not only served as a barrier to the development of new capabilities that would further strengthen public health and hospital preparedness and response, but also has threatened the sustainability of existing capabilities. Perhaps even more disheartening is the fact that cuts in funding have led to the erosion of capabilities essential for effective response to public health emergencies including emerging infectious diseases such as Ebola.[3,9]

Impact of PHEP and HPP Funding Cuts on Health Security

Beginning in 2006, the federal PHEP budget alone fell from 1.1 billion to 585 million dollars in 2013. During this period, nearly fifty thousand local and state public health professionals, many of whom were integral to the sustainment of preparedness initiatives, lost their jobs, or retired. The financial cut has made replacing individuals for these positions unattainable, and in many instances, the vacated positions have been eliminated. This has significantly hampered state and local capabilities to protect the nation's health security, and in many areas, has even retrogressed previously developed capabilities to do so.

The HPP provides resources essential for ensuring medical surge capacity and hospital preparedness for *all hazard* emergencies.[10] Funds awarded through the HPP allow hospitals to plan for emergencies, buy medication, medical supplies, communications equipment and other resources to help mitigate disasters and public health emergencies. HPP also supports education and training (including detection of threats, donning and doffing of personal protective equipment, and treatment of patients from a disaster) of hospital employees to ensure that response activities are conducted effectively, efficiently and without compromising the safety of responding personnel.

In Connecticut, as in other states, cuts to the HPP funding have resulted in job cuts or reduced work hours for state and hospital staff responsible for overseeing emergency preparedness activities in hospitals throughout the state. The purchase of response resources to replace those that have expired or are no longer functioning has also been indefinitely postponed. Together, these have adversely affected all aspects of hospital preparedness, principally, emergency preparedness planning, education and training, drills and exercises, and maintenance of adequate response assets. Worst yet, hospital staff cuts and reduced opportunities for education and training have eroded institutional knowledge that had accrued for preparing and responding to public health emergencies.

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[9] National Association of County and City Health Officials. 2014. Are Preparedness Funding Cuts Impacting the Capability of Local Health Departments to Respond to Global Health Security Threats? Available at: http://www.nacchopreparedness.org/?p=3263

[10] US Department of Health and Human Services. Hospital Preparedness Program. Available at: http://www.phe.gov/PREPAREDNESS/PLANNING/HPP/Pages/default.aspx

The importance of preserving existing preparedness and response capabilities was brought to the forefront by the news that a nurse who treated an Ebola patient in Dallas, TX had contracted the virus herself, purportedly due to the lack of appropriate PPE availability, training in the use of PPE, and care management protocols for patients infected with Ebola.[11,12] In addition to the nurse, 70 other hospital employees were exposed to virus due to lax hospital infection control practices.[13]

Although circumstances leading to the infection of the nurse caring for the Ebola patient in TX, and the potential exposure of additional caregivers to Ebola represent the most consequential fallout of reduced funding to date, the Trust for America's Health 2012 annual "Ready or Not?" report details many other adverse consequences to public health and hospital preparedness.[14] Among these are:

- Diminished capacity and capability for mass vaccination and dispensing of antibiotics;
- Reduced ability for timely detection and characterization of outbreaks resulting from the loss of top-level laboratory capabilities;
- Reduced ability to investigate suspicious disease outbreaks due to the loss of key epidemiologists; and
- Diminished ability to mount a comprehensive response to nuclear, radiologic, and chemical threats because of insufficient resources for environmental health programs

The federal government has continued to increase demand for public health and hospital preparedness, while cutting funding for PHEP and HPP that are vital for implementing the capacity and capability to prepare for, respond to, and recover from public health emergencies. As a result, hospitals and health departments are confronted with impossible choices between providing essential services or retrenching emergency preparedness initiatives. Building new public health and hospital preparedness capabilities and sustaining existing ones necessitates a steady and dedicated stream of funding.

Recommendations for Sustaining Public Health and Hospital Preparedness Initiatives

Funding for emergency preparedness frequently increases substantially following a disaster or public health emergency, only to decline during periods of fiscal restraint or when public interest goes astray

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[11] Cheryl Healton and Gbenga Ogedegbe. 2014. To be ready for Ebola, hospitals need proper equipment, training and a plan. New York Daily News. Published online Thursday, October 16, 2014, 1:16 PM. Available at: http://www.nydailynews.com/life-style/health/ebola-hospitals-proper-equipment-training-plan-article-1.1976110

[12] Lisa Schnirring. Center for Infectious Disease research and Policy. 2014. Ebola in Texas nurse triggers changes in battle plan. Available at: http://www.cidrap.umn.edu/news-perspective/2014/10/ebola-texas-nurse-triggershttp://www.cidrap.umn.edu/news-perspective/2014/10/ebola-texas-nurse-triggers-changes-battle-planchanges-battle-plan

[13] Martha Mendoza. 2014. About 70 hospital staffers cared for Ebola patient. Associated Press. Published online Monday, October 13, 2014, 9:24 PM. Available at: http://bigstory.ap.org/article/e17dd730c9574c109a3aa4b30b8deb43/about-70-hospital-staffers-cared-ebolahttp://bigstory.ap.org/article/e17dd730c9574c109a3aa4b30b8deb43/about-70-hospital-staffers-cared-ebola-patientpatient

[14] Trust for America's Health. Ready or Not? 2012: Protecting the public's health from diseases, disasters, and bioterrorism. Washington, DC: TFAH; 2012. Available at: http://www.healthyamericans.org/assets/files/TFAH2012ReadyorNot10.pdf

with time. The results of limited and fragmented funding are inefficiencies in developing andmaintaining preparedness capabilities and resources, as well as disorganized planning approaches. In a report published by the Institute of Medicine (IOM), seven recommendations are advanced to provide a blueprint for enhancing the sustainability of preparedness initiatives.[15] The recommendations are based on 1) the need for greater accountability on how federal dollars are spent on emergency preparedness, 2) gauging which communities are prepared and which are not, and 3) whether these communities better off in handling a disaster.

The report makes the following recommendations:

1. The federal government should develop and assess measures of emergency preparedness both at the community-level and across communities in the US;
2. Measures developed by the federal government should be used to conduct a nation-wide gap analysis of community preparedness;
3. Alternative ways of distributing funding should be considered to ensure all communities have the ability to build and sustain local coalitions to support sufficient infrastructure;
4. When funds are released for projects, there should be clear metrics of grant effectiveness;
5. There should be better coordination at the federal level, including funding and grant guidance;
6. Local communities should build coalitions or use existing coalitions to build public-private partnerships with local hospitals and other businesses with a stake in preparedness; and
7. Communities should be encouraged to engage in ways to finance local preparedness efforts

These recommendations place the onus on local communities and their ability to come up with creative approaches to finance preparedness efforts, as well as on more efficient allocation of federal funds to sustain preparedness initiatives. Although these approaches merit consideration and should be part of a comprehensive national strategy for sustaining preparedness initiatives, states and local communities cannot absorb financial reductions of magnitudes similar to those incurred in recent years by simply finding efficiencies.[3] Sustaining emergency preparedness capabilities requires strong and steady financial support, if these capabilities are to play a meaningful role in the battles for national security and health security. Emergency preparedness cannot be a one-time investment (usually in the shortterm aftermath of a disaster or public health emergency). In turn, this support must come with transparency and accountability for public health and hospital preparedness investments.

[15] Pines JM, Pilkington WF, and Seabury SA. 2014. Value-Based Models for Sustaining Emergency Preparedness Capacity and Capability in the United States. Available at: http://iom.edu/~/media/Files/Activity%20Files/PublicHealth/MedPrep/Final%20white%20paper%20Preparedness%20FinancingJan14.pdf