



October 6, 2022

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Director
Office of Science and Technology Policy
Executive Office of the President
1650 Pennsylvania Avenue
Washington, DC 20504

Dear Dr. Prabhakar:

On behalf of the Infectious Diseases Society of America (IDSA) and its HIV Medicine Association (HIVMA), thank you for the opportunity to comment on the First Annual Report on Progress Towards Implementation of the American Pandemic Preparedness Plan (AP3).

IDSA represents more than 12,000 infectious diseases (ID) physicians, scientists and other public health and health care professionals who are leading COVID-19 responses and responses to the current monkeypox virus (MPV) outbreak at their institutions and in their communities; caring for patients; designing and updating infection prevention, diagnostic testing and patient management protocols; collaborating with state and local health departments on communications and mitigation efforts; and conducting research to develop new tools for the prevention, diagnosis and treatment of COVID-19, MPV and other infectious diseases. HIVMA serves as a professional community to more than 5,000 physicians and other health care professionals working on the frontlines of the HIV epidemic in communities across the country.

As we have communicated before, IDSA and HIVMA strongly support the American Pandemic Preparedness Plan and hope to partner closely with you to ensure its success. We write to offer recommendations that we believe can strengthen your efforts and look forward to an opportunity to discuss these recommendations with you.

Workforce and Infrastructure

Without people to treat patients and carry out pandemic response plans, the health and safety of the public will suffer. We are grateful that the AP3 Annual Report recognizes the importance of workforce capacity and the need to have the right clinicians and public health professionals available at the right place and the right time. However, as more than 80% of U.S. counties lack an ID physician and the public health workforce has shrunk by at least 15% since 2011, we must shore up the health care and public health systems that are needed to respond to any outbreak and even more essential in a pandemic.¹

In addition, engaging a diverse workforce, who come from and/or represent patients' diversity, is key. Mechanisms to ensure culturally responsive health care services and communications are essential to avoid inequities in outbreak response and prevent disproportionate rates of illness and death for

¹ Walensky and McQuillen, "Where Is the ID in COVID-19?" *Annals of Internal Medicine*, <https://www.acpjournals.org/doi/10.7326/M20-2684>; deBeaumont Foundation and the Public Health National Center for Innovations: Staffing Up, <https://debeaumont.org/news/2021/staffing-up-research-brief/>

those who are disadvantaged due to factors such as race, ethnicity, gender identity, sexual orientation, geography, ability or socioeconomic status.

The following recommendations address the need to shore up the workforce and infrastructure needed in any future pandemic.

- Support the ID pipeline by investing in and implementing targeted, sustainable loan repayment for ID professionals in underserved areas (such as through the bipartisan **BIO Preparedness Workforce Act**).
- Support the soon to be introduced **Public Health Emergency Outbreak Activation Act**, which would create a mechanism to provide enhanced reimbursement during a PHE related to an infectious disease for frontline clinicians to cover the significant additional work associated with the prevention, diagnosis and treatment of the infectious disease.
- Invest in health care infrastructure (workforce, laboratory systems) to ensure the capacity to detect pathogens and identify patterns.
- Explore ways that ID and HIV clinicians can expand tele-home health and remote health partnerships with safety net, rural and critical access hospitals and community health centers, particularly to serve areas without access to ID or HIV specialists.
- Invest in public health infrastructure and workforce so that it is not being built during an emergency.
- Study and implement legal preparedness plans. In the past several years, many states and local jurisdictions have changed legal authority for public health. Legal implications need to be considered in any pandemic preparedness plans.
- Explore and test different models for surge staffing. In the wake of COVID-19, some states are implementing regional models where smaller, rural counties may share some public health staff and/or resources or the state may set up resources for use that are not tied to a particular location.
- Incentivize federally supported programs at academic institutions to develop partnerships with community-based organizations to serve patients where they are and provide opportunities for medical and graduate students to gain experience working in underserved communities and appreciate the importance of engaging affected communities in preparedness and response program development and design prior to a public health emergency or outbreak.
- Invest in programs that encourage more individuals from underrepresented populations to pursue careers in medicine, infectious diseases, HIV, pandemic preparedness and public health.
- Increase the availability of J-1 waivers under the Conrad State 30 Program, which are rarely available for ID specialists; create additional waiver slots at academic medical centers regardless of whether the facility is in a Health Professional Shortage Area if the physician's work is in the public interest; and add J-1 visa waiver FLEX slots for each state for specialties deemed essential to pandemic response and permit these slots to be used in all geographic areas, given the broad impact of pandemic-related workforce shortages.
- Remove requirements that trainees supported by NIH T32 grants be U.S. citizens or permanent residents to expand the workforce to include additional foreign medical graduates.

The following recommendations are in response to the sections of the report under "Key Goals Towards Implementation of Transformational Capabilities."

Utilizing Current Infectious Disease Health Challenges to 'Exercise' Pandemic Preparedness

ID clinicians and public health professionals are on the frontlines of responding to emerging infectious diseases as well as the HIV, sexually transmitted infections and viral hepatitis epidemics. They are poised to serve a key role in studying responses to current health threats to identify effective strategies for future pandemics. We look forward to exploring further how IDSA can partner with you in this endeavor.

IDSA has long been a leader in combating the worldwide spread of antimicrobial resistance (AR), and our members treat patients with resistant infections, lead antibiotic stewardship and infection prevention and control programs and conduct research into new treatments and methods of preventing AR. We particularly appreciate the recognition in the AP3 report of antimicrobial resistance as a key health threat with the need for greater prevention and control efforts. We further appreciate that the President's budget request for FY2023 included a proposal to revitalize antimicrobial R&D that aligns with the bipartisan **PASTEUR Act**, and we urge the Administration to call on Congress to enact PASTEUR this year. As a member of the Coalition to Stop Flu, we also support the use of the test-to-treat concept to respond to seasonal influenza and develop plans to quickly and efficiently respond to an influenza pandemic.

Transforming Our Medical Defenses

Vaccines

We appreciate the focus on development of next-generation vaccines and flexible vaccine administration techniques and offer the following recommendations to help ensure new and existing vaccines are equitably accessible.

- Plans and strategies should utilize innovative methods of vaccine distribution, as seen during the COVID-19 vaccine rollout.
- “Meet patients where they are,” by building relationships and trust and partnering with trusted community organizations.
 - This is particularly important for marginalized groups including Black, Indigenous, People of Color, Hispanic and Latino, and LGBTQ+ populations in addition to limited English proficiency patients.

Clinical Trials

To ensure that people have equitable access to the latest advances in health care, clinical trial investigators need to be attuned to issues of inequitable access and focus outreach to engage a diverse pool of individuals for enrollment in trials. These relationships must be built and developed over time and should be leveraged by all clinical trial investigators and not limited to clinical trials conducted during a public health emergency.

Therapeutics

Lack of access to health care, inadequate insurance coverage and lack of awareness among providers about therapeutics options can be barriers to patients getting the care they need when they need it.

- The Administration should invest in deeper partnerships with clinical societies to expand provider education on therapeutic options during outbreaks and ensure therapeutics are equitably available, particularly for individuals who are uninsured or underinsured.

- The Administration should evaluate the impact of its recently launched promising bebtelovimab product replacement initiative to understand its impact, limitations and opportunities to serve as a model to expand access to other therapeutics in current or future emergencies.

Diagnostics

COVID-19 has provided an example of the need for quick, accurate diagnostics that are readily available to the public and health care providers. Public acceptance of rapid testing has increased over the course of the COVID pandemic. Dependable rapid testing for other diseases is needed to expand our preparedness and ability to respond to any pathogen on a national and local scale.

- IDSA seeks opportunities to provide input to BARDA as new diagnostics are developed to ensure that new diagnostics have the greatest clinical utility and are distributed to the populations that are most at risk.
- During the MPV outbreak, we have seen a marked improvement of the emergency use authorization diagnostic process for CLIA-certified labs. The simple registration process for CLIA-certified labs and the quick and public release of CDC protocols for their MPV test and their non-variola Orthopox test facilitated access to testing. These examples provide a model for future pandemics.

Data for Decision Making

Without adequate data, good health care and public health decision making will suffer. Data surrounding COVID is still lacking; for example, public health departments still have very little data on inequities surrounding uptake of therapeutics, despite the fact that the federal government has been directly managing their allocation and distribution.

- Complete demographic data on test-to-treat and vaccination programs should be available to target efforts to make sure people have equitable access to therapeutics and preventive measures like vaccines.
- The federal government should continue robust funding for the CDC Data Modernization Initiative, including funding for local and state health departments to ensure interoperability with health care systems, and the Global Health Security Agenda, to build surveillance capacities in low- and middle-income countries, where many global infectious diseases threats may originate.
- The federal government should fully fund human-animal quarantine stations at U.S. borders to detect imported threats, as well as an integrated system housed at CDC to gather nationwide data and invest in surveillance of zoonotic diseases, which can provide an early warning system of emerging human disease.
- Increase infrastructure for surveillance that is not dependent on accessing the health care system, e.g., wastewater surveillance, pharmacy surveillance, school absenteeism, Google searches (Google flu) and animal surveillance.

Effectively Build Trust to Improve Innovation Uptake

In the past several years, misinformation and disinformation have impacted access to preventive measures and health care services and reduced trust in the health care and public health systems. Members of the public have trouble parsing out what is accurate information about the COVID-19 pandemic and related medical guidance and health care in general.

Following are some recommendations about how to build back trust in health care and public health.

- Support research into effective methods of communicating to the public and inform pandemic preparedness plans with an understanding of hesitancy and resistance. Research into “what works” in communications should test methods in real-world settings, among a variety of different populations, and be widely disseminated to clinicians and public health professionals.
 - Specific recommendations are needed about how to protect communities that have been historically marginalized and experience routine health inequities. Targeted outreach requires a concerted and enduring effort and an investment of resources and support for trusted messengers and clinicians with existing ties to the community proficient in the languages that residents speak. These relationships must be built and sustained over time and must be bidirectional so that messaging is informed by and led by community leaders who reflect the diversity of target populations most heavily impacted by infectious disease.
- Provide federal funding to train frontline clinicians in effective public health communications and create a public health ambassadors corps and utilize them early on in public health initiatives.
- Ensure that tailored communications developed by CDC or other federal experts for clinicians to use with their patients reach all frontline clinicians, using expanded partnerships with professional societies and community-based organizations.

IDSA and HIVMA welcome continued collaboration to improve pandemic preparedness. To find a mutually agreeable time to discuss these recommendations, please contact Amanda Jezek, IDSA senior VP, public policy and government relations, at ajezek@idsociety.org or Andrea Weddle, HIVMA executive director, at aweddle@hivma.org.

Sincerely,



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