March 13, 2023

The Honorable Richard Hudson
U.S. House of Representatives
2112 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna Eshoo
U.S. House of Representatives
272 Cannon House Office Building
Washington, DC 20515

Dear Representatives Hudson and Eshoo,

The Health Innovation Alliance (HIA) appreciates the opportunity to respond to the Request for Information regarding the Pandemic and All Hazards Preparedness Act (PAHPA). HIA is a diverse coalition of patient advocates, healthcare providers, consumer organizations, employers, technology companies, and payers who support the commonsense use of data and technology to improve health outcomes and lower costs.

As you work to further modernize our public health system and ensure we as a country are better prepared for any future public health threat, we thank you for considering our suggestions and recommendations. Our specific recommendations focus on:

- Reinforcing and ensuring implementation of past PAHPA policies;
- Leveraging the private sector to inform and operate necessary improvements and technologies; and
- Filling data gaps exposed by the recent COVID-19 pandemic and response.

Reinforcing and Ensuring Implementation of Past PAHPA Policies

While the past three years have put America's public health infrastructure and system under a microscope, policies called for in the original PAHPA (P.L. 109-417) have not yet been implemented. Since 2006, the Centers for Disease Control and Prevention (CDC) has been directed to establish,

> *"a near real-time electronic nationwide public health situational awareness capability through an interoperable network of systems to share data and information to enhance early detection of rapid response to, and management of, potentially catastrophic infectious disease outbreaks and other public health emergencies that originate domestically or abroad. Such network shall be built on existing State situational awareness systems or enhanced systems that enable such connectivity. (Section 202, P.L. 109-417)"*

This section modified Section 319D of the Public Health Services Act (42 U.S.C. 247d-4) and set a two-year implementation deadline. Fifteen years, an extensive amount of additional funding, and one global pandemic later, the provision still has not been implemented.

Policy in this area should focus on the CDC complying with the intent of the original 2006 law along with subsequent reauthorizations, but also guarantee that CDC is not using additional funding and authority to duplicate successful work already occurring in the private sector or creating additional reporting burdens for front-line providers and public health officials. We urge your offices to include language requiring the CDC and its state and local partners to collaborate with private industry to implement this network. This network should not be built in-house by the government. It should be built, maintained, and operated by the private sector through grants, contracts, or cooperative agreements with trusted entities that have experience and expertise in public health information, interoperability, and privacy and security. Any contract to build the system should be open, transparent, and competitively bid.

Leveraging the Private Sector

As HIA wrote to the CDC in 2021, the agency should build on a foundation of what works. Over the past three years, there have been immense resources provided to the CDC and other public health agencies specifically for data modernization and infrastructure updates – hundreds of millions on the low end. Instead of using that money to build in-house systems that would duplicate work that has already been done, Congress should focus on ensuring agencies partner with, or at the very least include, experts who have developed technology and systems from the ground up.

HIA believes that your offices should recognize and support state public health surveillance networks that work. Many states have successful surveillance networks that report near real-time, accurate data. CDC should work to model these state systems for adoption by other states and stay away from a central database. CDC's Vaccine Administration Management System (VAMS) program had a poor implementation, demonstrating that the CDC needs help navigating something as straightforward as vaccination scheduling. Congress should encourage the improvement of existing state systems to ensure their continued use, including robust protections for the privacy and security of the information included. There are legitimate reasons that the CDC would need certain data collected by state and local level surveillance systems, but that data should be aggregated, deidentified information with additional parameters placed on use, reuse, and sharing. Finally, we urge you to require direct consumer access to one's own immunization information to streamline data collection for families and individuals that need proof of vaccination for travel or other purposes.

We also believe there should be more transparency and direct engagement with private industry as the CDC and others at HHS work on modernization. The United States is the global leader in information management systems. It would be a disservice not to tap into this expertise in ways that are both meaningful and transparent to taxpayers. We suggest requiring the CDC to engage directly with the private sector on data modernization through at least quarterly meetings with stakeholders. The Food and Drug Administration (FDA) conducts many public and private meetings with the industry to inform the FDA's work, inform industry of the FDA's thinking, and create an environment of collaboration between the public and private spheres. The CDC should hear directly from industry on capabilities in development and in use in the private sector that could be adopted or modeled by the CDC. The private sector should also hear what the CDC is thinking and be given the opportunity to provide comments and advice to the CDC as it works to improve public health. Establishing a process like this will not only provide a public view of the CDC's progress but will also create more support and buy-in on the CDC's efforts. These stakeholder meetings could also address public concerns with the privacy and use of public health information by informing the public of current data protections and giving the CDC an opportunity to learn about common privacy and security practices in use outside of government. We believe requiring the CDC to engage with stakeholders will further the potential for success for all parties involved.

Additionally, we encourage your offices to include measures to use the private sector's extensive experience in managing supply chains to ensure that the Strategic National Stockpile (SNS) and other networks of critical supplies like medical countermeasures and personal protective equipment are functional. When the country needed materials from the SNS, we discovered that many of the supplies were expired, not functional, or too low. Members of HIA worked with the government to remedy these issues, often taking losses because it was the right thing to do. To ensure a functional supply chain going forward, we urge you to consider having portions of the supply chain operated and maintained by the private sector using systems and facilities already in place that could be easily adapted to accommodate public health and national security needs. By partnering with the private sector in places it makes sense like supply-chain management, we can ensure we are not under-resourced the next time catastrophe strikes.

Filling Data Gaps

From surveillance and response to treatment and vaccinations, the technology industry has responded with updates, new applications, and better equipment, medicines, testing, and care delivery options. From a data perspective, the PAHPA reauthorization should focus on priorities that ensure:

- Data is flowing bidirectionally: reporting needs to go from providers, hospitals, labs, and local public health entities up to the CDC, but data and best practices also need to be able to be reported back to the front lines.
- Data is standardized and able to be efficiently processed: this work should include organizations that are experts in developing consensus-based industry data standards.

We believe that bidirectional sharing with providers and the inclusion of laboratory information in reporting should not just be items for discussion as required in the 2023 Omnibus. They should be folded into the public health data network by moving this issue directly into the required activities enumerated at 42 U.S.C §247d-4(c)(5)(A). Consistent, accurate, and reliable testing information is critical to responding to public health threats, as we have all learned firsthand over the last three years. Additionally, providers on the ground caring for patients and exposing themselves to pathogens deserve to have robust public health information shared back with them to inform their decision-making and better coordinate response. Simply requiring providers to report up information and having that information shared between bureaucrats is not enough. We urge you to include laboratory information and the sharing of data back with providers as requirements of this system. This will add value to healthcare providers who see little return on burdensome public health reporting.

For standards, HIA supports requiring the CDC to designate data and technology standards in consultation with the Office of the National Coordinator for Health Information Technology (ONC) within two years as required by the Omnibus last year. There is a need to have common data sets and elements across public health, and we believe HHS should encourage the harmonization and use of standards to improve data collection, dissemination, exchange, and use. The CDC and ONC have been narrowly focused on FHIR standards. We encourage your offices to include language in the PAHPA reauthorization that requires all ANSI-accredited SDOs to be included in public health standards development and adoption.

Specifically, we urge the Committee to include pharmacy transactions in this section to ensure that the many public health activities that take place in pharmacies are incorporated into the desired future state of an interoperable public health system. Throughout the COVID-19 pandemic, Americans across the country have relied upon their neighborhood pharmacies for testing and vaccinations. The inclusion of pharmacy information systems in these data standardization activities will help ensure a more complete picture to inform our public health capabilities.

Thank you for your leadership on this critically important legislation and your careful consideration of our comments and suggestions as you move forward with reauthorization.

Sincerely,

Brett Meeks
Executive Director