

REPORT OF THE AMA YOUNG PHYSICIANS SECTION GOVERNING COUNCIL

AMA-YPS Report E-A-19

Subject: Improving Prevention and Emergency Response through Flexible Public Health Funding Based on Population Risks (Resolution 2-A-18)

Presented by: Christie Morgan, MD, Chair

Referred to: AMA-YPS Reference Committee

INTRODUCTION

Resolution 2-A-18, “Improving Prevention and Emergency Response through Flexible Public Health Funding Based on Population Risks,” asks the AMA to encourage federal, state, and local agencies to partake in syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with other stakeholders to enact actions for mitigation, preparedness, response, and recovery in the event of unexpected infectious disease outbreak.

Although comments received through the AMA-YPS online forum were generally supportive, there were numerous queries related to the development of funding formulas, acquisition of stable public health funding, preparing public health communications, and determining the scope of the emerging infectious diseases. Based on the concerns presented during the online forum, it was recommended that YPS Resolution 2-A-18 be referred with a report back at the 2019 Annual Assembly Meeting.

This report provides an overview of syndromic surveillance and public health funding. In addition, an analysis of the original resolution is presented along with recommendations for next steps.

BACKGROUND

The primary issues raised in YPS Resolution 2-A-18 pertain to the significance of syndromic surveillance and public health funding as resources to support communities in the event of an infectious disease outbreak.

Syndromic Surveillance

Surveillance is critical to detecting and characterizing disease outbreaks. The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L. 107-188)¹ mandated the establishment of an integrated national public health surveillance system for early detection and rapid assessment of potential bioterrorism-related illness. The CDC launched the BioSense platform in 2003, and expanded the focus of Biosense to include all-hazards preparedness and response in 2011.²

The National Syndromic Surveillance Program (NSSP) uses Biosense for the development of a surveillance system that allows for the timely exchange of syndromic data. Situational awareness and responsiveness to hazardous events and disease outbreaks across the country are enhanced with the use of this data. One key aspect of the NSSP is “collaboration among individuals and organizations at local, state, and federal levels of public health; federal agencies, including the U.S. Department of Defense and the U.S. Department of Veterans Affairs; public health partner organizations; and hospitals and health professionals.”²

As of March 2019, a total of 57 sites across 47 states and the District of Columbia participate in the NSSP. Currently, 4,141 facilities, including 2,766 emergency departments (ED), contribute data to the NSSP BioSense Platform. Data received from participating EDs cover approximately 65% of all ED visits.³

Public Health Funding

According to the Robert Wood Johnson Foundation (RWJF), “states that have local health departments are more likely to use public health funding formulas to determine the resources allocated for specific public health activities; the use of formulas, is related to the federal government providing a higher percentage of a state’s public health funds.”⁴ The use of funding formulas by various states has been positively associated with the number of local health departments and the percentage of public health funds allocated by the federal government.

Variances in the infrastructure for each state’s public health system, particularly at the local level, has implications for funding allocation and service provision. A 2012 study by the RWJF found that sixty-seven percent of state health departments use funding formulas. Some respondents cited a lack of local health departments as the reason for not using funding formulas while others noted that is problematic to create formulas that balance the needs of rural versus urban health departments.⁵

Funding formulas present only one of the obstacles facing public health departments. Even with the burden of preventable disease, health threats, and emerging infectious disease outbreaks, federal disease prevention and public health programs remain critically underfunded⁶ and poses a threat to adequately addressing health challenges when they arise.

The Prevention and Public Health Fund (also known as the “Prevention Fund” or “PPHF”), which was authorized under Section 4002 of Patient Protection and Affordable Care Act of 2010 (ACA).⁷ The Prevention Fund is intended to improve the U.S. public health system by providing “for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public health care costs.”⁸

In Fiscal Year (FY) 2016, more than 12 percent of total program funding for the CDC was supplied through the PPHF. This fund contributed to more than 40% of the CDC’s immunization funding in FY 2016 as well as complete subsidization of the Preventive Health and Health Services Block grant, which provides funding to all 50 states, the District of Columbia, two American Indian tribes, and eight U.S. territories.⁷

One of the provisions of the Bipartisan Budget Act of 2018 (P.L. 115-123) calls for a \$1.35 billion cut from the PPHF over the next 10 years.⁹ Along with other budget cuts that have impacted the PPHF since its inception, support for public health preparedness, public health workforce, and core health programs are likely to be compromised. Further, it is expected that reduced funding for PPHF will lead to diminished capacity for CDC efforts related to disease surveillance and preventive efforts.

DISCUSSION

YPS Resolution 2-A-18 calls for strengthening the infrastructure to protect the health of the public by addressing shortfalls with surveillance and funding. During review of YPS Resolution 2-A-18, the following issues were noted:

- Some of the terminology used in the Whereas and Resolve clauses were not precise and, at times, resulted in a lack of clarity regarding the intent of the resolution. A few examples are provided below:

- “Disease X” versus “unexpected infectious diseases”
- “fear and panic” versus “community reaction and resilience”

Where appropriate, the language in the Whereas and Resolve clauses need to be updated for consistency.

- Syndromic surveillance is dependent on patient encounter data from a variety of sources such as emergency departments, urgent care, ambulatory care, and inpatient healthcare settings. This encounter data is fundamental in the surveillance conducted by public health departments. The first Resolve clause should be updated to reflect the broader range of entities that typically play a role in syndromic surveillance.
- Funding formulas used by public health departments may potentially have an adverse impact on medically underserved communities. Although appropriate use of funding formulas needs to be addressed, this issue may be beyond the purview of the AMA. Therefore, deleting the second Resolve clause will strengthen this resolution.

Of note, the AMA has various policies on public health funding, pandemic preparedness, Next Generation Infectious Diseases and prevention research. These policies are outlined in the Appendix A of this report. In addition, Appendices B and C include modified language for YPS Resolution 2-A-18.

RECOMMENDATIONS

The YPS Governing Council recommends that the following statements be adopted and that the remainder of the report be filed.

- The AMA-YPS Governing Council recommends that YPS Resolution 2-A-18, “Improving Prevention and Emergency Response through Flexible Public Health Funding Based on Population Risks,” be amended with a change in title to read:

IMPROVED EMERGENCY RESPONSE PLANNING FOR INFECTIOUS DISEASE OUTBREAKS

RESOLVED, That our AMA encourage 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 federal, state, and local agencies to partake in syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with other stakeholders to enact actions for mitigation, preparedness, response, and recovery (Directive to Take Action); and be it further

~~RESOLVED, That our AMA encourage federal, state, and local agencies to develop funding formulas accounting for population risks and medically underserved areas (Directive to Take Action); and be it further~~

1 RESOLVED, That our AMA supports flexible funding in public health for “~~Disease X~~”
2 unexpected infectious disease to improve timely response to emerging outbreaks and build
3 public health infrastructure at the local level with attention to medically underserved areas
4 (Directive to Take Action); and be it further

5
6 RESOLVED, That our AMA ~~supports effective~~ encourage health departments to develop
7 public health messaging to ~~reduce climate of fear and panic~~ provide education on
8 unexpected infectious disease. (Directive to Take Action)
9

- 10 2. The AMA-YPS Governing Council recommends that YPS Resolution, “Improved Emergency
11 Response Planning for Infectious Disease Outbreaks,” be submitted for consideration at the
12 2019 Interim Meeting of the AMA House of Delegates.

Fiscal Note: Less than \$500 to implement.

APPENDIX A: AMA POLICY - PUBLIC HEALTH FUNDING AND PANDEMIC PREPAREDNESS

Federal Block Grants and Public Health H-440.912

(1) Our AMA should collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated; such efforts may include the development of a common core of knowledge for public health and medical professionals, as well as educational vehicles to disseminate this information. (2) Our AMA urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; and (c) involve national medical and public health organizations in deliberations on proposed changes in funding of public health programs. (3) Our AMA will work with and through state and county medical societies to: (a) improve understanding of public health, including the distinction between publicly funded medical care and public health; (b) determine the roles and responsibilities of private physicians in public health, particularly in the delivery of personal medical care to underserved populations; (c) advocate for essential public health programs and services; (d) monitor legislative proposals that affect the nation's public health system; (e) monitor the growing influence of managed care organizations and other third party payers and assess the roles and responsibilities of these organizations for providing preventive services in communities; and (f) effectively communicate with practicing physicians and the general public about important public health issues. (4) Our AMA urges state and county medical societies to: (a) establish more collegial relationships with public health agencies and increase interactions between private practice and public health physicians to develop mutual support of public health and clinical medicine; and (b) monitor and, to the extent possible, participate in state deliberations to ensure that block grant funds are used appropriately for health-related programs. (5) Our AMA urges physicians and medical societies to establish community partnerships comprised of concerned citizens, community groups, managed care organizations, hospitals, and public health agencies to: (a) assess the health status of their communities and determine the scope and quality of population- and personal-based health services in their respective regions; and (b) develop performance objectives that reflect the public health needs of their states and communities. 6. Our AMA: (a) supports the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, in order to assure preservation of many critical public health programs for chronic disease prevention and health promotion in California and nationwide, and to maintain training of the public health physician workforce; and (b) will communicate support of the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, to the US Congress.

Pandemic Preparedness for Influenza H-440.847

In order to prepare for a potential influenza pandemic, our AMA: (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare for and respond to an influenza pandemic or other serious public health emergency; (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare for, respond to, and protect the population from illness and death in an influenza pandemic or other serious public health emergency; (3) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings; (4) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care

professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers; (6) will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States.

Next Generation Infectious Diseases Diagnostics H-440.834

1. Our American Medical Association supports strong federal efforts to stimulate early research and development of emerging rapid ID (infectious disease) diagnostic technologies through increased funding for appropriate agencies. 2. Our AMA supports the reduction of regulatory barriers to allow for safe and effective emerging rapid diagnostic tests, particularly those that address unmet medical needs, to more rapidly reach laboratories for use in patient care. 3. Our AMA supports improving the clinical integration of new diagnostic technologies into patient care through outcomes research that demonstrates the impact of diagnostics on patient care and outcomes, educational programs and clinical practice guidelines for health care providers on the appropriate use of diagnostics, and integration of diagnostic tests results into electronic medical records. 4. Our AMA supports efforts to overcome reimbursement barriers to ensure coverage of the cost of emerging diagnostics.

Public and Private Funding of Prevention Research D-425.999

(1) Our AMA will work in partnership with the Centers for Disease Control and Prevention, the National Institutes of Health, and other Federal Agencies, the Public Health Community (via the medicine/public health initiative), and the managed care community to develop a national prevention research agenda and report back to the House of Delegates the current status of this agenda. (2) These groups work in partnership to develop a practical plan to implement recommendations which will allow such groups to support and participate more fully in prevention research.

AMA Leadership in the Medical Response to Terrorism and Other Disasters H-130.946

Our AMA: (1) Condemns terrorism in all its forms and provide leadership in coordinating efforts to improve the medical and public health response to terrorism and other disasters. (2) Will work collaboratively with the Federation in the development, dissemination, and evaluation of a national education and training initiative, called the National Disaster Life Support Program, to provide physicians, medical students, other health professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts. (3) Will join in working with the Department of Homeland Security, the Department of Health and Human Services, the Department of Defense, the Federal Emergency Management Agency, and other appropriate federal agencies; state, local, and medical specialty societies; other health care associations; and private foundations to (a) ensure adequate resources, supplies, and training to enhance the medical and public health response to terrorism and other disasters; (b) develop a comprehensive strategy to assure surge capacity to address mass casualty care; (c) implement communications strategies to inform health care professionals and the public about a terrorist attack or other major disaster, including local information on available medical and mental health services; (d) convene local and regional workshops to share "best practices" and "lessons learned" from disaster planning and response activities; (e) organize annual symposia to share new scientific knowledge and information for enhancing the medical and public health response to terrorism and other disasters; and (f) develop joint educational programs to enhance clinical collaboration and increase physician knowledge of the diagnosis and treatment of depression, anxiety, and post-traumatic stress disorders associated with exposure to disaster, tragedy, and trauma. (4) Believes all physicians should (a) be alert to the occurrence of unexplained illness and death in the community; (b) be knowledgeable of disease surveillance and control capabilities for responding to unusual clusters of diseases, symptoms, or presentations; (c) be knowledgeable of procedures used to collect patient information for surveillance as well as the rationale and procedures for reporting patients and patient information;

(d) be familiar with the clinical manifestations, diagnostic techniques, isolation precautions, decontamination protocols, and chemotherapy/prophylaxis of chemical, biological, and radioactive agents likely to be used in a terrorist attack; (e) utilize appropriate procedures to prevent exposure to themselves and others; (f) prescribe treatment plans that may include management of psychological and physical trauma; (g) understand the essentials of risk communication so that they can communicate clearly and nonthreateningly with patients, their families, and the media about issues such as exposure risks and potential preventive measures (e.g., smallpox vaccination); and (h) understand the role of the public health, emergency medical services, emergency management, and incident management systems in disaster response and the individual health professional's role in these systems. (5) Believes that physicians and other health professionals who have direct involvement in a mass casualty event should be knowledgeable of public health interventions that must be considered following the onset of a disaster including: (a) quarantine and other movement restriction options; (b) mass immunization/chemoprophylaxis; (c) mass triage; (d) public education about preventing or reducing exposures; (e) environmental decontamination and sanitation; (f) public health laws; and (g) state and federal resources that contribute to emergency management and response at the local level. (6) Believes that physicians and other health professionals should be knowledgeable of ethical and legal issues and disaster response. These include: (a) their professional responsibility to treat victims (including those with potentially contagious conditions); (b) their rights and responsibilities to protect themselves from harm; (c) issues surrounding their responsibilities and rights as volunteers, and (d) associated liability issues. (7) Believes physicians and medical societies should participate directly with state, local, and national public health, law enforcement, and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals, and practices in preparation for terrorism and other disasters. (8) Urges Congress to appropriate funds to support research and development (a) to improve understanding of the epidemiology, pathogenesis, and treatment of diseases caused by potential bioweapon agents and the immune response to such agents; (b) for new and more effective vaccines, pharmaceuticals, and antidotes against biological and chemical weapons; (c) for enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes; and (d) for improving biological chemical, and radioactive agent detection and defense capabilities.

Fund for Public Health Emergency Response H-440.825

Our AMA supports the reauthorization and appropriation of sufficient funds to a public health emergency fund within the Department of Health and Human Services to facilitate adequate responses to public health emergencies without redistributing funds from established public health accounts.

Global Tracking System of Zoonotic Diseases D-440.940

Our AMA will work with the American Veterinary Medical Association and other relevant stakeholders to encourage the US Departments of Health and Human Services, Agriculture, Interior, and other appropriate federal and state agencies to take the lead in establishing a robust, coordinated, and effective global surveillance system of zoonotic diseases in humans and syndromic outbreaks in animals, thereby enhancing collaboration of human and animal health sectors and resulting in improved early detection and response.

APPENDIX B: FULL TEXT OF AMENDED YPS RESOLUTION, “IMPROVED EMERGENCY RESPONSE PLANNING FOR INFECTIOUS DISEASE OUTBREAKS” (REDLINED VERSION)

Improved Emergency Response Planning for Infectious Disease Outbreaks

Whereas, In the Blueprint list of priority diseases released by the World Health Organization in February 2018, a “Disease X”, or an unexpected infectious disease, was added representing an unknown pathogen with a serious international epidemic potential¹; and

Whereas, The Center for Disease Control and Prevention (CDC) has faced budget cuts of 1.525 billion dollars over the last three fiscal years²; and

Whereas, Continued public health funding is fundamental to maintaining essential services to the general population in prevention, outbreak investigation, and emergency response; and

Whereas, Availability of funding for “Disease X” an unexpected infectious disease prior to its clinical presentation would allow for patterned syndromic surveillance; and

Whereas, Early identification of a potential infectious disease outbreak reduces transmission, morbidity, mortality; and

Whereas, Early identification and public health messaging provides education ~~reduced the climate of fear and panic in~~ for the general public; therefore be it

RESOLVED, That our AMA encourage 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 federal, state, and local agencies to partake in syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with ~~other~~ stakeholders to enact actions for mitigation, preparedness, response, and recovery (Directive to Take Action); and be it further

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RESOLVED, That our AMA ~~supports effective~~ encourage health departments to develop public health messaging to ~~reduce climate of fear and panic~~ provide education on unexpected infectious disease. (Directive to Take Action)

Fiscal Note: Less than \$500 to implement.

¹ World Health Organization. WHO | List of blueprint priority pathogens. WHO. <http://www.who.int/blueprint/priority-diseases/en/>. Published 2017. Accessed April 22, 2018.

² Center for Disease Control and Prevention. CDC—BUDGET REQUEST OVERVIEW. <https://www.cdc.gov/budget/documents/fy2019/cdc-overview-factsheet.pdf>. Accessed April 22, 2018.

APPENDIX C: FULL TEXT OF AMENDED YPS RESOLUTION, “IMPROVED EMERGENCY RESPONSE PLANNING FOR INFECTIOUS DISEASE OUTBREAKS” (CLEAN VERSION)

Improved Emergency Response Planning for Infectious Disease Outbreaks

Whereas, In the Blueprint list of priority diseases released by the World Health Organization in February 2018, a “Disease X”, or an unexpected infectious disease, was added representing an unknown pathogen with a serious international epidemic potential¹; and

Whereas, The Center for Disease Control and Prevention (CDC) has faced budget cuts of 1.525 billion dollars over the last three fiscal years²; and

Whereas, Continued public health funding is fundamental to maintaining essential services to the general population in prevention, outbreak investigation, and emergency response; and

Whereas, Availability of funding for an unexpected infectious disease prior to its clinical presentation would allow for patterned syndromic surveillance; and

Whereas, Early identification of a potential infectious disease outbreak reduces transmission, morbidity, mortality; and

Whereas, Early identification and public health messaging provides education for the general public; therefore be it

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² Center for Disease Control and Prevention. CDC—BUDGET REQUEST OVERVIEW. <https://www.cdc.gov/budget/documents/fy2019/cdc-overview-factsheet.pdf>. Accessed April 22, 2018.

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¹ Public Health Security and Bioterrorism Preparedness and Response Act of 2002. Available at www.congress.gov/107/plaws/publ188/PLAW-107publ188.htm. Accessed March 2019.

² National Syndromic Surveillance Program. Available at www.cdc.gov/nssp/documents/NSSP-fact-sheet-508.pdf. Accessed March 2019.

³ NSSP Update - March 2019. Available at www.cdc.gov/nssp/news.html#Participation. Accessed March 2019.

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⁵ Funding Formulas for Public Health Allocations. Available at www.rwjf.org/en/library/research/2012/07/funding-formulas-for-public-health-allocations.html. Accessed March 2019.

⁶ Joint Letter Urging the President to Preserve Funding for Public Health and Prevention. Available at nchc.org/joint-letter-urging-the-president-to-preserve-funding-for-public-health-and-prevention/. Accessed May 2018.

⁷ H.R.3590 - Patient Protection and Affordable Care Act. Available at www.congress.gov/bill/111th-congress/house-bill/3590. Accessed March 2019.

⁸ Prevention and Public Health Fund. Available at www.cdc.gov/funding/pphf/index.html. Accessed May 2018.

⁹ H.R.1892 - Bipartisan Budget Act of 2018. Available at www.congress.gov/bill/115th-congress/house-bill/1892. Accessed March 2019.