AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Patty Murray
Chair
Committee on Health, Education,
Labor and Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Richard Burr
Ranking Member
Committee on Health, Education,
Labor and Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

Dear Chair Murray and Ranking Member Burr:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide the following comments on the **Prepare for and Respond to Existing Viruses, Emerging New Threats, and Pandemics Act (PREVENT Pandemics Act)**. It is critical that we use the lessons learned during the unprecedented COVID-19 pandemic to improve pandemic preparedness, public health, and supply chain issues.

Federal Leadership and Accountability

One of the significant challenges of the current pandemic during its first year was the lack of clearly delineated roles and responsibilities with respect to the public health emergency response within federal departments and agencies. There was also a lack of coordination between individual states and the federal government, as well as a lack of understanding of what role each was supposed to play in the response. While much of this has improved, there is still a need to provide clarity and ensure coordination so that public officials may more quickly and efficiently respond to an impending public health crisis. As Congress considers how best to deal with future public health emergencies, we recommend that a national strategy for response coordination be put in place that clearly outlines the roles and responsibilities of both federal and state governments. **The AMA strongly recommends a mandate that requires creation of a national strategy for response coordination, clearly delineating the roles of federal and state governments in public health emergencies, so that each can properly prepare and move quickly the next time we face a national public health crisis like COVID-19.**

In addition, the needs of physicians and patients in all practice settings must be considered to ensure continuity of care for patients and continued viability of non-hospital practices. When responding to an emerging global health threat, we must urgently respond to and prioritize the needs of front-line providers who are helping to mitigate the impacts of public health emergencies. While these needs understandably take priority in the midst of a crisis, we also must continue to consider the impacts of public health emergencies on non-hospital providers and patients needing management of chronic conditions. Non-emergent medical services were rightly halted at the beginning of the COVID-19 pandemic, but we need to be better prepared in a future epidemic to address the needs of non-hospital providers and patients with chronic conditions who have to make in-person visits to a physician's office or other health care setting. We must be better prepared to help these practices and patients navigate uncertain times where access to physician practices may be temporarily unavailable. **The AMA recommends that both legislators and**

regulators consider the needs of non-hospital practices and patients when implementing new policies for pandemic response. This may include, for example, financial assistance considerations, and acquisition and distribution of personal protective equipment (PPE), and other important considerations.

Moreover, logistical planning for public health emergency response must have a permanent home within the federal government. As the federal government engaged in acquisition and distribution of critical medical supplies, such as PPE and ventilators, it became clear that expertise in supply chain management and logistics would play a critical role in the federal response to the COVID-19 pandemic. The AMA recommends that responsibility for coordination of these activities become part of a permanent role within the federal government, instead of part of a temporary task force where lessons learned are potentially lost after the end of the public health emergency. If responsibility for pandemic response supply chain and logistics rests with the Federal Emergency Management Agency (FEMA), the AMA recommends creation of a permanent/formalized bridge to the U.S. Department of Health and Human Services (HHS) to ensure coordination of the two agencies during times of need.

Interagency coordination must be improved by the creation of permanent roles responsible for coordination between the major departments and agencies responding to public health emergencies. The AMA recommends that each agency with a role to play in public health emergency response have dedicated individuals or units that will be responsible for interagency coordination. These individuals or units should be permanently tasked with this responsibility so that they are able to respond rapidly to emerging threats. These roles should not be created on a temporary basis, or as part of a task force that is rapidly disbanded when the threat subsides.

The AMA supports the goals of the PREVENT Pandemics Act's provisions to increase cooperation within HHS and among federal agencies, as well as between federal and state governments. While the AMA generally does not take a position on reorganizing or refocusing government agencies or functions, or requiring federal positions to be confirmed by Congress, we agree that federal leadership and accountability must be improved to better coordinate preparedness and response activities. In addition, we support the creation of a bipartisan task force or commission composed of scientists, physicians with expertise in pandemic preparedness and response, public health experts, legislators, and other stakeholders, to examine U.S. preparations for and response to the COVID-19 pandemic, in order to inform and support future public policy and health systems preparedness. We also agree that communication and dissemination of scientific and evidence-based public health information during public health emergencies must be improved by HHS and other agencies, and that the role and impact of misinformation must be examined and addressed to instill physician and public trust in government that actions and recommendations are evidence-based.

Improving State and Local Preparedness and Readiness

While the AMA does not have specific policy on changes to the Public Health Emergency Preparedness (PHEP) Program and its Cooperative Agreements, we strongly support the goals of the program. According to the Trust for America's Health (TFAH), the response systems, personnel, and infrastructure that states require to respond to public health emergencies like COVID-19 would not exist in most states without PHEP funding. TFAH notes that since 2002, the PHEP program has saved lives by building and maintaining a nationwide public health emergency management system that enables communities to prepare for and rapidly respond to public health threats. However, through both real funding decreases and inflation, funding for the PHEP Program has been reduced 48 percent since FY2003. Increased federal funding is crucial to maintaining state, local and territorial public health preparedness capacity.

The AMA supports the recommendation by TFAH and the Association of State and Territorial Health Officials (ASTHO) that the PHEP Program needs $824 million in funding. This level of funding would:

- Strengthen the nation's readiness to protect the public from future dangers caused by catastrophic emergencies like a pandemic as well as smaller regional emergencies;
- Help restore capacity at health departments impacted by budget cuts and address gaps identified in the PHEP capabilities operational readiness review process, in areas such as risk communications and medical countermeasures distribution;
- Modernize data systems to enhance surveillance systems, data management, and sharing and analysis of disease trends;
- Build the Laboratory Response Network (LRN) and CDC and public health expertise and capacity for radiological and nuclear events. There is currently no public health laboratory capacity outside of CDC for this kind of testing and only limited throughput at CDC's lab;
- Advance biological and chemical laboratory capacity in states to keep up with current technologies and threats; and
- Support field staff in additional states, who are highly trained personnel who can help jurisdictions build their disease surveillance and response capability.

The AMA also strongly supports the provisions in the PREVENT Pandemics Act directing Substance Abuse and Mental Health Services Administration (SAMHSA) to support continued access to mental health and substance use disorder services during public health emergencies and requiring SAMHSA's Strategic Plan and Biennial Report to Congress to include the agency's activities to support continued access to mental health and substance use disorder services during public health emergencies, including for at-risk individuals. According to the U.S. Centers for Disease Control and Prevention (CDC), the nation's drug overdose epidemic killed more than 100,000 Americans in the last year. The dangers of illicitly manufactured fentanyl, combined with increasing polysubstance use, have made the epidemic more deadly than ever, particularly during the ongoing COVID-19 pandemic, and access to treatment even more critical.

Addressing Disparities

The AMA recognizes racial and ethnic health inequities as a major public health problem in the U.S. and as a barrier to effective medical diagnosis and treatment. The elimination of racial and ethnic inequities in health care is an issue of highest priority for the AMA, and we advocate that health equity—defined as optimal health for all—be a goal for the U.S. health system. In order to address social determinants of health (SDOH) and health inequities, the AMA has created a Center for Health Equity whose mission is to strengthen, amplify, and sustain the AMA's work to eliminate health inequities—improving health outcomes and closing disparity gaps—which are rooted in historical and contemporary injustices and discrimination.

Additionally, the AMA has identified several other federal policies and strategies which should be established to further strengthen efforts to address SDOH, including, but not limited to: removing barriers to access to health insurance coverage and care (including expanding access to insurance subsidies to promote purchasing of health insurance coverage offered on the Affordable Care Act exchanges and the expansion of Medicaid); directing the Centers for Medicare & Medicaid Services (CMS) to incorporate SDOH data and provide support for addressing patients' SDOH in Medicare and Medicaid payment systems and alternative payment models; funding efforts to address SDOH along with identifying and

overcoming existing barriers to implementing SDOH-related programs; and increasing funding to community-based organizations to strengthen infrastructure and capacity to coordinate and collaborate with patients and health care organizations.

The AMA supports the grant programs in the PREVENT Pandemics Act to address SDOH and improve patient outcomes. However, the AMA supports including S. 509/H.R. 6072, "the Leveraging Integrated Networks in Communities (LINC) to Address Social Needs Act," in its entirety in the pandemic legislation. S. 509 would require the Secretary of HHS to award grants to states, on a competitive basis, to support the establishment of new or enhancement of existing community integration network infrastructure to connect health care providers to social services organizations in order to help patients overcome longstanding accessibility challenges related to various SDOH (e.g., food, housing, child development, job training, transportation, etc.). This federal effort to enhance communication between physicians and community social services infrastructure will undoubtedly improve patient outcomes. The AMA is working with the bills' sponsors to ensure that the data is protected by appropriate privacy and security standards.

Improving Public Health Data

Syndromic surveillance by public health authorities is critical to pandemic response and ensuring coordination of medical resources across the country to leverage the greatest and most equitable level of care possible for all patients. Public health experts have emphasized to us the importance of prioritizing transmission of information to public health officials at the state and local levels since these officials urgently need data to make decisions for the general public. Absent such surveillance and other types of data collection at all levels of government, it is difficult to know where virus "hot spots" are occurring, and where testing and other resources need to be focused. This information is also important to pandemic recovery: for example, it helps to inform policymakers as the country lifts restrictions on physical distancing and as businesses, schools, and governments reopen. Unfortunately, issues with accurate, consistent, and complete data have been a continuing concern throughout the current pandemic, including on the number of cases, testing results (e.g., the CDC and many states combined statistics on diagnostic tests and antibody tests), hospitalizations, and deaths.

Public health data systems are outdated and in dire need of modernization. During the COVID-19 pandemic, many public health agencies did not have access to real-time data around testing results and incidence of infections and illness to efficiently respond to the emerging crisis. Health departments are often unable to access accurate, complete, and timely data to effectively surveil disease outbreaks and promote healthy communities. Many state and local public health departments rely on paper documents, phone calls, and faxes to communicate. Many also require manual input of data into systems with limited functionality. Consistency of demographic data collection has been particularly poor. Race and ethnicity data for infections, hospitalizations, and deaths have been missing, or slow to be published, in many states.

While financial investments were made to modernize the health care data infrastructure, this has not happened on the public health side. In health care, data are collected in the electronic health record (EHR) and despite requirements for such data to be reported to public health departments, it can be days and weeks before public health is alerted. When public health departments receive case reports, they are often missing key information, including race and ethnicity data. Reports are also missing data elements like a patient's address, so public health officials cannot use geolocation or map the cases to determine if there

is an outbreak occurring in a particular area. Case reports are also often missing a patient's phone number, which is needed to conduct interviews for contact tracing.

To make matters worse, public health department data systems are siloed. They work independently of each other and do not have an easy way to share information across state lines or even, at times, between agencies within a given state, preventing them from efficiently supporting each other. Even with public health data modernization, data shared with public health agencies for review and action, will only be shared in accordance with applicable health care privacy and public health reporting laws. Improving antiquated data systems will improve overall data governance and security, as well as improve access to vital surveillance data.

Priorities for public health data modernization should include automating the reporting of clinical and laboratory data from clinical health area data systems to public health. The U.S. also needs to ensure interoperability among health care and public health as well as among core public health surveillance systems. Core pieces of the public health data infrastructure need to be modernized, such as the National Notifiable Diseases Surveillance System and the vital records systems which capture data from births and deaths annually and which can signal changes in trends, monitor urgent events, and provide faster notification of cause of death. It is also important to support modernization of our syndromic surveillance system so that public health receives data in real-time from hospital emergency departments and urgent care centers to maintain a pulse on emergency-type visits and how the health care system is being impacted by emerging syndromes.

The AMA recognizes that public health surveillance is a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats. Physicians play an important role in public health surveillance through reporting diseases and conditions to public health authorities. We support increased federal, state, and local funding to modernize the nation's public health data systems to improve the quality and timeliness of data and support electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from EHRs to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws. The AMA also supports increased federal coordination and funding to support the modernization and standardization of public health surveillance systems data collection by the CDC and state and local health departments, as well as data standardization that provides for minimum national standards, while preserving the ability of states and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations. The AMA encourages hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery.

The AMA supports the provisions in the PREVENT Pandemics Act that would update biosurveillance capabilities by clarifying the Secretary's public health situational awareness authority to include modernizing applicable existing public health data systems and networks of HHS to reflect technological advancements. We also support the goals of updating the strategy and implementation plan to improve collaboration among federal departments, implement lessons learned from previous public health emergencies, and identify steps the Secretary will take to further develop and integrate infectious disease detection, support rapid and accurate reporting of laboratory test results during a public health emergency,

and improve coordination with public health officials, clinical laboratories, and other entities with expertise in public health surveillance.

Revitalizing the Public Health Workforce

Physicians are a vital component of our nation's health care infrastructure, and the COVID-19 pandemic has highlighted the health inequities which continue to exist in our nation and impact the most vulnerable in our communities. To advance health equity we must promote greater diversity among medical school applicants and enrollees. We know from research and experience that all patients, but particularly those from minoritized and marginalized communities, benefit from a diverse physician workforce and are even likely to see improved outcomes. Studies show that patient satisfaction and health outcomes are improved when health providers and their patients have concordance in their racial, ethnic, and language backgrounds. Diversity also enhances students' learning environments and fosters greater innovation.

Federal investments to increase the number and diversity of physicians are profoundly needed. When the number of active physicians is delineated by race, and then overlaid with U.S. Census Bureau data broken down by race, one can easily see the need to focus on developing a more diverse physician workforce. Specifically, while Hispanic Americans make up 18 percent of the U.S. population, they make up only 5.8 percent of active physicians in the U.S., and while Black Americans make up 13 percent of the U.S. population, they make up only 5 percent of active physicians in the U.S. As a result, the AMA strongly urges Congress to provide the appropriate funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.

There is a growing public health workforce shortage at the local, state, and federal levels. Within the next few years, state and federal public health agencies could lose up to half of their workforce to retirement and to the private sector. Due to local and state budget crises and federal budget cuts and the recent trend of politicizing public health activities and threats of violence against public health workers and officials, the potential for a shortage of highly skilled public health professionals has become more immediate and severe in scope. In addition, governmental public health salaries are not competitive with other industries. Recent public health graduates are opting for careers in other industries. Public health agencies struggle to attract and retain top talent because they cannot afford to pay them salaries comparable to the private sector.

To strengthen the workforce, the visibility of public health as a potential career choice needs to be raised and promoted as a valuable component to keeping populations healthy. In addition, providing competitive salaries would help attract talent, as would student debt reduction or elimination programs and loan repayment programs, including through the National Health Service Corps. The public health workforce is aging and efforts to recruit young talent are direly needed. The AMA urges Congress to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program, strengthening of the Commissioned Corps of the U.S. Public Health Service, and expanding preventive medicine residency training programs.

The AMA supports the provisions in the PREVENT Pandemics Act, that reauthorize the Public Health Workforce Loan Repayment Program to provide loan repayment to individuals in exchange for working in a State, Territorial, Tribal, or local public health department.

Accelerating Research and Countermeasure Discovery

The AMA strongly supports Congressional commitments to increased funding for advanced research, including continued research on discovery and development of countermeasures for pathogens with a significant potential of causing a future pandemic. We have long-standing policy supporting research innovation and funding for NIH and believe these efforts would expand on our priorities of public and private investment in innovation. In addition, the AMA believes that ensuring robust communication between federal entities engaged in research on pathogens or other agents that present a risk of a public health emergency is vital to ensuring that all such research is advanced in a timely and coordinated manner.

The AMA also supports the provisions in the PREVENT Pandemics Act on further understanding the implications of long-COVID, including directing the Secretary of HHS to continue to conduct and support studies of long-COVID as well as develop and inform recommendations and provide educational materials for health care providers and the general public on long-term effects of COVID-19. Moreover, the AMA supports efforts to improve collaboration and coordination among HHS agencies on medical countermeasure research and other research needs related to emerging public health threats.

Modernizing and Strengthening the Supply Chain for Vital Medical Products and Enhancing Development and Combatting Shortages of Medical Products

As you are aware, the intense global demand for test kits and testing supplies during the pandemic has significantly impacted access to tests at many locations where those tests are critical to the treatment of seriously ill patients. While we appreciate the federal government's efforts to procure needed supplies, both domestically and abroad, there has been very little transparency about those supplies provided to laboratories in need. The AMA strongly recommends new requirements for transparency and clarity in the testing supply chain, including what is in shortage, what is available, when additional supplies may be expected, and quantities that may be expected so that laboratories can develop strategies to best deal with available supplies. This responsibility should be clearly delineated by Congress and ultimately housed in a single federal entity that is responsible for gathering all information on the supply chain and delivering that information to relevant stakeholders at the state and local levels.

Recognizing that the COVID-19 pandemic has exacerbated many long-standing access and quality issues that threaten the resilience of our nation's health care supply chain, the AMA, along with the American Society of Anesthesiologists, American Society of Clinical Oncology, American Society of Health-System Pharmacists, and the United States Pharmacopeia worked together to craft recommendations to address gaps and deficiencies in the pharmaceutical and medical supply chains. Supply chain issues can adversely impact patient care by delaying treatment, worsening patients' health outcomes, or requiring patients to switch to non-optimal treatment regimens.

The broad recommendations are as follows:

- Incentivize advanced manufacturing technology and develop new continuous manufacturing technology for critical drugs and active pharmaceutical ingredients;
- Improve the function and composition of the Strategic National Stockpile;
- Improve multinational cooperation on supply chain resilience;
- Incentivize quality and resilience; and

- Replicate asks for critical drug manufacturing transparency and oversight for medical devices and ancillary supplies (e.g., PPE).

The complete recommendations can be found at https://www.ashp.org/-/media/assets/news-and-media/docs/Healthcare-Supply-Chain-Recommendations.

The AMA supports efforts in the PREVENT Pandemics Act consistent with these recommendations, including updates to the Strategic National Stockpile (SNS) strategy and Annual Threat-Based Review that ensures preparation for potential future public health emergencies through regular assessment of supply chain capabilities and the condition of the current contents of the SNS. The AMA also strongly supports requirements for and commitments to regular communication across the federal level and between the federal and state governments to ensure that stockpiles have the supplies they need. Communication and transparency are key to ensuring that the mistakes made during the early stages of the COVID-19 pandemic are not replicated in future public health emergencies. Similarly, the AMA supports commitments by the federal government to work with states to help establish, maintain, or enhance stockpiles of medical supplies that may be used during public health emergencies and applauds Congressional efforts to ensure the development of such collaborative programs.

The AMA also strongly supports efforts to ensure registration of all foreign facilities that produce pharmaceutical products or chemical components of pharmaceutical products. Similarly, the AMA supports timely and effective inspection of foreign establishments that produce pharmaceutical products or chemical components of finished pharmaceutical products. Finally, the AMA strongly supports provisions in the PREVENT Pandemics Act to strengthen penalties against manufacturers and distributors of counterfeit medical devices and personal protective equipment. Eliminating fraudulent products from the market is vital to ensure public safety and confidence in the supply of medical counter measures during public health emergencies.

The AMA appreciates the opportunity to provide comments on the PREVENT Pandemics Act and looks forward to working with Congress to implement necessary changes to America's public health system and public health preparedness.

Sincerely,

James L. Madara, MD