



March 29, 2023

The Honorable Bernie Sanders
Chairman
Health, Education, Labor & Pensions Committee
US Senate
Washington, DC 20510

The Honorable Bill Cassidy
Ranking Member
Health, Education, Labor & Pensions Committee
US Senate
Washington, DC 20510

Dear Chairman Sanders and Ranking Member Cassidy:

The American Academy of Nursing (Academy) appreciates the opportunity to offer comments in response to the request for information sent on March 15, 2023, regarding the reauthorization of the Pandemic and All-Hazards Preparedness Act (PAHPA). For 50 years, the Academy has been advancing health policy and practice through the generation, synthesis, and dissemination of nursing knowledge. With more than 2,900 Fellows, the Academy represents nursing's most accomplished leaders in policy, research, administration, practice, and academia. The vision of the Academy is *Healthy Lives for All People*. To actualize this vision, the Academy's mission is to improve health and achieve health equity by influencing policy through nursing leadership, innovation, and science.

The Academy applauds efforts to improve coordination and response to public health threats and is on record in support of numerous policies to streamline and bolster the nation's response to emerging threats.¹ Additionally, we are pleased to note some of our recommendations such as those on addressing health equity and biosurveillance were incorporated into the Prepare for and Respond to Existing Viruses, Emerging New Threats, and Pandemics (PREVENT Pandemics) Act² (passed in the Consolidated Appropriations Act of 2023, Public Law No. 117-328). As the Committee strengthens the nation's public health preparedness capacity, the Academy encourages you to consider how PAHPA reauthorization will work in conjunction with the implementation of the PREVENT Pandemics Act to ensure strategic incorporation and functioning of key infrastructure components. After reviewing the request for information, the Academy offers the following recommendations in the areas identified by the Committee:

- Public Health Emergency Coordination and Policy;
- Medical Countermeasures Development and Deployment;
- Support for Jurisdictional Preparedness and Response Capacity; and
- Gaps in Current Activities and Capabilities.

Public Health Emergency Coordination and Policy

Responsibilities and Authorities of the Secretary of Health and Human Services (HHS); Responsibilities and Authorities of the Assistant Secretary for Preparedness and Response; The National Health Security Strategy

¹ American Academy of Nursing. (2020, June 26). Letter to the Senate Health, Education, Labor, and Pensions Committee Regarding Recommendations on Pandemic Preparedness. https://higherlogicdownload.s3.amazonaws.com/AANNET/c8a8da9e-918c-4dae-b0c6-6d630c46007f/UploadedImages/FINAL_AAN_HELP_Committee_Pandemic_Response.pdf

² American Academy of Nursing. (2022, April 4). Letter to the Senate Health, Education, Labor, and Pensions Committee Regarding PREVENT Pandemics Act. https://higherlogicdownload.s3.amazonaws.com/AANNET/c8a8da9e-918c-4dae-b0c6-6d630c46007f/UploadedImages/PREVENT_Pandemics_Act_Support_Letter.pdf

Under the National Response Framework, HHS is tasked as both the Lead and Coordinating Agency for Emergency Support Function (ESF) #8 - Public Health and Emergency Response³, which assigns national responsibilities to both the lead and supporting agencies. ESF #8 provides planning and coordination of Federal public health, health care delivery, and emergency response systems to minimize and/or prevent health emergencies from occurring. One of the responsibilities includes coordination of Federal public health and medical messaging. The COVID-19 pandemic demonstrated that there are significant gaps in communication between federal government agencies, state and local governments, and the public. As noted in 2020¹, the Academy recommended Congress establish a chain of command and authority to clarify leadership during a pandemic and other emergency preparedness efforts, including which agencies will coordinate and be responsible for sharing accurate and timely information with state and local governments and the public. These roles and responsibilities must also be clearly communicated from HHS to states and from the states to the local communities so they can include this information in their preparedness planning. The Academy recommends the roles and responsibilities in an emergency be clarified before, during, and after a pandemic or national emergency as the Committee drafts legislation to reauthorize PAHPA. The United States should also have a permanent pandemic and national emergency response team. This response team should have a clear chain of command of government agencies' roles and responsibilities to prevent equipment shortages and ensure coordination at all levels. The response team should meet regularly and hold response drills to ensure continued readiness. Additionally, the Academy urges the reinstatement of the National Security Council Directorate for Global Health Security and Biodefense.

Misinformation was spread during the COVID-19 pandemic and had adverse effects on disease prevention and transmission measures such as mask-wearing and vaccine uptake.⁴ Addressing misinformation through targeted messaging backed by scientific evidence will be a critical component of future preparedness and response efforts. The announcement of an emerging public health threat has the potential to create environments of increased anxiety, and as we saw during the COVID-19 pandemic concerns related to public transit. We recommend coordinated evidence-based protocols be developed on travel, particularly international travel centered around airports, in collaboration with the Department of Transportation, Homeland Security, and the Centers for Disease Control and Prevention (CDC).

Medical Countermeasures Development and Deployment

Bolstering the Strategic National Stockpile (SNS)

The Academy has long supported measures to ensure that adequate amounts of personal protective equipment (PPE) are available to nurses, other health care providers, and essential personnel. The supply chain is critical to ensure adequate resources are available as hospitals and other settings experience surges, and it must be strengthened to aid preparedness efforts and emergency response. The Academy appreciates that the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Public Law No. 116-136, Sec. 3101) required HHS to work with the National Academy of Sciences, Engineering, and Medicine (NASEM) to report on the security of the US medical product supply chain. We recommend the full set of recommendations from that report, "Building Resilience into the Nation's Medical Product Supply Chains,"⁵ be implemented, particularly regarding transparency in supply chain information and data sharing including across various health care settings; diversification strategies; and preparedness efforts including capacity building and contingency planning.

³ National Response Framework, Emergency Support Function 8- Public Health and Emergency Response.

<https://www.fema.gov/pdf/emergency/nrf/nrf-esf-08.pdf>

⁴ Ferreira Caceres, M. M., Sosa, J. P., Lawrence, J. A., Sestacovschi, C., Tidd-Johnson, A., Rasool, M. H. U., Gadami, V. K., Ozair, S., Pandav, K., Cuevas-Lou, C., Parrish, M., Rodriguez, I., & Fernandez, J. P. (2022). The impact of misinformation on the COVID-19 pandemic. *AIMS Public Health*, 9(2), 262–277. <https://doi.org/10.3934/publichealth.2022018>

⁵ National Academies of Sciences, Engineering, and Medicine. 2022. *Building Resilience into the Nation's Medical Product Supply Chains*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/26420>.

The Academy cannot stress enough how indispensably important it is to ensure that nurses, other providers, and other essential personnel have the appropriate personal protective equipment (PPE) and other supplies they need to provide optimal patient care and protect themselves. The Academy consistently called upon the use of the Defense Production Act during the COVID pandemic to increase production of PPE and appreciated its use to increase production of much-needed medical supplies. In preparing for future pandemics and national emergencies, the Academy calls for the development of a plan to maintain and manage the National Strategic Stockpile. This plan should include a list of US manufacturers who have the capability to alter their product production efforts to produce PPE and other essential medical supplies, as Ford Motor Company and General Motors did in producing ventilators during the COVID-19 pandemic.⁶ The plan must include procedures for the regular inventory and rotation of PPE and supplies nearing expiration dates to schools, academic health centers, hospitals, and clinics, particularly in underserved areas for use and training. This plan should also include resources needed for maintaining the stockpile to prevent the shortages we experienced in the early stages of the COVID-19 pandemic. The distribution of PPE should not be limited to our hospitals and medical centers but to all health care providers and essential personnel working within our communities including distribution to public health, home health, nursing home facilities, and first responders.

The Academy further recommends that PPE and other supplies in the National Strategic Stockpile should be sufficient so that the rate at which supplies are used is not changed, even during a pandemic or national emergency. We encourage the Committee to establish or assign an existing entity with this responsibility to determine the amount of PPE and other supplies for the stockpile. This determination should be based on data from the COVID-19 pandemic PPE use. The Academy further recommends nurses and other providers with public health infrastructure backgrounds be included in determining the types and amount of supplies needed both under normal situations and during a crisis. Additionally, we urge Congress to provide resources for the development of safe and effective reusable PPE with evidence-based policies and procedures on fitting, testing, cleaning, and disinfecting of equipment to prevent further damage to the environment that can be brought about through the disposal of single-use PPE in future pandemics.

Emergency Use Authorizations and Related Authorities

During the Public Health Emergency (PHE) declared for the COVID-19 pandemic, several key waivers were put in place to expand access to care. These waivers expanded the use of telehealth to an unprecedented level and allowed Advanced Practice Registered Nurses (APRNs)⁷ to practice to the top of their licensure. The ability for APRNs to practice to the top of their licensure—utilizing the full extent of their education and clinical training—expands access to care, strengthens the health care workforce, and improves health equity.⁸ The Academy recommends that Congress make telehealth waivers permanent beyond the COVID-19 PHE.⁹ Additionally, we have highlighted that broadband access is fundamental to telehealth.^{1,2} We appreciate that programs such as the Affordable Connectivity Program (ACP) have expanded access to broadband infrastructure to access telehealth services. We further highlight the need to continue funding such programs and monitor their uptake across the nation to ensure all people, regardless of location or other structural barriers, can access care in times of public health emergencies.² We urge your Committee to consider the critical role of telehealth in access to services. The Academy is a longstanding supporter of telehealth expansion to increase access to care, especially

⁶ GM, Ford coronavirus U.S. ventilator projects close in on their finish lines. (2020, August 25). *Reuters*.

<https://www.reuters.com/article/us-health-coronavirus-autos-ventilators-idUSKBN25L2P4>

⁷ APRNs include certified nurse-midwives (CNMs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs) and nurse practitioners (NPs).

⁸ APRN Workgroup. (2022, August 24). APRN letter on CMS REH CoP Proposed Rule.

https://higherlogicdownload.s3.amazonaws.com/AANNET/c8a8da9e-918c-4dae-b0c6-6d630c46007f/UploadedImages/20220824_APRN_letter_on_CMS_REH_CoP_Proposed_Rule_FINAL.pdf

⁹ Nursing Community Coalition. (2022, April 25). NCC Waiver Request Letter.

https://higherlogicdownload.s3.amazonaws.com/AANNET/c8a8da9e-918c-4dae-b0c6-6d630c46007f/UploadedImages/NCC_Waiver_Request_Letter_Final_4_25_22.pdf

to our populations most at-risk during PHE and national emergencies. In the Academy's 2020 comments to the HELP Committee as well as to the Centers for Medicare & Medicaid Services (CMS) in 2020¹⁰, we noted just how important telehealth was in providing patients with timely and safe care during the COVID-19 pandemic. We have encouraged CMS to continue to evaluate ways to expand telehealth access to Medicare and Medicaid beneficiaries, while also noting the health equity challenge this poses as many patients and providers may not have access to reliable internet service, broadband speed, or devices with video capabilities. Greater investment in technological infrastructure and an expansion in telehealth policy are needed to ensure that all patients, regardless of location or other structural barriers, can access the care they need during health emergencies and beyond.

The COVID-19 PHE expires on May 11, 2023, along with the waivers and regulatory actions taken to allow nurses and other health care clinicians to provide lifesaving care. Throughout the PHE, removing practice barriers imposed on providers not only improved health care and health equity during the pandemic but enhanced workforce flexibility in rural and underserved communities where provider shortages were exacerbated, expanding telehealth coverage in particular.⁸ The Academy urges Congress to make these waivers permanent so APRNs can continue to provide high-quality health care to patients in all communities, including rural and underserved areas, now as well as during future pandemics and national emergencies. These expiring waivers⁸ include:

- *Physician Services. 42 CFR §482.12(c)(1)–(2) and §482.12(c)(4):* Waiving requirements that Medicare patients admitted to a hospital be under the care of a physician, allowing other practitioners to practice to the top of their licensure while authorizing hospitals to optimize their workforce strategies. For example, a recent report outlined that Certified Registered Nurse Anesthetists (CRNAs) in states that experienced a major impact due to executive orders (including the removal of both state and federal requirements), were significantly more likely to experience expanded clinical practice.¹¹
- *Physician Visits. 42 CFR 483.30(c)(3):* Allowing nurse practitioners (NPs) and clinical nurse specialists (CNS) to perform all mandatory visits in a skilled nursing facility (SNF) has enabled practices and SNFs to maximize their workforce. This waiver improves continuity of care and infection control by reducing unnecessary contact between patients and multiple providers.
- *Physician Delegation of Tasks in SNFs. 42 CFR 483.30(e)(4):* Allowing APRNs to practice to the top of their licensure ensures that patients continue to receive immediate access to high-quality health care.
- *Responsibilities of Physicians in Critical Access Hospitals (CAHs). 42 CFR § 485.631(b)(2):* Making the physician physical presence waiver permanent allows certain APRNs in CAHs to practice to the top of their licensure and enables the entire health care team to practice to its fullest capacity in provider shortage areas.
- *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Physician Supervision of NPs in RHCs and FQHCs. 42 CFR 491.8(b)(1):* Waiving the physician supervision of NPs in RHCs and FQHCs requirement has provided much-needed workforce flexibility in rural and underserved communities where provider shortages were exacerbated by COVID-19.

¹⁰ American Academy of Nursing. (2020, October 5). *Comments on the FY 2021 Physician Fee Schedule Proposed Rule*. https://higherlogicdownload.s3.amazonaws.com/AANNET/c8a8da9e-918c-4dae-b0c6-6d630c46007f/UploadedImages/FINAL_CMS_Response_Letter_Draft.pdf

¹¹ Callan et al. (August 2021). *Impact of COVID-19 Pandemic on Certified Registered Nurse Anesthetist Practice*. AANA Journal. Vol 89., No.4.

- *Anesthesia Services. 42 CFR §482.52(a)(5), §485.639(c) (2), and §416.42 (b)(2):* Allowing CRNAs to practice to the full extent of their license by permanently extending the CMS waiver removing physician supervision as a Condition of Participation.

Support for Jurisdictional Preparedness and Response Capacity

Data Collection & Reporting

The COVID-19 pandemic exposed the fragmented public health data collection and reporting methods utilized across the nation. Challenges such as outdated systems, including at times manual data entry and fax machines; varying reporting methodologies; and regulatory barriers hindered public health response efforts and made it difficult to allocate resources effectively and address health disparities during an evolving PHE.¹² The original Pandemic and All-Hazards Preparedness Act of 2006 (Public Law No. 109-417), and its subsequent reauthorizations in 2013 (Public Law No. 113–5) and 2019 (Public Law No. 116-22), mandated the implementation of nationwide public health situational awareness and biosurveillance capabilities through interoperable systems, which HHS has failed to implement.¹¹ The Academy recommends these interoperable systems be implemented with attention to regulatory barriers that may hinder data collection and/or reporting. Furthermore, reporting on vaccine uptake presents an additional challenge as there is no national vaccine registry, nor does CDC receive personally identifiable information on administered vaccine doses to link whether an individual has received multiple shots. This has resulted in significant unreliability in COVID-19 vaccination rate estimates¹³ and further obscures public health response efforts. We recommend a national strategy be developed to advance accuracy in vaccination reporting and data retrieval for future pandemics.

Biosurveillance and Public Health Situational Awareness

The Academy is on the record emphasizing the importance of testing and contact tracing to identify COVID-19 cases during the PHE.¹⁴ As the Committee considers PAHPA reauthorization, it will be important to ensure there are resources for education and testing as well as the efficient and accurate interpretation of these results. Testing capacity should be rapidly expanded as soon as a surge is identified with the use of other laboratories as needed. In future PHEs, it will be important to ensure state and local communities have the capacity to rapidly and accurately test everyone with an emphasis on our most at-risk populations and perform contact tracing until herd immunity is reached or a vaccine is developed. This will be especially important as we continue to learn more about COVID and future pandemics.

Additionally, the Academy encourages the Committee to consider mechanisms for capturing and recognizing unusual signs, symptoms, and timing of illnesses that could be contributing to the spread of future pandemics. Specifically, we need to be able to capture symptoms outside of the normally recognized symptoms of an infectious disease to be able to trace its spread. Examples from the COVID-19 pandemic include the mysterious inflammatory condition similar to Kawasaki disease that impacted children¹⁵ as well as the sudden loss of smell or taste.¹⁶ As we are still learning about the impact of Long

¹² *Historically Unprepared: Examination of the Federal Government's Pandemic Preparedness and Initial COVID-19 Response* (pp. 12–13). (2022). United States Senate Committee on Homeland Security & Governmental Affairs.

https://www.hsgac.senate.gov/wp-content/uploads/imo/media/doc/221208_HSGACMajorityReport_Covid-19.pdf

¹³ *Estimating Current Vaccination Rates | The COVID States Project.* (n.d.). <https://www.covidstates.org/reports/estimating-current-vaccination-rates>

¹⁴ American Academy of Nursing. (2020, April 29). American Academy of Nursing letter to Congressional leaders with recommendations to address the coronavirus pandemic. https://higherlogicdownload.s3.amazonaws.com/AANNET/c8a8da9e-918c-4dae-b0c6-6d630c46007f/UploadedImages/04_29_2020_FINAL_American_Academy_of_Nursing_COVID-19_Rescue_Package.pdf

¹⁵ Mostafavi, B. (2020, May 14). *Rare, COVID-Related Inflammatory Disease Affecting Children*. Michigan Health. <https://labblog.uofmhealth.org/rounds/rare-covid-related-inflammatory-disease-affecting-children>

¹⁶ *Coronavirus Disease 2019 (COVID-19) – Symptoms.* (2020, May 13). Centers for Disease Control and Prevention. <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

COVID on the population, mechanisms should also be in place to ensure that we study the long-term effects of pandemics on future public health needs.

Early warning of disease spread in communities can be best identified using wastewater surveillance. In September 2020, CDC launched the National Wastewater Surveillance System¹⁷ (NWSS) to coordinate and build the nation's capacity to track the presence of SARS-CoV-2 in wastewater samples collected across the country. Wastewater surveillance provides community-level data quickly and efficiently and can show changes in disease trends four to six days before those changes in trends are seen in clinical cases. A single wastewater sample can capture the infection status of populations with thousands to millions of individuals. Wastewater surveillance could be implemented in many communities since nearly 80 percent of U.S. households are served by municipal wastewater collection systems. For example, New York State has expanded its wastewater surveillance program¹⁸ and several counties are now exploring using wastewater surveillance to track opioids and their metabolites, antimicrobial-resistant pathogens, influenza, RSV, Hepatitis A, Hepatitis E, and polio.¹⁸ The Academy recommends that wastewater surveillance should be expanded to all eligible jurisdictions by increasing the amount of funding authorized for CDC's Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases.

As Congress looks for legislative solutions related to modernizing our disease surveillance systems, the Academy encourages Congress to consider the following recommendations. The nation's current surveillance system leads to confusion and duplication. The Academy recommends standardized and uniform operating systems to assist in collecting this data. We further recommend reduced complexity of data that also includes specific information such as ethnicity as well as other uniform data such as risk factors. This will require significant investment into the public health infrastructure at all levels of government. The Kaiser Family Foundation reported in 2020 that data from 32 states and Washington, DC showed that communities of color were disproportionately affected by COVID-19. In the majority of states reporting data, African-Americans accounted for a higher share of confirmed cases (in 20 of 31 states) and deaths (in 19 of 24 states) compared to their share of the total population.¹⁹ The data also showed disparate impacts for Hispanics and Asians in some states, although a smaller number of states reported data for these groups and there were inconsistencies in how states reported these data. In the later stages of the pandemic, the CDC began reporting national data on confirmed coronavirus cases by race and ethnicity. Similar to the state data, CDC also found that were disproportionate, with African-Americans accounting for a higher share of confirmed cases with known race/ethnicity compared to their share of the total population.¹⁸ Missing or unspecified race and ethnicity data absent for the majority of the CDC-reported cases limited the ability to interpret the data and take timely and necessary measures to protect communities, including indigenous populations. The Academy supports widespread, consistent, comprehensive, accurate, and timely data collection of health and economic factors associated with race and ethnicity.

Additionally, the Academy encourages the Committee to not just focus on ethnicity in data collection but to also focus on risk factors in a legislative solution. At-risk populations, of all age groups, such as those with pre-existing conditions and immunodeficiencies, older adults, socially isolated individuals, as well as people who have serious acute and chronic medical conditions, require essential safeguards that extend to their family members and other caregivers. We implore the Committee to also consider populations at a higher risk due to their surroundings such as in our indigenous communities. In the Navajo community, 15 percent of homes do not have access to running water and that number may be

¹⁷ National Wastewater Surveillance System. (2023, March 2). Centers for Disease Control and Prevention. <https://www.cdc.gov/nwss/wastewater-surveillance/index.html>

¹⁸ Polio Wastewater Surveillance. (n.d.). <https://www.health.ny.gov/diseases/communicable/polio/wastewater.htm>

¹⁹ Growing Data Underscore that Communities of Color are Being Harder Hit by COVID-19. (2020, April 21). Kaiser Family Foundation. <https://www.kff.org/coronavirus-policy-watch/growing-data-underscore-communities-color-harder-hit-covid-19/>

higher.²⁰ Lack of running water contributed to the spread of COVID in these communities. We must also consider those in densely populated living environments like Veteran group homes, long-term care facilities, homeless shelters, and others living in crowded conditions, such as incarcerated individuals, where social distancing was difficult, if not impossible. Active monitoring and testing are vital as community spread occurred in these environments with devastating effects.

Further, the Academy recommends the Committee consider incorporating culturally and linguistically appropriate services (CLAS) standards²¹ as developed by HHS as a way to improve communication and the quality of services provided to all individuals during a public health crisis. CLAS standards information distributed with multiple modalities could help to inform, educate, and support the communities most at risk of infectious disease during a pandemic. By tailoring information to an individual's culture and language preferences, community spread could potentially be slowed or eliminated in populations who are at higher risk during PHE.

Policies for the Inclusion of At-Risk Populations in Public Health Emergency Preparedness and Response Activities

Advancements in quicker and more accurate data collection and reporting will be key to better-addressing health disparities in future public health emergencies. The 2013 PAHPA defined at-risk individuals as children, older adults, pregnant women, and individuals who may need additional response assistance.²² The Academy is on record in support of the provision of patient-centered, culturally supportive and safe as well as linguistically sensitive care as components of emergency response.²³ We encourage Congress to ensure these services are available in times of crisis and beyond.

The Academy also suggests the Committee emphasize health equity in this area as the HHS did for the Healthy People 2030 guidelines. Emphasis on health equity within Healthy People 2030 marked a critical shift away from focusing on disease outcomes, which are often attributed to individual behaviors. A health equity approach in preparation for future emergencies should address historical and current structural as well as systematic racism, prejudice, and discrimination that result in health disparities. Prejudice and discrimination lead to unfair practices within public and private institutions, broader health systems, and society at large. As we experienced during the pandemic, certain populations are at a higher risk for COVID-19.¹⁹ Equitable access to and distribution of tests, treatments, and vaccines, especially for at-risk populations will be key to future pandemic preparations.

Gaps in Current Activities and Capabilities

A key lesson from the COVID-19 pandemic was that plans and systems cannot be improved upon if they are not practiced. While many state and local governments conduct natural disaster and terrorism training there is little to no sustained training in response to a pandemic. This highlights the urgent need for pandemic training drills across agencies, departments, and health systems at both the local, regional, and federal levels. Training for pandemics can help identify challenges in areas such as communication and gaps in care to better prepare for a future pandemic. The Academy recommends support for emergency and disaster preparedness training so that nurses and other providers will be better

²⁰ Debra Utacia Krol, The Arizona Republic. (2020, April 28). *Navajo Nation's water shortage may be supporting COVID-19 spread*. Arizona Republic. <https://www.azcentral.com/story/news/local/arizona-health/2020/04/18/navajo-nation-water-shortage-contributing-covid-19-spread/2992288001/>

²¹ US Department of Health and Human Services Office of Minority Health. (n.d.). *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*. <https://Thinkculturalhealth.Hhs.Gov/Assets/Pdfs/EnhancedNationalCLASStandards.Pdf>

²² *At-Risk Individuals*. (n.d.). Office of the Assistant Secretary for Preparedness and Response. <https://www.phe.gov/Preparedness/planning/abc/Pages/atrisk.aspx>

²³ *Public Health Preparedness and IT: Lessons from the Field*. American Academy of Nursing. https://higherlogicdownload.s3.amazonaws.com/AANNET/c8a8da9e-918c-4dae-b0c6-6d630c46007f/UploadedImages/Public_Health_Preparedness_and_IT_Lessons_from_the_Field_Meeting_Proceedings.pdf

prepared to face the next pandemic and respond to other emergencies. This training should include an emphasis on at-risk populations.

To better support domestic emergency pandemic crisis response and sustained recovery, the Academy supports U.S. government agencies, organizations, and sectors to strengthen available global health frameworks, partnerships, and collaborations. This may include the World Health Organization, International Health Regulations, United Nations, World Trade Organization, or World Bank to support improved equitable access to food/agriculture, PPE, and other necessary vaccines, pharmaceuticals, medical device supplies, and equipment.

During a pandemic, the Academy agrees there are areas of an emergency response that require less regulation. The federal government should allow states to use Public Health Emergency Preparedness and Hospital Preparedness Program funds to respond to a public health emergency and report back to HHS on how they were used, rather than having to wait for written approval from Washington. Our organization encourages the Committee to consider other non-hospital facilities that were directly impacted during the COVID pandemic. As you know, long-term care facilities, group homes, homeless shelters, and prison systems became hot spots for COVID transmission. Health care in settings other than acute care hospitals remains a priority to slow community spread in pandemics. These facilities should not be overlooked as they need resources and support to protect not only at-risk residents, but also the employees. Support for interprofessional teams to immediately bolster care to decrease mortality among vulnerable populations in these facilities is vital. The Academy recommends increased resources to these facilities, better coordination of services, and most critically, testing to support older adults, at-risk populations, and those with disabilities needing long-term services during this pandemic.

The Academy appreciates the opportunity to comment on the reauthorization of the Pandemic and All-Hazards Preparedness Act (PAHPA). If we can be of further assistance, please do not hesitate to contact the Academy's Senior Director of Policy, Christine Murphy, at cmurphy@aannet.org or 202-777-1174.

Sincerely,



Kenneth R. White, PhD, AGACNP, ACHPN, FACHE, FAAN
President