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PANDEMIC AND ALL-HAZARDS PREPAREDNESS ACT

AUGUST 3, 2006.—Ordered to be printed

Mr. ENZI, from the Committee on Health, Education, Labor, and Pensions, submitted the following

R E P O R T

[To accompany S. 3678]

The Committee on Health, Education, Labor, and Pensions, to which was referred the bill (S. 3678) to amend the Public Health Service Act with respect to public health security and all-hazards preparedness and response, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill (as amended) do pass.

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I. PURPOSE AND SUMMARY OF BILL

The purpose of S. 3678, the “Pandemic and All-Hazards Preparedness Act” is to improve the Nation’s public health and medical preparedness and response capabilities for emergencies, whether deliberate, accidental, or natural.

S. 3678 amends the Public Health Service Act (PHSA) to reauthorize Title I of the “Public Health Security and Bioterrorism Preparedness and Response Act of 2002” for a period of 5 years. Specifically, the “Pandemic and All-Hazards Preparedness Act” does the following:

- Identifies the Secretary of Health and Human Services (HHS) as the lead official for all Federal public health and medical re-

sponses to public health emergencies and other incidents covered by the National Response Plan.

- Consolidates Federal public health and medical response programs under the re-named Assistant Secretary for Preparedness and Response (ASPR), who will lead and coordinate HHS preparedness and response activities and advise the Secretary of HHS during an emergency. The ASPR will also lead the coordination of emergency preparedness and response efforts between HHS and other Federal agencies.
- Improves communication and interoperability, and enhances coordination between all levels of government.
- Emphasizes that State and local public health departments and medical first responders are the infrastructure of our Nation's public health security system.
- Promotes public health security preparedness by authorizing a nationwide public health situational awareness capability to rapidly detect, respond to, and manage public health threats.
- Strengthens the State and local public health workforce by establishing a demonstration project and grants to States, through the National Health Service Corps, for loan repayments for individuals who agree to serve in State or local health departments in underserved or at-risk areas.
- Enhances the Nation's capacity to handle a major medical surge during an emergency by establishing a national infrastructure for registering health professional volunteers, improving core training, strengthening logistical support, and developing a clear organizational framework for health care providers.

The legislation establishes overarching preparedness goals for essential Federal, State, and local public health and medical capabilities to increase accountability and incentivize regional coordination, including:

- (1) Integrating public health and public and private medical capabilities with other first responder systems;
- (2) Developing and maintaining Federal, State, local and tribal essential public health security capabilities;
- (3) Increasing the preparedness and response capabilities, and the surge capacity of hospitals and health care facilities;
- (4) Taking into account the needs of at-risk individuals during a public health emergency;
- (5) Ensuring coordination of Federal, State, local and tribal planning, preparedness and response activities; and
- (6) Maintaining continuity of operations of vital public health and medical services in the event of a public health emergency.

II. BACKGROUND AND NEED FOR LEGISLATION

After the terrorist attacks of September 11, 2001 and the subsequent anthrax mailings in October, Congress passed the "Public Health Security and Bioterrorism Preparedness and Response Act of 2002" (P.L. 107-188) to improve the Nation's ability to respond to acts of biological terrorism. However, several years later, issued reports indicated the need for additional Congressional action.

In 2005, RAND found that many local public health agencies were still unprepared to quickly learn about and respond to potentially deadly infectious disease outbreaks (Gaps in Public Health Agency Responsiveness to Reports of Suspicious Illnesses, August

2005). GAO found that few States have the capacity to evaluate, diagnose, and treat 500 or more patients in a single incident (Testimony: "Response Capacity Improving, but Much Remains to be Accomplished", February 2004). The Department of Homeland Security also reported that 68 percent of States did not feel fully confident that their current health disaster plans were adequate enough to manage a catastrophic event (DHS Nationwide Plan Review Phase I Report, February 2006).

A prepared and effective public health infrastructure can only be built on a robust and well trained public health workforce. However, according to the Council on State and Territorial Epidemiologists, 48 percent of epidemiologists in State and territorial health departments have no academic degree in epidemiology (CDC Morbidity and Mortality Weekly Report, "Assessment of Epidemiologic Capacity in State and Territorial Health Departments, United States, 2004, May 13, 2005, 54(18); 457-459). Furthermore, the American Public Health Association reported that as much as 45 percent of the State government public health workforce is expected to retire in the next few years (APHA Issue Brief: Public Health Workforce Shortage, December 2004).

In August 2005, the United States faced one of the worst natural disasters in the Nation's history when Hurricanes Katrina and Rita devastated much of the Gulf Coast. The local, State, and Federal responses to the disaster were uncoordinated and inadequate. The White House completed a report on the lessons learned from that experience and stated that the Department of Health and Human Services "should lead a unified and strengthened public health and medical command for Federal disaster response. Public health professionals and emergency medical responses should be managed and overseen by HHS, which has the greatest health experience and expertise."

The Gulf Coast hurricanes coincided with the spread of avian influenza, H5N1, overseas. The Wall Street Journal reported that 44 percent of Americans felt the United States was not prepared to deal with avian flu (Wall Street Journal Online/Harris Interactive Healthcare Poll, May 2006). The Congressional Budget Office estimate of the number of sick individuals who would be hospitalized due to a pandemic influenza ranged from 5 to 10 million. However, the United States only had approximately 970,000 staffed hospital beds and 100,000 ventilators, with three-quarters of them in use on any given day (A Potential Influenza Pandemic: Possible Macroeconomics Effects and Policy Issues, A letter to the Honorable William H. Frist, Dec. 8, 2005). The threat of an avian flu pandemic and the inadequate response to the hurricanes that hit the Gulf Coast were reminders that the public health and medical infrastructure plays a critical role in national security.

Through several public hearings and roundtables, the committee examined the state of the current public health infrastructure and identified gaps that were not addressed in current law. The committee found that it was important to develop a comprehensive, all-hazards approach to public health and medical preparedness, so that the Nation can better respond to disasters of all kinds, whether deliberate, accidental or natural. The "Pandemic and All-Hazards Response Act" builds on the lessons learned from the September 11th terrorist attacks and Hurricanes Katrina and Rita and

improves the Nation’s public health and medical preparedness and response capabilities for health emergencies.

III. LEGISLATIVE HISTORY AND COMMITTEE ACTION

On March 16, 2006, the committee held a formal hearing on the reauthorization of the “Public Health Security and Bioterrorism Preparedness and Response Act of 2002”. The Subcommittee on Bioterrorism and Public Health Preparedness also held five public hearings and roundtables on public health preparedness in the 21st Century (March 28), all-hazards medical preparedness and response (April 5), public health situational awareness (March 6), and lessons learned from Hurricane Katrina during a field hearing held in New Orleans, LA (July 16).

On July 18, 2006, Senators Burr, Kennedy, Enzi, Harkin, Gregg, and Frist introduced S. 3678, the “Pandemic and All-Hazards Preparedness Act”. On July 19, 2006, the committee held an executive session to consider S. 3678. Additional cosponsors were added at the executive session, including Senators Alexander, Mikulski, Isakson, DeWine, Clinton, Hatch, and Roberts. After accepting a substitute amendment offered by Senator Burr by unanimous voice vote, the committee approved S. 3678, as amended, by unanimous voice vote.

S. 3678 builds upon the implementation of two pieces of legislation enacted in recent years—one bill pre-dated the terrorist attacks of September 11, 2001; while the other was enacted after those attacks.

THE PUBLIC HEALTH THREATS AND EMERGENCIES ACT

On November 13, 2000, P.L. 106–505, the “Public Health Improvement Act” was signed into law. This act was a comprehensive package of public health bills that authorized funding for a wide range of public health initiatives. Title I of this act is known separately as the “Public Health Threats and Emergencies Act”.

The “Public Health Threats and Emergencies Act” amended the PHSA to give the Secretary of HHS the authority to determine that a public health emergency exists or that a disease or disorder presents a public health emergency. This legislation allowed the Secretary to take such action as may be appropriate to respond to such a public health emergency. The act also established a Public Health Emergency Fund to be made available to the Secretary of HHS, without fiscal year limitations, to carry out appropriate actions if a public health emergency is declared.

P.L. 106–505 also authorized competitive grants to State and local governments to identify, detect, monitor, and respond to threats to the public health. Grantees could use the funds to train public health personnel, develop an electronic network by which disease detection and public health information can be shared, develop a plan for responding to public health emergencies (including significant outbreaks of infectious diseases or bioterrorism attacks); and enhance laboratory capacity and facilities.

The act authorized the appropriation of funds for the construction of new facilities and renovation of existing facilities for the Centers for Disease Control and Prevention (CDC), including laboratories, office buildings, and other facilities and infrastructure.

The Secretary of HHS was also directed to establish two distinct working groups:

1. A Working Group on Preparedness for Acts of Bioterrorism, in coordination with the Secretary of Defense, to address preparedness and readiness for the medical and public health effects of a bioterrorist attack.

2. A Working Group on the Public Health and Medical Consequences of Bioterrorism, in coordination with the Director of the Federal Emergency Management Agency, the Attorney General, and the Secretary of Agriculture to address the public health and medical consequences of a bioterrorist attack on the civilian population.

In the wake of the terrorist attacks of September 2001, and the anthrax attacks of October 2001, the threat of bioterrorism assumed a higher profile in Congress, which led to the passage of another law that built on P.L. 106–505.

THE PUBLIC HEALTH SECURITY AND BIOTERRORISM PREPAREDNESS
AND RESPONSE ACT OF 2002

On June 12, 2002, P.L. 107–188, the “Public Health Security and Bioterrorism Preparedness and Response Act of 2002” was signed into law. This Act reflected new priorities in public health preparedness. In some cases, new programs were created and funded. In other cases, existing programs were expanded, both in scope and in funding.

Title I of P.L. 107–188, which S. 3678 reauthorizes, included several important provisions for building Federal, State, and local public health and medical capacity for emergencies.

- The act established the new position of Assistant Secretary for Public Health Emergency Preparedness at HHS to coordinate HHS preparedness activities. This provision also authorized the National Disaster Medical System, under the new Assistant Secretary to provide for further national capacity during public health emergencies. However, NDMS was later transferred to the Department of Homeland Security in the Homeland Security Act of 2002 (P.L. 107–296).

- A State block grant funding formula was authorized to improve State, local, and hospital preparedness for and response to bioterrorism and other public health emergencies.

- A system for the advanced registration and verification of health professional volunteers was authorized, and the establishment of core curriculum materials for public health emergencies was required for the education and training of health professionals.

- The Strategic National Stockpile, a national stockpile of drugs, vaccines and medical devices, was established to meet the health needs of the United States in times of emergency.

- The Secretary of Veterans Affairs was instructed to enhance the readiness of the Department’s medical centers and research facilities for a chemical or biological attack.

IV. COST ESTIMATE

Due to time constraints the Congressional Budget Office estimate was not included in the report. When received by the committee, it will appear in the Congressional Record at a later time.

V. APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Section 102(b)(3) of Public Law 104–1, the Congressional Accountability Act (CAA), requires a description of the application of this bill to the legislative branch. S. 3678 would amend the PHSA and reauthorize Title I of P.L. 107–188. The committee has determined that there is no impact of this bill on the Legislative Branch.

VI. REGULATORY IMPACT STATEMENT

Pursuant to the requirements of paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the committee has determined that the bill will not have a significant regulatory impact.

VII. SECTION BY SECTION ANALYSIS AND COMMITTEE VIEWS

Section 1. Short title

Pandemic and All-Hazards Preparedness Act.

Section 101. Public health and medical preparedness and response functions of the Secretary of Health and Human Services

This section amends the PHSA and authorizes the Secretary of Health and Human Services to lead all federal public health and medical responses to public health emergencies, and incidents covered by the National Response Plan developed pursuant to the Homeland Security Act of 2002.

The Secretary of HHS shall establish interagency agreements with the Secretaries of Veterans Affairs, Transportation, Defense, and Homeland Security in which the Secretary of HHS shall assume operational control of emergency public health and medical response assets, as necessary, in the event of an emergency. These agreements will outline the operational roles and relationships of such federal agencies and will pre-designate assets that can be mobilized in support of HHS in response to a catastrophic event. Such agreements may also address the coordination of public health preparedness and response activities abroad through inclusion of the Secretaries of State, Agriculture, and Defense.

The committee intends for these provisions to clarify the roles and responsibilities of Federal officials during preparations for and responses to emergencies, whether deliberate, accidental, or natural. The lack of a durable incident command system, providing clear roles and responsibilities, was identified by the White House as a problem during the response to Hurricanes Katrina and Rita that hit the Gulf Coast in 2005 (Federal Response to Hurricane Katrina: Lessons Learned). Lessons learned from the last three Top Officials (TOPOFF) exercises also highlighted deficiencies in the Federal response to catastrophic deliberate attacks. Of principle concern is the ambiguity concerning the Federal public health and medical leadership role under the National Response Plan. With continued potential threats from an influenza pandemic and possible terrorist attacks using chemical, biological, radiological or nuclear agents, clarifying leadership roles and ensuring unified command and control during a public health emergency is vital. The need to clarify such roles led the committee to identify the Secretary of HHS as the lead Federal official for public health and

medical preparedness and response, consistent with the National Response Plan.

Section 102. Assistant Secretary for Preparedness and Response

This section re-names the Assistant Secretary for Public Health Emergency Preparedness as the Assistant Secretary for Preparedness and Response and codifies this position under the Secretary of HHS. The President, with the advice and consent of the Senate, shall appoint an individual to serve in this position.

Using the approach utilized in the Goldwater-Nicholas Department of Defense Reorganization Act of 1986 (P.L. 99-433) to restructure the Department of Defense, this section consolidates public health and medical authorities, responsibilities and resources under the Assistant Secretary for Preparedness and Response (ASPR). It is the committee's view that aligning these functions under a single individual achieves unity of command and control under a clearly identified authority. The practical consequence of this approach is to consolidate existing Federal preparedness and medical response capabilities within HHS under the ASPR, including the National Disaster Medical System (NDMS) and its Disaster Medical Assistance Teams (DMATs), which are transferred from the Department of Homeland Security, the Strategic National Stockpile, the Cities Readiness Initiative, and the hospital preparedness and public health preparedness cooperative agreement programs. The ASPR may also assume other duties and authorities as deemed appropriate by the Secretary.

The committee intends that the Secretary may determine how best to administer the hospital preparedness and public health preparedness cooperative agreement programs, including by maintaining day to day program management at the Centers for Disease Control and Prevention and the Health Resources and Services Administration, while ensuring that necessary oversight, coordination, policy setting, and responsibility is maintained by the ASPR. In making any necessary transfers of personnel or assets, the Secretary shall ensure an orderly transition that minimizes duplication of effort and confusion at the state and local levels.

The Medical Reserve Corps and the Emergency System for Advance Registration of Volunteer Health Professionals, which are maintained at the state and local levels, shall be coordinated by the ASPR and integrated with other Federal response capabilities. The ASPR should also promote the use of the State Emergency Management Assistance Compact for sharing public health and medical mutual aid between states.

One of the duties of the ASPR is to augment the emergency medical services system through medical direction and integration. Emergency Medical Services operates at the intersection of health care, public health, and public safety and is therefore an integral part of the medical and public health infrastructure.

One of the additional duties of the ASPR is to provide leadership in international programs, initiatives, and policies that deal with public health and medical emergency preparedness and response.

Section 103. National health security strategy

The Committee finds that public health preparedness is an integral part of national security. As such, it requires a national strat-

egy, continuous assessments and periodic reviews to evaluate trends and identify gaps. Therefore, this section requires that every 4 years the Secretary of HHS submit to Congress a comprehensive national health security strategy. Similar to the Quadrennial Defense Review conducted by the Department of Defense, this section requires the Secretary of HHS to evaluate future challenges to national public health security and outline a strategy and plan for public health and medical preparedness and response. This strategy should reflect an all-hazards approach to public health emergency preparedness. The plan should identify requirements for the capabilities necessary to meet the preparedness goals included in this section, benchmarks and standards, timelines for accomplishing preparedness goals and a process for ensuring continuous improvements in preparedness. The strategy should also include a plan to collaborate with appropriate foreign governments and international public health organizations to enhance public health disease situational awareness capabilities.

The committee recognizes that all catastrophic natural disasters and acts of terrorism inflict psychological as well as physical harm to its victims. Accordingly, in laying the foundation for advancing the goals of public health security and medical preparedness, the committee underscores that such preparedness must address all aspects of health, including mental health. Importantly, the mental health consequences of disasters and attacks may be reduced by comprehensive response planning that addresses both risk communication and public preparedness to mitigate the short and long-term mental health impacts from such events. The reported bill anticipates that, just as mental health is essential to overall health, mental health must be an element of the National Health Security Strategy and all aspects of public health and medical preparedness and response activities for public health emergencies, and must be addressed comprehensively and in a fully coordinated manner at the Federal, state and local levels.

As is reflected in the public health security goals, the committee recognizes the importance of decontamination of medical assets and facilities.

A critical component of the strategy required in this section is creating a robust, trained public health workforce. HHS is required to assess the status of and remedies to correct near and long-term shortages in the public health workforce. Reportedly, 45 percent of the State government public health workforce is expected to retire in the next few years. Workforce shortages figure prominently in the determination of surge capacity. Recent surveys suggest that as many as 46 percent of local public health workers are unlikely to show up for work during an influenza pandemic (BMC Public Health, April 18, 2006). Current estimates indicate the human case fatality rate from H5N1 avian influenza virus is 20 times that of the 1918 pandemic influenza virus (World Health Organization, June 2006).

The committee recognizes that the importance of protecting health care workers and health care first responders from workplace exposures during a public health emergency is inextricably linked to accomplishing the strategy established in this section. Health care workers and health care first responders are on the frontline in a public health emergency. If they are not protected

from workplace exposures to hazards, they will be unable to care for the rest of the population and medical surge capacity will collapse. They are particularly at risk in the event of a public health emergency, such as a pandemic influenza outbreak. In the SARS outbreak of 2003 that occurred in China, other countries in East Asia, and Canada, when appropriate protections for workers were not adequate, the consequence was a high rate of infection and death among the nurses treating SARS patients and the further spread of a disease. The committee has identified the development of plans as appropriate pre-disaster planning and preparedness activities to reduce the risk of workplace exposure during a public health emergency and the negative consequences of the 2003 SARS outbreak.

The committee recognizes that disasters place children, pregnant women, senior citizens and other individuals at risk for increased morbidity and mortality. It is not possible to entirely specify what constitutes individuals at-risk as it depends on the nature of the disaster, the degradation of local medical services and infrastructure and other factors including language, mobility and other potential disabilities. Children represent a special subset of individuals at-risk, however, as they comprise several distinct sub-groups such as neonates and toddlers that have unique physiological and pharmacological considerations. The committee notes and encourages HHS to promote appropriate pre-disaster planning and preparedness activities at the State and local level to address the medical and public health needs of at-risk individuals in local communities during a public health emergency.

Section 201. Improving state and local health security

This section reauthorizes through 2011 HHS cooperative agreements for states, political subdivisions or consortium of such entities to enhance public health security preparedness. New requirements are included that the committee intends will ensure fiscal accountability, progress measured through evidence-based benchmarks and objective standards as determined by the Secretary, and regular exercises. HHS is authorized to provide technical assistance to entities to assist in achieving preparedness goals. This section also establishes a new state matching requirement, beginning in 2009, to ensure a shared financial responsibility between Federal and State investments in public health preparedness and to ensure maintenance of state efforts.

While allowing states to apply for funding as part of a consortium, the committee does not intend this section to change any funding formulas or amounts to individual states. The committee intends to encourage regionalized funding opportunities and interstate collaboration. A consortium would be eligible to receive the same amount of funding as each entity would have been eligible to receive on its own, unless the Secretary determines that a funding incentive is necessary to encourage states to develop regional approaches to preparedness that cross state boundaries.

The funds authorized in this section are primarily intended to assist states and localities in developing and sustaining the minimum essential public health security capabilities identified in section 103. However, this list should be interpreted broadly as the com-

mittee recognizes that there are a broad range of activities that will assist entities in achieving these capabilities.

States and localities are required to participate in regular drills and exercises and report back to HHS on the strengths and weaknesses identified in such exercises, and corrective measures taken to address such material weaknesses. HHS should evaluate and disseminate best practices and lessons learned through such activities. These best practices and lessons learned should undergo peer review and be disseminated and shared widely. This best practice effort should be closely coordinated and jointly disseminated with the Department of Homeland Security's Lessons Learned Information System (LLIS).

Additionally, the committee supports the research performed by the Agency for Healthcare Research and Quality with regard to best practices and standards of care during disasters. The committee also recommends the Secretary to support public health systems research that contributes to the development of evidence-based benchmarks and objective standards to measure public health preparedness.

The committee recognizes that no state is prepared unless every community in the state is prepared. This section therefore requires the Secretary to evaluate the emergency preparedness plans and exercises and compliance with benchmarks and standards by States and political subdivisions. This evaluation should distinguish between preparedness activities that have statewide impact and those that necessarily take place at the local level and that are in direct coordination with local emergency management plans, local first responders, and local hospitals, health care providers, schools, businesses, and others.

The committee recognizes that local health departments and other emergency medical first responders (regardless of their form of governance) will be the first responders to any public health emergency that affects the communities they serve. The committee requires the Secretary to establish procedures for ensuring funding of local entities, to provide assistance in instances where local consensus, approval or concurrence with entities' spending plans has not been achieved, and to inform all parties in advance about such procedures and assistance. The committee intends that nothing in this section be interpreted to weaken existing HHS/CDC requirements for local consensus, approval or concurrence.

Section 202. Using information technology to improve situational awareness in public health emergencies

This section requires the Secretary of HHS to build on existing State and local public health situational awareness capabilities to establish a near real-time nationwide public health situational awareness capability to enhance early detection of, rapid response to, and management of potentially catastrophic infectious disease outbreaks and public health emergencies.

It is the committee's view that HHS should establish explicit goals and a coherent strategy for achieving adequate "situational awareness" relevant to public health emergencies before making additional major investments in related information technology systems. The strategy should include clear timelines and goals for building these systems at local, State, regional and national levels.

This strategy should adopt a network of systems architecture that allows entities such as Federal, State, tribal and local agencies, organizations that monitor zoonotic diseases, public and private sector health care entities, pharmacies, Poison Control Centers, clinical laboratories and others to share data and information. Each system will transmit a minimal set of key data to a national expert system that will compile and analyze the data and disseminate information to member systems on a near real-time basis. Data and analyses should be available to all participating members, except when prohibited by law. This architecture is intended to provide flexibility to the member systems and foster greater communication between local and State partners and between State and Federal agencies. To the extent appropriate and feasible, the committee expects the Secretary to work with other Departments within the Administration and work with foreign governments, international organizations, and private sector entities to facilitate the exchange of public health data or summaries of such data with the public health reporting networks of such governments, organizations, and entities.

In addition, it is essential that the Nation make it a priority to ensure that there are robust and redundant communication connections between health care providers—especially hospitals—and public health departments. These connections are essential to situational awareness and informed decisionmaking during public health emergencies.

The nationwide public health situational awareness capacity implemented by the Secretary should take into account public health data collection and reporting systems maintained by foreign governments, international organizations, and the private sector, to enhance early detection of public health threats abroad. The committee encourages the Secretary to continue to work with the World Health Organizations and other stakeholders to improve situational awareness of potentially catastrophic infectious diseases. This strategy should include an emphasis on States bordering Canada and Mexico, and would encourage cooperative work that improves and strengthens situational awareness capabilities in those areas.

An eligible entity that receives a grant under this subsection (f)(4)(A) is strongly recommended to use the funds awarded to purchase and implement the use of the most innovative and advanced automated rapid detection diagnostic medical laboratory equipment available to analyze real-time clinical specimens for pathogens of public health or bioterrorism significance.

Amounts made available to carry out subsection (f)(4)(B) should be used to supplement and not supplant other Federal, State or local funds provided for such center or professional organization.

Section 203. Public health workforce enhancements

This section builds on an existing demonstration project and grants to States through the National Health Service Corps. It authorizes a new demonstration project for loan repayments to individuals who agree to complete their service obligation in a state or local health department that serves a health professional shortage area or area at high risk of a public health emergency. The Secretary must report to Congress within 3 years regarding the impact

of such demonstration project and the feasibility of permanently allowing such placements in the National Health Service Corps Loan Repayment Program. The committee expects that this report will provide initial useful data to be supplemented by additional information on the impact of such project. The section also authorizes competitive grants to States to fund State loan repayment programs for individuals who serve in a State or local health department in a health professional shortage area or other area at risk of a public health emergency, as determined by the Secretary.

The demonstration project and any health professionals who are selected to participate in such project should be placed so as to enhance local public health capabilities but not disrupt or limit community access to basic medical care.

Section 204. Vaccine tracking and distribution

With the United States having experienced multiple shortages of seasonal flu vaccine since 2000, the committee notes the interest in developing a system to track the distribution of vaccine supplies, especially as we face the threat of pandemic influenza. It is the goal of this section to promote communication so as to help maximize the delivery and availability of vaccines to patients, with a particular focus on high priority populations.

This section requires the Secretary to promote communication between state and local public health officials and such manufacturers, wholesalers and distributors as agree to participate regarding the effective distribution of seasonal influenza vaccine. The committee intends for this communication to be voluntary for manufacturers, distributors and wholesalers, and the committee encourages all relevant entities to participate in the communication. The language does not provide the Secretary with the authority to apply or enforce any sanctions or reward for participation on such entities that choose not to participate in this communication. The committee does intend for this communication to include estimates of high priority populations, as determined by the Secretary, in state and local jurisdictions in order to inform Federal, state and local decision makers during vaccine shortages and supply disruptions. It is the sense of the committee that in developing such estimates, the Secretary should work in conjunction with State and local health departments and incorporate existing information available through Federal, State and local databases, and surveys to better guide the distribution of influenza vaccine.

The committee recognizes CDC's efforts since 2004 to work with State and local public health officials, provider groups, manufacturers, distributors and other stakeholders to improve seasonal flu vaccine communication and distribution through the Flu Vaccine Finder. The committee appreciates these efforts, and encourages CDC to continue to work with such entities to grow and expand these efforts as necessary. The committee encourages State, local and tribal public health officials to work through the CDC to obtain information relevant to the effective distribution of seasonal flu vaccine.

While a tracking system is one component of helping to develop a stable vaccine market, the committee recognizes that another important component is raising awareness of the importance of flu vaccines. The committee would like to highlight the CDC's efforts

in this area, and emphasize that it is important for them to carry out such efforts in conjunction with State and local health departments, provider groups, mass vaccination clinics, health care institutions, and groups representing high priority populations.

Section 205. National Science Advisory Board for Biosecurity

This section authorizes the National Science Advisory Board for Biosecurity, at the request of the Secretary, to provide advice, guidance or recommendations to relevant Federal departments concerning evaluations of biosafety level 4 laboratory capacity nationwide and a core curriculum for workers in such laboratories. The committee recognizes that the CDC has a role in training workers for and providing oversight of these laboratories and expects the NSABB to collaborate with CDC when appropriate.

Section 301. National Disaster Medical System

This section transfers the National Disaster Medical System (NDMS) from the Department of Homeland Security to the Department of Health and Human Services. The committee believes that the best way to ensure a coordinated public health and medical response to emergencies is to have clear lines of authority and unity of command. Based on the White House report following Hurricane Katrina in 2005, which recommended transferring NDMS back to HHS, the committee authorizes such transfer effective January 1, 2007.

The Secretary of HHS, in coordination with the Secretaries of Homeland Security, Defense, and Veterans Affairs, shall conduct a joint review of NDMS that includes an evaluation of the roles and mission of NDMS in the future; the roles and responsibilities of the Departments of Homeland Security, Defense, and Veterans Affairs in support of NDMS; the appropriate organizational structure, size and number of teams, and methods for deploying teams; a plan for providing initial and ongoing logistical support, including appropriate cache inventory and deployment, and communications capabilities; Federal capabilities, including Federal facilities and mobile medical assets that are capable of being used during a public health emergency and pre-designating such capabilities and facilities; methods to integrate other medical response assets, including assets supported jointly by public and private funding, with such System; methods to increase health care facility participation and the capacity of the facilities involved; requirements to strengthen necessary medical evacuation capabilities; and other matters determined appropriate by such Secretaries.

Based on the joint review, the Secretary shall modify the policies of the National Disaster Medical System as the Secretary deems necessary, including with respect to command and coordination of overall operations, team deployments, and participating hospitals; enrolling, licensing, and credentialing of system participants; training, exercising, and continuing education of system participants; methods for providing logistical support; medical evacuation; and participating hospital requirements, benefits, and methods to increase hospital participation.

As the United States continues to re-evaluate its disaster preparedness, the needs of children in both bioterrorism attacks and natural disasters need to be addressed at all levels. In the wake

of Hurricane Katrina, where the Nation was faced not only with large numbers of displaced and dehydrated children but also with the large scale evacuation of children's hospitals, the creation of a more robust pediatric specialty team response should be examined. The teams stationed in Boston and Atlanta are examples of how high quality pediatric care can be taken into the disaster field using Pediatric Specialty Teams (PST's). One example of a new program in formation is PST-Ohio. This group combines the talents of Ohio's network of 7 children's hospitals and offers a potential model of PST's across the Nation by combining the resources of several children's hospitals to form a team so that not one hospital in particular has to shoulder the burden of staffing changes during deployment, drawing of talent across many specialties, and allowing rapid deployment of a regional asset.

As the National Disaster Medical System is transferred to HHS, the committee encourages the development of pediatric specialty teams to help augment the current Disaster Medical Assistance Team (DMAT) infrastructure.

Building on the authority given to the Secretary in the Project Bioshield Act of 2004, this section also authorizes the Secretary to extend the waiver of the Emergency Medical Treatment and Active Labor Act in the case of a pandemic infectious disease that is declared a public health emergency under section 319 of the PHSA, for 60 days or such less time upon the termination of the applicable public health emergency declaration. The committee strongly supports modifying such waiver requirements to permit hospital emergency rooms to follow State pandemic plans during an outbreak of pandemic influenza, which may include separate triage facilities or vaccination sites. This approach will ensure patients receive the care they need during a pandemic.

This section also reauthorizes and expands the scope of the National Advisory Committee on Children and Terrorism (NACCT) to include at-risk individuals, including pregnant women, senior citizens, and other individuals who have special public health and medical needs during a public health emergency, as determined by the Secretary. The Advisory Committee was disbanded in 2003, following the release of recommendations to the Secretary. The committee encourages the Secretary to review and take into account the findings of the NACCT.

The intent of this expansion is not to deemphasize the issues faced by pediatric populations, but to revitalize our efforts in developing an all-hazards response capacity in which the public health and medical needs of children are effectively addressed. The committee notes that some of this work will entail cooperation with other Federal agencies, including the Department of Education, and believes that such coordination should be a priority for the Assistant Secretary for Preparedness and Response.

Section 302. Enhancing medical surge capacity

This section requires the Secretary of HHS to evaluate strategies to improve medical surge capacity, such as considering the acquisition and operation of mobile medical assets and utilization of Federal facilities, including former health care facilities from Federal departments and agencies. The committee encourages the Secretary to consider establishing memorandum of understanding with

other Federal departments and agencies to permit such facilities to be used to augment local surge capacity in the event of a disaster. This section requires the Secretary to consider joint public and private sector funding of mobile medical assets that can be utilized by the Secretary to respond to public health emergencies.

Section 303. Encouraging health professional volunteers

This section codifies the existing local volunteer Medical Reserve Corps (MRC) and establishes a national infrastructure to utilize the deployment of willing health professional volunteers during a national public health emergency. This section is not intended to federalize state or local MRC teams. The section provides the national infrastructure so that willing MRC volunteers can be utilized to augment Federal medical responses to catastrophic emergencies. When activating or deploying MRC volunteers who are managed locally, the committee encourages the Secretary and local officials to also notify relevant State officials. The committee recommends that the Secretary use discretion in deploying members of the MRC who are already serving in areas designated as health professional shortage areas so as not to exacerbate the health professional need in the MRC members' areas of origin.

The MRC should utilize the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) to verify the credentials of MRC volunteers. In addition, MRC volunteers should have completed core training, as determined by the Secretary.

MRC volunteers, if designated by the Secretary as intermittent Federal response personnel and deployed during a public health emergency, would receive liability and disability protections, consistent with the National Disaster Medical System. The liability protection for volunteers of the MRC is intended to cover actions performed within the scope of their employment and will not cover actions taken outside the scope of their employment.

This section also builds on the existing ESAR-VHP by requiring the Secretary to link existing state-based verification systems into a single interoperable network of systems. Such verification network shall be used to quickly identify and utilize pre-registered health professional volunteers in an emergency. In order to protect the confidentiality of such health professional volunteers, the Secretary shall establish and require the application of and compliance with measures to ensure the effective security of, integrity of, and access to the data included in the network.

Section 304. Core education and training

This section requires the Secretary to refocus and consolidate current health professions curricula development and training programs funded by the Health Resources and Services Administration to establish core public health and medical response curricula and training. Such curricula and training shall establish minimum levels of expertise appropriate to the type of trainee. These courses could be tiered to include basic, advanced, and specialized levels of training. The training would be designed for those included in ESAR-VHP, or participating in MRC and DMAT.

The Secretary of HHS, in collaboration with the Secretary of Defense could convene expert panels to develop these curricula that

would be aimed at training health care providers treating patients, including at risk individuals, who were victims of natural disasters or deliberate attacks involving chemical, biological, radiological and nuclear and explosive agents. In partnership with the Secretary of Veterans Affairs and other public and private entities, the Secretary of HHS should provide for the dissemination and teaching of these materials for health professional volunteers including physicians, nurses, pharmacists, emergency medical technicians, mental health providers, and allied and support personnel, including public health, law enforcement and fire fighters, who may provide basic first aid or pre-hospital medical care. Such dissemination could be implemented through classroom, field, or on line instruction and could emphasize a train-the-trainer approach to effectively train large numbers of volunteers. The committee recommends that the materials developed under this section be comprehensive and implementable. The core content included in such materials can be expanded to address particular local or regional all-hazards emergency preparedness training needs. To maximize the effectiveness of such materials, the committee finds that the content should be disseminated through training modalities such as distance learning and train the trainer approaches.

The committee affirms the need to ensure that mental health preparedness is a component of such training. It is the sense of the committee that the training provided through this section should improve the care for mental health consequences in the event of a public health emergency and ensure that health and mental health professionals, and volunteers are able to respond effectively to the psychological needs of affected individuals, relief personnel and communities. Such response may include identifying symptoms of mental health distress and referring affected persons, as needed, for mental health care.

The committee also affirms the need to include a focus on protecting health care workers and health care first responders from workplace exposures during public health emergencies as a component of this training.

This section also expands the CDC's Epidemic Intelligence Service Program by 20 officer positions for individuals who agree to practice in underserved areas.

This section also authorizes the existing Centers for Public Health Preparedness program, administered by the CDC. To be eligible for funding through this program, accredited schools of public health must agree to develop core public health curricula and training for use by such schools. Eligible schools of public health must also collaborate with a state or local health department to ensure that any materials and trainings being developed by such school meet the needs of such department and are not duplicative of existing materials and trainings. The committee finds that the field of public health is extremely diverse and individuals graduating from schools of public health have varying skills and knowledge. The committee intends for the schools of public health that are Centers for Public Health Preparedness to develop core preparedness curricula and training that reflect the essential public health security capabilities identified in section 103.

This section also authorizes the Secretary of HHS to establish a research agenda for public health preparedness and response sys-

tems in order to document outcomes and establish evidence-based public health benchmarks and standards. The committee finds that public health systems research is a priority because there has been tremendous financial investment made to date for public health preparedness with no evidence-based measures for evaluating progress or preparedness. Over time, this research will contribute sufficiently to the knowledge base to further develop benchmarks and standards. The schools of public health that are Centers for Public Health Preparedness shall conduct public health systems research that is consistent with the agenda established by the Secretary.

In developing metrics and evaluating best practices under this section, the committee encourages CDC to take into account the continued work of the CDC Advanced Practice Centers. CDC has funded eight local Advanced Practice Centers at local health departments to develop, test and evaluate cutting-edge preparedness tools for local health departments. The committee encourages the development of best practices by local health departments to aid other local health departments in achieving critical benchmarks. The committee notes that CDC now requires all grantees to measure progress in pandemic influenza preparedness by using an innovative computer model for mass vaccination clinic operations developed by one such Advanced Practice Center. The committee does not intend anything in this Act to preclude continued funding of the Advanced Practice Centers and encourages their continued collaboration with Centers for Public Health Preparedness.

Section 305. Partnerships for state and regional hospital preparedness to improve surge capacity

This section reauthorizes through 2011 cooperative agreements to enhance the capacity of hospitals and other health care facilities for responding to emergencies. The Secretary shall continue to distribute funds to states and political subdivisions through the existing funding formula. In order to encourage regional health care partnerships, the Secretary may also distribute funds to partnerships of hospitals and other health care facilities that partner with a State or political subdivision and apply for funds directly from HHS. The Secretary may not award a cooperative agreement to a partnership unless the application is coordinated with an applicable state emergency preparedness plan.

The Secretary shall give preferences to partnerships that include a significant percentage of the hospitals and health care facilities within the geographic area served by such partnership. The Committee encourages the Secretary to take into account partnerships that incorporate emergency medical services as well as other health care facilities. Preferences shall also be awarded for partnerships that include at least one hospital that is a participant in the NDMS, partnerships that are located in a geographic area that faces a high degree of risk as determined in consultation with the Department of Homeland Security, and partnerships that have a significant need for funds to achieve the medical preparedness goals identified in section 103. In order to ensure a more robust NDMS, the committee encourages all hospitals to participate in NDMS. The committee believes that it is important to ensure an appropriate consideration of risk in making awards under this sec-

tion. Risk is challenging to quantify, but the committee suggests that the Secretary of HHS, in consultation with the Secretary of the Department of Homeland Security, develops an objective formula for risk based on a quantitative assessment. This section should not be interpreted as precluding regional coordination across international borders with Canada or Mexico.

The funds authorized in this section are intended to achieve the medical preparedness goals identified in section 103. However, this list should be interpreted broadly as the committee recognizes that there are a broad range of activities that will assist entities in achieving these goals. The committee approves of the limitation for state administrative expenses included in the recent grant guidance from the Health Resources and Services Administration.

At the Secretary's discretion, the funds authorized in this section may be used to fund regional training medical centers and to support activities and programs that will provide for a coordinated medical response to emergencies. Such centers would support dynamic, flexible plans that would enable health care providers to respond effectively to the rapidly changing situations that occur during a disaster.

Section 306. Enhancing the role of the Department of Veterans Affairs

This section authorizes the Department of Veterans Affairs (VA) to organize, train and equip its personnel and medical treatment facilities to support responses to public health emergencies consistent with the National Response Plan. It also authorizes the VA to provide medical logistical support on a reimbursable basis for federal disaster responses to public health emergencies. The committee intends for HHS to utilize the VA's existing extensive medical procurement system to minimize duplication of effort and reduce costs by avoiding the creation of a new separate HHS logistics system.

VIII. CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * *

[SEC. 319A. NATIONAL NEEDS TO COMBAT THREATS TO PUBLIC HEALTH.

[(a) CAPACITIES.—

[(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this section, the Secretary, and such Administrators, directors, or Commissioners, as may be appropriate, and in collaboration with State and local health officials, shall establish reasonable capacities that are appropriate for national, State, and local public health systems and the personnel or work forces of such systems. Such capacities shall be revised

every five years, or more frequently as the Secretary determines to be necessary.

[(2) BASIS.—The capacities established under paragraph (1) shall improve, enhance or expand the capacity of national, State and local public health agencies to detect and respond effectively to significant public health threats, including major outbreaks of infectious disease, pathogens resistant to antimicrobial agents and acts of bioterrorism. Such capacities may include the capacity to—

[(A) recognize the clinical signs and epidemiological characteristic of significant outbreaks of infectious disease;

[(B) identify disease-causing pathogens rapidly and accurately;

[(C) develop and implement plans to provide medical care for persons infected with disease-causing agents and to provide preventive care as needed for individuals likely to be exposed to disease-causing agents;

[(D) communicate information relevant to significant public health threats rapidly to local, State and national health agencies, and health care providers; or

[(E) develop or implement policies to prevent the spread of infectious disease or antimicrobial resistance.

[(b) SUPPLEMENT NOT SUPPLANT.—Funds appropriated under this section shall be used to supplement and not supplant other Federal, State, and local public funds provided for activities under this section.

[(c) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to the States to assist such States in fulfilling the requirements of this section.

[(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section \$4,000,000 for fiscal year 2001, and such sums as may be necessary for each subsequent fiscal year through 2006.]

SEC. 319A. VACCINE TRACKING AND DISTRIBUTION.

(a) *TRACKING.*—The Secretary, together with relevant manufacturers, wholesalers, and distributors as may agree to cooperate, may track the initial distribution of federally purchased influenza vaccine in an influenza pandemic. Such tracking information shall be used to inform Federal, State, local, and tribal decision makers during an influenza pandemic.

(b) *DISTRIBUTION.*—The Secretary shall promote communication between State, local, and tribal public health officials and such manufacturers, wholesalers, and distributors as agree to participate, regarding the effective distribution of seasonal influenza vaccine. Such communication shall include estimates of high priority populations, as determined by the Secretary, in State, local, and tribal jurisdictions in order to inform Federal, State, local, and tribal decision makers during vaccine shortages and supply disruptions.

(c) *CONFIDENTIALITY.*—The information submitted to the Secretary or its contractors, if any, under this section or under any other section of this Act related to vaccine distribution information shall remain confidential in accordance with the exception from the public disclosure of trade secrets, commercial or financial information, and information obtained from an individual that is privileged and confidential, as provided for in section 552(b)(4) of title 5,

United States Code, and subject to the penalties and exceptions under sections 1832 and 1833 of title 18, United States Code, relating to the protection and theft of trade secrets, and subject to privacy protections that are consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996. None of such information provided by a manufacturer, wholesaler, or distributor shall be disclosed without its consent to another manufacturer, wholesaler, or distributor, or shall be used in any manner to give a manufacturer, wholesaler, or distributor a proprietary advantage.

(d) GUIDELINES.—The Secretary, in order to maintain the confidentiality of relevant information and ensure that none of the information contained in the systems involved may be used to provide proprietary advantage within the vaccine market, while allowing State, local, and tribal health officials access to such information to maximize the delivery and availability of vaccines to high priority populations, during times of influenza pandemics, vaccine shortages, and supply disruptions, in consultation with manufacturers, distributors, wholesalers and State, local, and tribal health departments, shall develop guidelines for subsections (a) and (b).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums for each of fiscal years 2007 through 2011.

(f) REPORT TO CONGRESS.—As part of the National Health Security Strategy described in section 2802, the Secretary shall provide an update on the implementation of subsections (a) through (d).

* * * * *

SEC. 319C-1. [GRANTS TO IMPROVE STATE, LOCAL, AND HOSPITAL PREPAREDNESS FOR AND RESPONSE TO BIOTERRORISM AND OTHER PUBLIC HEALTH EMERGENCIES.] [IMPROVING STATE AND LOCAL PUBLIC HEALTH SECURITY.]

[(a) IN GENERAL.—To enhance the security of the United States with respect to bioterrorism and other public health emergencies, the Secretary shall make awards of grants or cooperative agreements to eligible entities to enable such entities to conduct the activities described in subsection (d).

[(b) ELIGIBLE ENTITIES.—

[(1) IN GENERAL.—To be eligible to receive an award under subsection (a), an entity shall—

[(A)(i) be a State; and

[(ii) prepare and submit to the Secretary an application at such time, and in such manner, and containing such information as the Secretary may require, including an assurance that the State—

[(I) has completed an evaluation under section 319B(a), or an evaluation that is substantially equivalent to an evaluation described in such section (as determined by the Secretary);

[(II) has prepared, or will (within 60 days of receiving an award under this section) prepare, a Bioterrorism and Other Public Health Emergency Preparedness and Response Plan in accordance with subsection (c);

[(III) has established a means by which to obtain public comment and input on the plan pre-

pared under subclause (II), and on the implementation of such plan, that shall include an advisory committee or other similar mechanism for obtaining comment from the public at large as well as from other State and local stakeholders;

[(IV) will use amounts received under the award in accordance with the plan prepared under subclause (II), including making expenditures to carry out the strategy contained in the plan; and

[(V) with respect to the plan prepared under subclause (II), will establish reasonable criteria to evaluate the effective performance of entities that receive funds under the award and include relevant benchmarks in the plan; or

[(B)(i) be a political subdivision of a State or a consortium of 2 or more such subdivisions; and

[(ii) prepare and submit to the Secretary an application at such time, and in such manner, and containing such information as the Secretary may require.

[(2) COORDINATION WITH STATEWIDE PLANS.—An award under subsection (a) to an eligible entity described in paragraph (1)(B) may not be made unless the application of such entity is in coordination with, and consistent with, applicable Statewide plans described in subsection (d)(1).

[(c) BIOTERRORISM AND OTHER PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE PLAN.—Not later than 60 days after receiving amounts under an award under subsection (a), an eligible entity described in subsection (b)(1)(A) shall prepare and submit to the Secretary a Bioterrorism and Other Public Health Emergency Preparedness and Response Plan. Recognizing the assessment of public health needs conducted under section 319B, such plan shall include a description of activities to be carried out by the entity to address the needs identified in such assessment (or an equivalent assessment).

[(d) USE OF FUNDS.—An award under subsection (a) may be expended for activities that may include the following and similar activities:

[(1) To develop Statewide plans (including the development of the Bioterrorism and Other Public Health Emergency Preparedness and Response Plan required under subsection (c)), and community-wide plans for responding to bioterrorism and other public health emergencies that are coordinated with the capacities of applicable national, State, and local health agencies and health care providers, including poison control centers.

[(2) To address deficiencies identified in the assessment conducted under section 319B.

[(3) To purchase or upgrade equipment (including stationary or mobile communications equipment), supplies, pharmaceuticals or other priority countermeasures to enhance preparedness for and response to bioterrorism or other public health emergencies, consistent with the plan described in subsection (c).

[(4) To conduct exercises to test the test the capability and timeliness of public health emergency response activities.

[(5) To develop and implement the trauma care and burn center care components of the State plans for the provision of emergency medical services.

[(6) To improve training or workforce development to enhance public health laboratories.

[(7) To train public health and health care personnel to enhance the ability of such personnel—

[(A) to detect, provide accurate identification of, and recognize the symptoms and epidemiological characteristics of exposure to a biological agent that may cause a public health emergency; and

[(B) to provide treatment to individuals who are exposed to such an agent.

[(8) To develop, enhance, coordinate, or improve participation in systems by which disease detection and information about biological attacks and other public health emergencies can be rapidly communicated among national, State, and local health agencies, emergency response personnel, and health care providers and facilities to detect and respond to a bioterrorist attack or other public health emergency, including activities to improve information technology and communications equipment available to health care and public health officials for use in responding to a biological threat or attack or other public health emergency.

[(9) To enhance communication to the public of information on bioterrorism and other public health emergencies, including through the use of 2-1-1 call centers.

[(10) To address the health security needs of children and other vulnerable populations with respect to bioterrorism and other public health emergencies.

[(11) To provide training and develop, enhance, coordinate, or improve methods to enhance the safety of workers and workplaces in the event of bioterrorism.

[(12) To prepare and plan for contamination prevention efforts related to public health that may be implemented in the event of a bioterrorist attack, including training and planning to protect the health and safety of workers conducting the activities described in this paragraph.

[(13) To prepare a plan for triage and transport management in the event of bioterrorism or other public health emergencies.

[(14) To enhance the training of health care professionals to recognize and treat the mental health consequences of bioterrorism or other public health emergencies.

[(15) To enhance the training of health care professionals to assist in providing appropriate health care for large numbers of individuals exposed to a bioweapon.

[(16) To enhance training and planning to protect the health and safety of personnel, including health care professionals, involved in responding to a biological attack.

[(17) To improve surveillance, detection, and response activities to prepare for emergency response activities including biological threats or attacks, including training personnel in these and other necessary functions and including early warning and surveillance networks that use advanced information tech-

nology to provide early detection of biological threats or attacks.

[(18) To develop, enhance, and coordinate or improve the ability of existing telemedicine programs to provide health care information and advice as part of the emergency public health response to bioterrorism or other public health emergencies.

[Nothing in this subsection may be construed as establishing new regulatory authority or as modifying any existing regulatory authority.

[(e) PRIORITIES IN USE OF GRANTS.—

[(1) IN GENERAL.—

[(A) PRIORITIES.—Except as provided in subparagraph (B), the Secretary shall, in carrying out the activities described in this section, address the following hazards in the following priority:

[(i) Bioterrorism or acute outbreaks of infectious diseases.

[(ii) Other public health threats and emergencies.

[(B) DETERMINATION OF THE SECRETARY.—In the case of the hazard involved, the degree of priority that would apply to the hazard based on the categories specified in clauses (i) and (ii) of subparagraph (A) may be modified by the Secretary if the following conditions are met:

[(i) The Secretary determines that the modification is appropriate on the basis of the following factors:

[(I) The extent to which eligible entities are adequately prepared for responding to hazards within the category specified in clause (i) of subparagraph (A).

[(II) There has been a significant change in the assessment of risks to the public health posed by hazards within the category specified in clause (ii) of such subparagraphs.

[(ii) Prior to modifying the priority, the Secretary notifies the appropriate committees of the Congress of the determination of the Secretary under clause (i) of this subparagraph.

[(2) AREAS OF EMPHASIS WITHIN CATEGORIES.—The Secretary shall determine areas of emphasis within the category of hazards specified in clause (i) of paragraph (1)(A), and shall determine areas of emphasis within the category of hazards specified in clause (ii) of such paragraph, based on an assessment of the risk and likely consequences of such hazards and on an evaluation of Federal, State, and local needs, and may also take into account the extent to which receiving an award under subsection (a) will develop capacities that can be sued for public health emergencies of varying types.

[(f) CERTAIN ACTIVITIES.—In administering activities under section 319C(c)(4) or similar activities, the Secretary shall, where appropriate, give priority to activities that include State or local government financial commitments, that seek to incorporate multiple public health and safety services or diagnostic databases into an integrated public health entity, and that cover geographic areas lacking advanced diagnostics and laboratory capabilities.

[(g) COORDINATION WITH LOCAL MEDICAL RESPONSE SYSTEM.—An eligible entity and local Metropolitan medical Response Systems shall, to the extent practicable, ensure that activities carried out under an award under subsection 9a) are coordinated with activities that are carried out by local Metropolitan Medical Response Systems.]

[(h) COORDINATION OF FEDERAL ACTIVITIES.—In making awards under subsection (a), the Secretary shall—

[(1) annually notify the Director of the Federal emergency Management Agency, the Director of the Office of Justice Programs, and the Director of the National Domestic Preparedness Office, as to the amount, activities covered under, and status of such awards; and

[(2) coordinate such awards with other activities conducted or supported by the Secretary to enhance preparedness for bioterrorism and other public health emergencies.]

[(i) DEFINITION.—For purposes of this section, the term “eligible entity” means an entity that meets the conditions described in subparagraph (A) or (B) of subsection (b)(1).]

(a) *IN GENERAL.*—*To enhance the security of the United States with respect to public health emergencies, the Secretary shall award cooperative agreements to eligible entities to enable such entities to conduct the activities described in subsection (d).*

(b) *ELIGIBLE ENTITIES.*—*To be eligible to receive an award under subsection (a), an entity shall—*

(1)(A) *be a State;*

(B) *be a political subdivision determined by the Secretary to be eligible for an award under this section (based on criteria described in subsection (h)(4); or*

(C) *be a consortium of entities described in subparagraph (A); and*

(2) *prepare and submit to the Secretary an application at such time, and in such manner, and containing such information as the Secretary may require, including—*

(A) *an All-Hazards Public Health Emergency Preparedness and Response Plan which shall include—*

(i) *a description of the activities such entity will carry out under the agreement to meet the goals identified under section 2802;*

(ii) *a pandemic influenza plan consistent with the requirements of paragraphs (2) and (5) of subsection (g);*

(iii) *preparedness and response strategies and capabilities that take into account the medical and public health needs of at-risk individuals in the event of a public health emergency;*

(iv) *a description of the mechanism the entity will implement to utilize the Emergency Management Assistance Compact or other mutual aid agreements for medical and public health mutual aid; and*

(v) *a description of how the entity will include the State Area Agency on Aging in public health emergency preparedness;*

(B) *an assurance that the entity will report to the Secretary on an annual basis (or more frequently as determined by the Secretary) on the evidence-based benchmarks*

and objective standards established by the Secretary to evaluate the preparedness and response capabilities of such entity;

(C) an assurance that the entity will conduct, on at least an annual basis, an exercise or drill that meets any criteria established by the Secretary to test the preparedness and response capabilities of such entity, and that the entity will report back to the Secretary within the application of the following year on the strengths and weaknesses identified through such exercise or drill, and corrective actions taken to address material weaknesses;

(D) an assurance that the entity will provide to the Secretary the data described under section 319D(d)(3) as determined feasible by the Secretary;

(E) an assurance that the entity will conduct activities to inform and educate the hospitals within the jurisdiction of such entity on the role of such hospitals in the plan required under subparagraph (A);

(F) an assurance that the entity, with respect to the plan described under subparagraph (A), has developed and will implement an accountability system to ensure that such entity make satisfactory annual improvement and describe such system in the plan under subparagraph (A);

(G) a description of the means by which to obtain public comment and input on the plan described in subparagraph (A) and on the implementation of such plan, that shall include an advisory committee or other similar mechanism for obtaining comment from the public and from other State, local, and tribal stakeholders; and

(H) as relevant, a description of the process used by the entity to consult with local departments of public health to reach consensus, approval, or concurrence on the relative distribution of amounts received under this section.

(c) **LIMITATION.**—Beginning in fiscal year 2009, the Secretary may not award a cooperative agreement to a State unless such State is a participant in the Emergency System for Advance Registration of Volunteer Health Professionals described in section 319I.

(d) **USE OF FUNDS.**—

(1) **IN GENERAL.**—An award under subsection (a) shall be expended for activities to achieve the preparedness goals described under paragraphs (1), (2), (4), (5), and (6) of section 2802(b).

(2) **EFFECT OF SECTION.**—Nothing in this subsection may be construed as establishing new regulatory authority or as modifying any existing regulatory authority.

(e) **COORDINATION WITH LOCAL RESPONSE CAPABILITIES.**—An entity shall, to the extent practicable, ensure that activities carried out under an award under subsection (a) are coordinated with activities of relevant Metropolitan Medical Response Systems, local public health departments, the Cities Readiness Initiative, and local emergency plans.

(f) **CONSULTATION WITH HOMELAND SECURITY.**—In making awards under subsection (a), the Secretary shall consult with the Secretary of Homeland Security to—

(1) ensure maximum coordination of public health and medical preparedness and response activities with the Metropolitan Medical Response System, and other relevant activities;

(2) minimize duplicative funding of programs and activities;

(3) analyze activities, including exercises and drills, conducted under this section to develop recommendations and guidance on best practices for such activities; and

(4) disseminate such recommendations and guidance, including through expanding existing lessons learned information system to create a single Internet-based point of access for sharing and distributing medical and public health best practices and lessons learned from drills, exercises, disasters, and other emergencies.

(g) **ACHIEVEMENT OF MEASURABLE EVIDENCE-BASED BENCHMARKS AND OBJECTIVE STANDARDS.**—

(1) **IN GENERAL.**—Not later than 180 days after the date of enactment of the Pandemic and All-Hazards Preparedness Act, the Secretary shall develop or where appropriate adopt, and require the application of measurable evidence-based benchmarks and objective standards that measure levels of preparedness with respect to the activities described in this section and with respect to activities described in section 319C-2. In developing such benchmarks and standards, the Secretary shall consult with and seek comments from State, local, and tribal officials and private entities, as appropriate. Where appropriate, the Secretary shall incorporate existing objective standards. Such benchmarks and standards shall, at a minimum, require entities to—

(A) demonstrate progress toward achieving the preparedness goals described in section 2802 in a reasonable time-frame determined by the Secretary;

(B) annually report grant expenditures to the Secretary (in a form prescribed by the Secretary) who shall ensure that such information is included on the Federal Internet-based point of access developed under subsection (f); and

(C) at least annually, test and exercise the public health and medical emergency preparedness and response capabilities of the grantee, based on criteria established by the Secretary.

(2) **CRITERIA FOR PANDEMIC INFLUENZA PLANS.**—

(A) **IN GENERAL.**—Not later than 180 days after the date of enactment of the Pandemic and All-Hazards Preparedness Act, the Secretary shall develop and disseminate to the chief executive officer of each State criteria for an effective State plan for responding to pandemic influenza.

(B) **RULE OF CONSTRUCTION.**—Nothing in this section shall be construed to require the duplication of Federal efforts with respect to the development of criteria or standards, without regard to whether such efforts were carried out prior to or after the date of enactment of this section.

(3) **TECHNICAL ASSISTANCE.**—The Secretary shall, as determined appropriate by the Secretary, provide to a State, upon request, technical assistance in meeting the requirements of this section, including the provision of advice by experts in the development of high-quality assessments, the setting of State ob-

jectives and assessment methods, the development of measures of satisfactory annual improvement that are valid and reliable, and other relevant areas.

(4) *NOTIFICATION OF FAILURES.*—The Secretary shall develop and implement a process to notify entities that are determined by the Secretary to have failed to meet the requirements of paragraph (1) or (2). Such process shall provide such entities with the opportunity to correct such noncompliance. An entity that fails to correct such noncompliance shall be subject to paragraph (5).

(5) *WITHHOLDING OF AMOUNTS FROM ENTITIES THAT FAIL TO ACHIEVE BENCHMARKS OR SUBMIT INFLUENZA PLAN.*—Beginning with fiscal year 2009, and in each succeeding fiscal year, the Secretary shall—

(A) withhold from each entity that has failed substantially to meet the benchmarks and performance measures described in paragraph (1) for a previous fiscal year (beginning with fiscal year 2008), pursuant to the process developed under paragraph (4), the amount described in paragraph (6); and

(B) withhold from each entity that has failed to submit to the Secretary a plan for responding to pandemic influenza that meets the criteria developed under paragraph (2), the amount described in paragraph (6).

(6) *AMOUNTS DESCRIBED.*—

(A) *IN GENERAL.*—The amounts described in this paragraph are the following amounts that are payable to an entity for activities described in section 319C-1 or 319C-2:

(i) For the fiscal year immediately following a fiscal year in which an entity experienced a failure described in subparagraph (A) or (B) of paragraph (5) by the entity, an amount equal to 10 percent of the amount the entity was eligible to receive for such fiscal year.

(ii) For the fiscal year immediately following two consecutive fiscal years in which an entity experienced such a failure, an amount equal to 15 percent of the amount the entity was eligible to receive for such fiscal year, taking into account the withholding of funds for the immediately preceding fiscal year under clause (i).

(iii) For the fiscal year immediately following three consecutive fiscal years in which an entity experienced such a failure, an amount equal to 20 percent of the amount the entity was eligible to receive for such fiscal year, taking into account the withholding of funds for the immediately preceding fiscal years under clauses (i) and (ii).

(iv) For the fiscal year immediately following four consecutive fiscal years in which an entity experienced such a failure, an amount equal to 25 percent of the amount the entity was eligible to receive for such a fiscal year, taking into account the withholding of funds for the immediately preceding fiscal years under clauses (i), (ii), and (iii).

(B) *SEPARATE ACCOUNTING.*—Each failure described in subparagraph (A) or (B) of paragraph (5) shall be treated

as a separate failure for purposes of calculating amounts withheld under subparagraph (A).

(7) REALLOCATION OF AMOUNTS WITHHELD.—

(A) IN GENERAL.—*The Secretary shall make amounts withheld under paragraph (6) available for making awards under section 319C–2 to entities described in subsection (b)(1) of such section.*

(B) PREFERENCE IN REALLOCATION.—*In making awards under section 319C–2 with amounts described in subparagraph (A), the Secretary shall give preference to eligible entities (as described in section 319C–2(b)(1)) that are located in whole or in part in States from which amounts have been withheld under paragraph (6).*

(8) WAIVER OR REDUCE WITHHOLDING.—*The Secretary may waive or reduce the withholding described in paragraph (6), for a single entity or for all entities in a fiscal year, if the Secretary determines that mitigating conditions exist that justify the waiver or reduction.*

[(j)] (h) FUNDING.—

[(1) AUTHORIZATIONS OF APPROPRIATIONS.—

[(A) FISCAL YEAR 2003.—

[(i) AUTHORIZATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated \$1,600,000,000 for fiscal year 2003, of which—

[(I) \$1,080,000,000 is authorized to be appropriated for awards pursuant to paragraph (3) (subject to the authority of the Secretary to make awards pursuant to paragraphs (4) and (5)); and

[(II) \$520,000,000 is authorized to be appropriated—

[(aa) for awards under subsection (a) to States, notwithstanding the eligibility conditions under subsection (b), for the purpose of enhancing the preparedness of hospitals (including children’s hospitals), clinics, health centers, and primary care facilities for bioterrorism and other public health emergencies; and

[(bb) for Federal, State, and local planning and administrative activities related to such purpose.

[(ii) CONTINGENT ADDITIONAL AUTHORIZATION.—If a significant change in circumstances warrants an increase in the amount authorized to be appropriated under clause (i) for fiscal year 2003, there are authorized to be appropriated such sums as may be necessary for such year for carrying out this section, in addition to the amount authorized in clause (i).

[(B) OTHER FISCAL YEARS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2004 through 2006.

[(2) SUPPLEMENT NOT SUPPLANT.—Amounts appropriated under paragraph (1) shall be used to supplement and not sup-

plant other State and local public funds provided for activities under this section.

[(3) STATE BIOTERRORISM AND OTHER PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE BLOCK GRANT FOR FISCAL YEAR 2003.—

[(A) IN GENERAL.—For fiscal year 2003, the Secretary shall, in an amount determined in accordance with subparagraphs (B) through (D), make an award under subsection (a) to each State, notwithstanding the eligibility conditions described in subsection (b), that submits to the Secretary an application for the award that meets the criteria of the Secretary for the receipt of such an award and that meets other implementation conditions established by the Secretary for such awards. No other awards may be made under subsection (a) for such fiscal year, except as provided in paragraph (1)(A)(i)(II) and paragraphs (4) and (5).]

(1) AUTHORIZATION OF APPROPRIATIONS.—

(A) IN GENERAL.—For the purpose of carrying out this section, there is authorized to be appropriated \$824,000,000 fiscal year 2007 for awards pursuant to paragraph (3) (subject to the authority of the Secretary to make awards pursuant to paragraphs (4) and (5)), and such sums as may be necessary for each of fiscal years 2008 through 2011.

(B) COORDINATION.—There are authorized to be appropriated, \$10,000,000 for fiscal year 2007 to carry out subsection (f)(3).

(C) REQUIREMENT FOR STATE MATCHING FUNDS.—Beginning in fiscal year 2009, in the case of any State or consortium of two or more States, the Secretary may not award a cooperative agreement under this section unless the State or consortium of States agree that, with respect to the amount of the cooperative agreement awarded by the Secretary, the State or consortium of States will make available (directly or through donations from public or private entities) non-Federal contributions in an amount equal to—

(i) for the first fiscal year of the cooperative agreement, not less than 5 percent of such costs (\$1 for each \$20 of Federal funds provided in the cooperative agreement); and

(ii) for any second fiscal year of the cooperative agreement, and for any subsequent fiscal year of such cooperative agreement, not less than 10 percent of such costs (\$1 for each \$10 of Federal funds provided in the cooperative agreement).

(D) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTIONS.—As determined by the Secretary, non-Federal contributions required in subparagraph (C) may be provided directly or through donations from public or private entities and may be in cash or in kind, fairly evaluated, including plant, equipment or services. Amounts provided by the Federal government, or services assisted or subsidized to any significant extent by the Federal government, may not be included in determining the amount of such non-Federal contributions.

(2) MAINTAINING STATE FUNDING.—

(A) IN GENERAL.—An entity that receives an award under this section shall maintain expenditures for public health security at a level that is not less than the average level of such expenditures maintained by the entity for the preceding 2 year period.

(B) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit the use of awards under this section to pay salary and related expenses of public health and other professionals employed by State, local, or tribal public health agencies who are carrying out activities supported by such awards (regardless of whether the primary assignment of such personnel is to carry out such activities).

(3) DETERMINATION OF AMOUNT.—

(A) IN GENERAL.—The Secretary shall award cooperative agreements under subsection (a) to each State or consortium of 2 or more States that submits to the Secretary an application that meets the criteria of the Secretary for the receipt of such an award and that meets other implementation conditions established by the Secretary for such awards.

* * * * *

(4) CERTAIN POLITICAL SUBDIVISIONS.—

(A) IN GENERAL.—For fiscal year ~~2003~~ 2007, the Secretary may, before making awards pursuant to paragraph (3) for such year, reserve from the amount appropriated under paragraph (1)(A)(i)(I) for the year an amount determined necessary by the Secretary to make awards under subsection (a) to political subdivisions that have a substantial number of residents, have a substantial local infrastructure for responding to public health emergencies, and face a high degree of risk from bioterrorist attacks or other public health emergencies. Not more than three political subdivisions may receive awards pursuant to this subparagraph.

* * * * *

(D) CONTINUITY OF FUNDING.—In determining whether to make an award pursuant to subparagraph (A) to a political subdivision, the Secretary may consider, as a factor indicating that the award should be made, that the political subdivision received public health funding from the Secretary for fiscal year ~~2002~~ 2006.

(5) SIGNIFICANT UNMET NEEDS; DEGREE OF RISK.—

(A) IN GENERAL.—For fiscal year ~~2003~~ 2007, the Secretary may, before making awards pursuant to paragraph (3) for such year, reserve awards pursuant to paragraph (3) for such year, reserve from the amount appropriated under paragraph (1)(A)(i)(I) for the year an amount determined necessary by the Secretary to make awards under subsection (a) to eligible entities that—

(i) * * *

* * * * *

【(6) FUNDING OF LOCAL ENTITIES.—For fiscal year 2003, the Secretary shall in making awards under this section ensure that appropriate portions of such awards are made available to political subdivisions, local departments of public health hospitals (including children’s hospitals), clinics, health centers, or primary care facilities, or consortia of such entities.】

(6) *FUNDING OF LOCAL ENTITIES.—The Secretary shall, in making awards under this section, ensure that with respect to the cooperative agreement awarded, the entity make available appropriate portions of such award to political subdivisions and local departments of public health through a process involving the consensus, approval or concurrence with such local entities.*

(i) *ADMINISTRATIVE AND FISCAL RESPONSIBILITY.—*

(1) *ANNUAL REPORTING REQUIREMENTS.—Each entity shall prepare and submit to the Secretary annual reports on its activities under this section and section 319C-2. Each such report shall be prepared by, or in consultation with, the health department. In order to properly evaluate and compare the performance of different entities assisted under this section and section 319C-2 and to assure the proper expenditure of funds under this section and section 319C-2, such reports shall be in such standardized form and contain such information as the Secretary determines (after consultation with the States) to be necessary to—*

(A) *secure an accurate description of those activities;*

(B) *secure a complete record of the purposes for which funds were spent, and of the recipients of such funds;*

(C) *describe the extent to which the entity has met the goals and objectives it set forth under this section or section 319C-2; and*

(D) *determine the extent to which funds were expended consistent with the entity’s application transmitted under this section or section 319C-2.*

(2) *AUDITS; IMPLEMENTATION.—*

(A) *IN GENERAL.—Each entity receiving funds under this section or section 319C-2 shall, not less often than once every 2 years, audit its expenditures from amounts received under this section or section 319C-2. Such audits shall be conducted by an entity independent of the agency administering a program funded under this section or section 319C-2 in accordance with the Comptroller General’s standards for auditing governmental organizations, programs, activities, and functions and generally accepted auditing standards. Within 30 days following the completion of each audit report, the entity shall submit a copy of that audit report to the Secretary.*

(B) *REPAYMENT.—Each entity shall repay to the United States amounts found by the Secretary, after notice and opportunity for a hearing to the entity, not to have been expended in accordance with this section or section 319C-2 and, if such repayment is not made, the Secretary may offset such amounts against the amount of any allotment to which the entity is or may become entitled under this sec-*

tion or section 319C-2 or may otherwise recover such amounts.

(C) *WITHHOLDING OF PAYMENT.*—The Secretary may, after notice and opportunity for a hearing, withhold payment of funds to any entity which is not using its allotment under this section or section 319C-2 in accordance with such section. The Secretary may withhold such funds until the Secretary finds that the reason for the withholding has been removed and there is reasonable assurance that it will not recur.

(3) *MAXIMUM CARRYOVER AMOUNT.*—

(A) *IN GENERAL.*—For each fiscal year, the Secretary, in consultation with the States and political subdivisions, shall determine the maximum percentage amount of an award under this section that an entity may carryover to the succeeding fiscal year.

(B) *AMOUNT EXCEEDED.*—For each fiscal year, if the percentage amount of an award under this section unexpended by an entity exceeds the maximum percentage permitted by the Secretary under subparagraph (A), the entity shall return to the Secretary the portion of the unexpended amount that exceeds the maximum amount permitted to be carried over by the Secretary.

(C) *ACTION BY SECRETARY.*—The Secretary shall make amounts returned to the Secretary under subparagraph (B) available for awards under section 319C-2(b)(1). In making awards under section 319C-2(b)(1) with amounts collected under this paragraph the Secretary shall give preference to entities that are located in whole or in part in States from which amounts have been returned under subparagraph (B).

(D) *WAIVER.*—An entity may apply to the Secretary for a waiver of the maximum percentage amount under subparagraph (A). Such an application for a waiver shall include an explanation why such requirement should not apply to the entity and the steps taken by such entity to ensure that all funds under an award under this section will be expended appropriately.

(E) *WAIVE OR REDUCE WITHHOLDING.*—The Secretary may waive the application of subparagraph (B) for a single entity pursuant to subparagraph (D) or for all entities in a fiscal year, if the Secretary determines that mitigating conditions exist that justify the waiver or reduction.

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[SEC. 319C-2. PARTNERSHIPS FOR COMMUNITY AND HOSPITAL PREPAREDNESS.

[(a) GRANTS.—The Secretary shall make awards of grants or cooperative agreements to eligible entities to enable such entities to improve community and hospital preparedness for bioterrorism and other public health emergencies.

[(b) ELIGIBILITY.—To be eligible for an award under subsection (a), an entity shall—

[(1) be a partnership consisting of—

[(A) one or more hospitals (including children's hospitals), clinics, health centers, or primary care facilities; and

[(B)(i) one or more political subdivisions of States;

[(ii) one or more States; or

[(iii) one or more States and one or more political subdivisions of States; and

[(2) prepare, in consultation with the Chief Executive Officer of the State, District, or territory in which the hospital, clinic, health center, or primary care facility described the paragraph (1)(A) is located, and submit to the Secretary, an application at such time, in such manner, and containing such information as the Secretary may require.

[(c) REGIONAL COORDINATION.—In making awards under subsection (a), the Secretary shall give preference to eligible entities that submit applications that, in the determination of the Secretary, will—

[(1) enhance coordination—

[(A) among the entities described in subsection (b)(1)(A); and

[(B) between such entities and the entities described in subsection (b)(1)(B); and

[(2) serve the needs of a defined geographic area.

[(d) CONSISTENCY OF PLANNED ACTIVITIES.—An entity described in subsection (b)(1) shall utilize amounts received under an award under subsection (a) in a manner that is coordinated and consistent, as determined by the Secretary, with an applicable State Bioterrorism and Other Public Health Emergency Preparedness and Response Plan.

[(e) USE OF FUNDS.—An award under subsection (a) may be expended for activities that may include the following and similar activities—

[(1) planning and administration for such award;

[(2) preparing a plan for triage and transport management in the event of bioterrorism or other public health emergencies;

[(3) enhancing the training of health care professionals to improve the ability of such professionals to recognize the symptoms of exposure to a potential bioweapon, to make appropriate diagnosis, and to provide treatment to those individuals so exposed;

[(4) enhancing the training of health care professionals to recognize and treat the mental health consequences of bioterrorism or other public health emergencies;

[(5) enhancing the training of health care professionals to assist in providing appropriate health care for large numbers of individuals exposed to a bioweapon;

[(6) enhancing training and planning to protect the health and safety of personnel involved in responding to a biological attack;

[(7) developing and implementing the trauma care and burn center care components of the State plans for the provision of emergency medical services; or

[(8) conducting such activities as are described in section 319C–1(d) that are appropriate for hospitals (including chil-

dren's hospitals), clinics, health centers, or primary care facilities.

[(f) LIMITATION ON AWARDS.—A political subdivision of a State shall not participate in more than one partnership described in subsection (b)(1).

[(g) PRIORITIES IN USE OF GRANTS.—

[(1) IN GENERAL.—

[(A) PRIORITIES.—Except as provided in subparagraph (B), the Secretary shall, in carrying out the activities described in this section, address the following hazards in the following priority:

[(i) Bioterrorism or acute outbreaks of infectious diseases.

[(ii) Other public health threats and emergencies.

[(B) DETERMINATION OF THE SECRETARY.—In the case of the hazard involved, the degree of priority that would apply to the hazard based on the categories specified in clauses (i) and (ii) of subparagraph (A) may be modified by the Secretary if the following conditions are met:

[(i) The Secretary determines that the modification is appropriate on the basis of the following factors:

[(I) The intent to which eligible entities are adequately prepared for responding to hazards within the category specified in clause (i) of subparagraph (A).

[(II) There has been a significant change in the assessment of risks to the public health posed by hazards within the category specified in clause (ii) of such subparagraph.

[(ii) Prior to modifying the priority, the Secretary notifies the appropriate committees of the Congress of the determination of the Secretary under clause (i) of this subparagraph.

[(2) AREAS OF EMPHASIS WITHIN CATEGORIES.—The Secretary shall determine areas of emphasis within the category of hazards specified in clause (i) of paragraph (1)(A), and shall determine in clause (ii) of such paragraph, based on an assessment of the risk and likely consequences of such hazards and on an evaluation of Federal, State, and local needs, and may also take into account the extent to which receiving an award under subsection (a) will develop capacities that can be used for public health emergencies of varying types.

[(h) COORDINATION WITH LOCAL MEDICAL RESPONSE SYSTEM.—An eligible entity and local Metropolitan Medical Response Systems shall, to the extent practicable, ensure that activities carried out under an award under subsection (a) are coordinated with activities that are carried out by local Metropolitan Medical Response Systems.

[(i) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2004 through 2006.]

SEC. 319C-2. PARTNERSHIPS FOR STATE AND REGIONAL HOSPITAL PREPAREDNESS TO IMPROVE SURGE CAPACITY.

(a) *IN GENERAL.*—The Secretary shall award competitive grants or cooperative agreements to eligible entities to enable such entities to improve surge capacity and enhance community and hospital preparedness for public health emergencies.

(b) *ELIGIBILITY.*—To be eligible for an award under subsection (a), an entity shall—

(1)(A) be a partnership consisting of—

(i) one or more hospitals, at least one of which shall be a designated trauma center, consistent with section 1213(c);

(ii) one or more other local health care facilities, including clinics, health centers, primary care facilities, mental health centers, mobile medical assets, or nursing homes; and

(iii)(I) one or more political subdivisions;

(II) one or more States; or

(III) one or more States and one or more political subdivisions; and

(B) prepare, in consultation with the Chief Executive Officer and the lead health officials of the State, District, or territory in which the hospital and health care facilities described in subparagraph (A) are located, and submit to the Secretary, an application at such time, in such manner, and containing such information as the Secretary may require; or

(2)(A) be an entity described in section 319C-1(b)(1); and

(B) submit an application at such time, in such manner, and containing such information as the Secretary may require, including the information or assurances required under section 319C-1(b)(2) and an assurance that the State will retain not more than 25 percent of the funds awarded for administrative and other support functions.

(c) *USE OF FUNDS.*—An award under subsection (a) shall be expended for activities to achieve the preparedness goals described under paragraphs (1), (3), (4), (5), and (6) of section 2802(b).

(d) *PREFERENCES.*—

(1) *REGIONAL COORDINATION.*—In making awards under subsection (a), the Secretary shall give preference to eligible entities that submit applications that, in the determination of the Secretary—

(A) will enhance coordination—

(i) among the entities described in subsection (b)(1)(A)(i); and

(ii) between such entities and the entities described in subsection (b)(1)(A)(ii); and

(B) include, in the partnership described in subsection (b)(1)(A), a significant percentage of the hospitals and health care facilities within the geographic area served by such partnership.

(2) *OTHER PREFERENCES.*—In making awards under subsection (a), the Secretary shall give preference to eligible entities that, in the determination of the Secretary—

(A) include one or more hospitals that are participants in the National Disaster Medical System;

(B) are located in a geographic area that faces a high degree of risk, as determined by the Secretary in consultation with the Secretary of Homeland Security; or

(C) have a significant need for funds to achieve the medical preparedness goals described in section 2802(b)(2).

(e) **CONSISTENCY OF PLANNED ACTIVITIES.**—The Secretary may not award a cooperative agreement to an eligible entity described in subsection (b)(1) unless the application submitted by the entity is coordinated and consistent with an applicable State All-Hazards Public Health Emergency Preparedness and Response Plan and relevant local plans, as determined by the Secretary in consultation with relevant State health officials.

(f) **LIMITATION ON AWARDS.**—A political subdivision shall not participate in more than one partnership described in subsection (b)(1).

(g) **COORDINATION WITH LOCAL RESPONSE CAPABILITIES.**—An eligible entity shall, to the extent practicable, ensure that activities carried out under an award under subsection (a) are coordinated with activities of relevant local Metropolitan Medical Response Systems, local Medical Reserve Corps, the Cities Readiness Initiative, and local emergency plans.

(h) **MAINTENANCE OF STATE FUNDING.**—

(1) **IN GENERAL.**—An entity that receives an award under this section shall maintain expenditures for health care preparedness at a level that is not less than the average level of such expenditures maintained by the entity for the preceding 2 year period.

(2) **RULE OF CONSTRUCTION.**—Nothing in this section shall be construed to prohibit the use of awards under this section to pay salary and related expenses of public health and other professionals employed by State, local, or tribal agencies who are carrying out activities supported by such awards (regardless of whether the primary assignment of such personnel is to carry out such activities).

(i) **PERFORMANCE AND ACCOUNTABILITY.**—The requirements of section 319C-1(g) and (i) shall apply to entities receiving awards under this section (regardless of whether such entities are described under subsection (b)(1)(A) or (b)(2)(A)) in the same manner as such requirements apply to entities under section 319C-1.

(j) **AUTHORIZATION OF APPROPRIATIONS.**—

(1) **IN GENERAL.**—For the purpose of carrying out this section, there is authorized to be appropriated \$474,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.

(2) **RESERVATION OF AMOUNTS FOR PARTNERSHIPS.**—Prior to making awards described in paragraph (3), the Secretary may reserve from the amount appropriated under paragraph (1) for a fiscal year, an amount determined appropriate by the Secretary for making awards to entities described in subsection (b)(1)(A).

(3) **AWARDS TO STATES AND POLITICAL SUBDIVISIONS.**—

(A) **IN GENERAL.**—From amounts appropriated for a fiscal year under paragraph (1) and not reserved under paragraph (2), the Secretary shall make awards to entities described in subsection (b)(2)(A) that have completed an application as described in subsection (b)(2)(B).

(B) AMOUNT.—*The Secretary shall determine the amount of an award to each entity described in subparagraph (A) in the same manner as such amounts are determined under section 319C–1(h).*

SEC. 319D. REVITALIZING THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) FACILITIES; CAPACITIES.—

(1) FINDINGS.—Congress finds that the Centers for Disease Control and Prevention has an essential role in defending against and combatting public health threats *domestically and abroad* and requires secure and modern facilities, and expanded and improve capabilities related to bioterrorism and other public health emergencies, sufficient to enable such Centers to conduct this important mission.

* * * * *

(c) * * *

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(d) PUBLIC HEALTH SITUATIONAL AWARENESS.—

(1) IN GENERAL.—*Not later than 2 years after the date of enactment of the Pandemic and All-Hazards Preparedness Act, the Secretary, in collaboration with State, local, and tribal public health officials, shall 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.*

(2) STRATEGIC PLAN.—*Not later than 180 days after the date of enactment the Pandemic and All-Hazards Preparedness Act, the Secretary shall submit to the appropriate committees of Congress, a strategic plan that demonstrates the steps the Secretary will undertake to develop, implement, and evaluate the network described in paragraph (1), utilizing the elements described in paragraph (3).*

(3) ELEMENTS.—*The network described in paragraph (1) shall include data and information transmitted in a standardized format from—*

(A) *State, local, and tribal public health entities, including public health laboratories;*

(B) *Federal health agencies;*

(C) *zoonotic disease monitoring systems;*

(D) *public and private sector health care entities, hospitals, pharmacies, poison control centers or professional organizations in the field of poison control, and clinical laboratories, to the extent practicable and provided that such data are voluntarily provided simultaneously to the Secretary and appropriate State, local, and tribal public health agencies; and*

(E) *such other sources as the Secretary may deem appropriate.*

(4) *RULE OF CONSTRUCTION.*—Paragraph (3) shall not be construed as requiring separate reporting of data and information from each source listed.

(5) *REQUIRED ACTIVITIES.*—In establishing and operating the network described in paragraph (1), the Secretary shall—

(A) utilize applicable interoperability standards as determined by the Secretary through a joint public and private sector process;

(B) define minimal data elements for such network;

(C) in collaboration with State, local, and tribal public health officials, integrate and build upon existing State, local, and tribal capabilities, ensuring simultaneous sharing of data, information, and analyses from the network described in paragraph (1) with State, local, and tribal public health agencies; and

(D) in collaboration with State, local, and tribal public health officials, develop procedures and standards for the collection, analysis, and interpretation of data that States, regions, or other entities collect and report to the network described in paragraph (1).

(e) *STATE AND REGIONAL SYSTEMS TO ENHANCE SITUATIONAL AWARENESS IN PUBLIC HEALTH EMERGENCIES.*—

(1) *IN GENERAL.*—To implement the network described in section (d), the Secretary may award grants to States to enhance the ability of such States to establish or operate a coordinated public health situational awareness system for regional or Statewide early detection of, rapid response to, and management of potentially catastrophic infectious disease outbreaks and public health emergencies, in collaboration with public health agencies, sentinel hospitals, clinical laboratories, pharmacies, poison control centers, other health care organizations, and animal health organizations within such States.

(2) *ELIGIBILITY.*—To be eligible to receive a grant under paragraph (1), the State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including an assurance that the State will submit to the Secretary—

(A) reports of such data, information, and metrics as the Secretary may require;

(B) a report on the effectiveness of the systems funded under the grant; and

(C) a description of the manner in which grant funds will be used to enhance the timelines and comprehensiveness of efforts to detect, respond to, and manage potentially catastrophic infectious disease outbreaks and public health emergencies.

(3) *USE OF FUNDS.*—A State that receives an award under this subsection—

(A) shall establish, enhance, or operate a coordinated public health situational awareness system for regional or Statewide early detection of, rapid response to, and management of potentially catastrophic infectious disease outbreaks and public health emergencies; and

(B) may award grants or contracts to entities described in paragraph (1) within or serving such State to assist such

entities in improving the operation of information technology systems, facilitating the secure exchange of data and information, and training personnel to enhance the operation of the system described in paragraph (A).

(4) *LIMITATION.*—Information technology systems acquired or implemented using grants awarded under this section must be compliant with—

(A) interoperability and other technological standards, as determined by the Secretary; and

(B) data collection and reporting requirements for the network described in subsection (d).

(5) *INDEPENDENT EVALUATION.*—Not later than 4 years after the date of enactment of the Pandemic and All-Hazards Preparedness Act, the Government Accountability Office shall conduct an independent evaluation, and submit to the Secretary and the appropriate committees of Congress a report, concerning the activities conducted under this subsection and subsection (d).

(f) *GRANTS FOR REAL-TIME SURVEILLANCE IMPROVEMENT.*—

(1) *IN GENERAL.*—The Secretary may award grants to eligible entities to carry out projects described under paragraph (4).

(2) *ELIGIBLE ENTITY.*—For purposes of this section, the term “eligible entity” means an entity that is—

(A)(i) a hospital, clinical laboratory, university; or

(ii) poison control center or professional organization in the field of poison control; and

(B) a participant in the network established under subsection (d).

(3) *APPLICATION.*—Each eligible entity desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(4) *USE OF FUNDS.*—

(A) *IN GENERAL.*—An eligible entity described in paragraph (2)(A)(i) that receives a grant under this section shall use the funds awarded pursuant to such grant to carry out a pilot demonstration project to purchase and implement the use of advanced diagnostic medical equipment to analyze real-time clinical specimens for pathogens of public health or bioterrorism significance and report any results from such project to State, local, and tribal public health entities and the network established under subsection (d).

(B) *OTHER ENTITIES.*—An eligible entity described in paragraph (2)(A)(ii) that receives a grant under this section shall use the funds awarded pursuant to such grant to—

(i) improve the early detection, surveillance, and investigative capabilities of poison control centers for chemical, biological, radiological, and nuclear events by training poison information personnel to improve the accuracy of surveillance data, improving the definitions used by the poison control centers for surveillance, and enhancing timely and efficient investigation of data anomalies;

(ii) improve the capabilities of poison control centers to provide information to health care providers and the

public with regard to chemical, biological, radiological, or nuclear threats or exposures, in consultation with the appropriate State, local, and tribal public health entities; or

(iii) provide surge capacity in the event of a chemical, biological, radiological, or nuclear event through the establishment of alternative poison control center worksites and the training of nontraditional personnel.

(g) **AUTHORIZATION OF APPROPRIATIONS.**—

(1) **FISCAL YEAR 2007.**—*There are authorized to be appropriated to carry out subsections (d), (e), and (f) \$102,000,000 for fiscal year 2007, of which \$35,000,000 is authorized to be appropriated to carry out subsection (f).*

(2) **SUBSEQUENT FISCAL YEARS.**—*There are authorized to be appropriated such sums as may be necessary to carry out subsections (d), (e), and (f) for each of fiscal years 2008 through 2011.*

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SEC. 319F. PUBLIC HEALTH COUNTERMEASURES TO A BIO-TERRORIST ATTACK.

[(a) WORKING GROUP ON BIOTERRORISM AND OTHER PUBLIC HEALTH EMERGENCIES.—

[(1) IN GENERAL.—The Secretary, in coordination with the Secretary of Agriculture, the Attorney General, the Director of Central Intelligence, the Secretary of Defense, the Secretary of Energy, the Administrator of the Environmental Protection Agency, the Director of the Federal Emergency Management Agency, the Secretary of Homeland Security, the Secretary of Labor, the Secretary of Veterans Affairs, and with other similar Federal officials as determined appropriate, shall establish a working group on the prevention, preparedness, and response to bioterrorism and other public health emergencies. Such joint working group, or subcommittees thereof, shall meet periodically for the purpose of consultation on, assisting in, and making recommendations on—

[(A) responding to a bioterrorist attack, including the provision of appropriate safety and health training and protective measures for medical, emergency service, and other personnel responding to such attacks;

[(B) prioritizing countermeasures required to treat, prevent, or identify exposure to a biological agent or toxin pursuant to section 351A;

[(C) facilitation of the awarding of grants, contracts, or cooperative agreements for the development, manufacture, distribution, supply-chain management, and purchase of priority countermeasures;

[(D) research on pathogens likely to be used in a biological threat on the civilian population;

[(E) development of shared standards for equipment to detect and to protect against biological agents and toxins;

[(F) assessment of the priorities for and enhancement of the preparedness of public health institutions, providers of medical care, and other emergency service personnel (including firefighters) to detect, diagnose, and respond (in-

cluding mental health response) to a biological threat or attack;

[(G) in the recognition that medical and public health professionals are likely to provide much of the first response to such an attack, development and enhancement of the quality of joint planning and training programs that address the public health and medical consequences of a biological threat or attack on the civilian population between—

[(i) local firefighters, ambulance personnel, police and public security officers, or other emergency response personnel (including private response contractors); and

[(ii) hospitals, primary care facilities, and public health agencies;

[(H) development of strategies for Federal, State, and local agencies to communicate information to the public regarding biological threats or attacks;

[(I) ensuring that the activities under this subsection address the health security needs of children and other vulnerable populations;

[(J) strategies for decontaminating facilities contaminated as a result of a biological attack, including appropriate protections for the safety of workers conducting such activities;

[(K) subject to compliance with other provisions of Federal law, clarifying the responsibilities among Federal officials for the investigation of suspicious outbreaks of disease and other potential public health emergencies, and for related revisions of the interagency plan known as the Federal response plan; and

[(L) in consultation with the National Highway Traffic Safety Administration and the U.S. Fire Administration, ways to enhance coordination among Federal agencies involved with State, local and community based emergency medical services, including issuing a report that—

[(i) identifies needs of community-based emergency medical services; and

[(ii) identifies ways to streamline and enhance the process through which Federal agencies support community-based emergency medical services.

[(2) CONSULTATION WITH EXPERTS.—In carrying out subparagraphs (B) and (C) of paragraph (1), the working group under such paragraph shall consult with the pharmaceutical, biotechnology, and medical device industries, and other appropriate experts.

[(3) USE OF SUBCOMMITTEES REGARDING CONSULTATION REQUIREMENTS.—With respect to a requirement under law that the working group under paragraph (1) be consulted on a matter, the working group may designate an appropriate subcommittee of the working group to engage in the consultation.

[(4) DISCRETION IN EXERCISE OF DUTIES.—Determinations made by the working group under paragraph (1) with respect to carrying out duties under such paragraph are matters com-

mitted to agency discretion for purposes of section 701(a) of title 5, United States Code.

【(5) RULE OF CONSTRUCTION.—This subsection may not be construed as establishing new regulatory authority for any of the officials specified in paragraph (1), or as having any legal effect on any other provision of law, including the responsibilities and authorities of the Environmental Protection Agency.】

(a) *ALL-HAZARDS PUBLIC HEALTH AND MEDICAL RESPONSE CURRICULA AND TRAINING.*—

(1) *IN GENERAL.*—*The Secretary, in collaboration with the Secretary of Defense, and in consultation with relevant public and private entities, shall develop core health and medical response curricula and trainings by adapting applicable existing curricula and training programs to improve responses to public health emergencies.*

(2) *CURRICULUM.*—*The public health and medical response training program may include course work related to—*

(A) *medical management of casualties, taking into account the needs of at-risk individuals;*

(B) *public health aspects of public health emergencies;*

(C) *mental health aspects of public health emergencies;*

(D) *national incident management, including coordination among Federal, State, local, tribal, international agencies, and other entities; and*

(E) *protecting health care workers and health care first responders from workplace exposures during a public health emergency.*

(3) *PEER REVIEW.*—*On a periodic basis, products prepared as part of the program shall be rigorously tested and peer-reviewed by experts in the relevant fields.*

(4) *CREDIT.*—*The Secretary and the Secretary of Defense shall—*

(A) *take into account continuing professional education requirements of public health and healthcare professions; and*

(B) *cooperate with State, local, and tribal accrediting agencies and with professional associations in arranging for students enrolled in the program to obtain continuing professional education credit for program courses.*

(5) *DISSEMINATION AND TRAINING.*—

(A) *IN GENERAL.*—*The Secretary may provide for the dissemination and teaching of the materials described in paragraphs (1) and (2) by appropriate means, as determined by the Secretary.*

(B) *CERTAIN ENTITIES.*—*The education and training activities described in subparagraph (A) may be carried out by Federal public health or medical entities, appropriate educational entities, professional organizations and societies, private accrediting organizations, and other nonprofit institutions or entities meeting criteria established by the Secretary.*

(C) *GRANTS AND CONTRACTS.*—*In carrying out this subsection, the Secretary may carry out activities directly or through the award of grants and contracts, and may enter into interagency agreements with other Federal agencies.*

(b) ADVICE TO THE FEDERAL GOVERNMENT.—

(1) REQUIRED ADVISORY COMMITTEES.—* * *

(2) NATIONAL ADVISORY COMMITTEE ON **CHILDREN AND TERRORISM** *AT-RISK INDIVIDUALS AND PUBLIC HEALTH EMERGENCIES*.—

(A) IN GENERAL.—For purposes of paragraph (1), the Secretary shall establish an advisory committee to be known as the National Advisory Committee on **Children and Terrorism** *At-Risk Individuals and Public Health Emergencies* (referred to in this paragraph as the “Advisory Committee”).

(B) DUTIES.—The Advisory Committee shall provide recommendations regarding—

(i) the preparedness of the health care (including mental health care) system to respond to **bioterrorism as it relates to children** *public health emergencies as they relate to at-risk individuals*;

(ii) needed changes to the health care and emergency medical service systems and emergency medical services protocols to meet the special needs of **children** *at-risk individuals*; and

(iii) changes, if necessary, to the national stockpile under section 121 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 to meet the emergency health security of **children** *at-risk individuals*.

(C) COMPOSITION.—The Advisory Committee shall be composed of such Federal officials as may be appropriate to address the special needs of the diverse population groups of **children, and child health experts on infectious disease, environmental health, toxicology, and other relevant professional disciplines** *at-risk populations*.

(D) TERMINATION.—The Advisory Committee terminates **one year** *six years* after the date of the enactment of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.

* * * * *

(3) EMERGENCY PUBLIC INFORMATION AND COMMUNICATIONS ADVISORY COMMITTEE.—

(A) IN GENERAL.—* * *

* * * * *

(B) DUTIES.—The EPIC Advisory Committee shall make recommendations to the Secretary **and the working group under subsection (a)** and report on appropriate ways to communicate public health information regarding bioterrorism and other public health emergencies to the public.

* * * * *

[(c) STRATEGY FOR COMMUNICATION OF INFORMATION REGARDING BIOTERRORISM AND OTHER PUBLIC HEALTH EMERGENCIES.—In coordination with working group under subsection (a), the Secretary shall develop a strategy for effectively communicating information regarding bioterrorism and other public health emergencies, and shall develop means by which to communicate such information.

The Secretary may carry out the preceding sentence directly or through grants, contracts, or cooperative agreements.

[(d) RECOMMENDATION OF CONGRESS REGARDING OFFICIAL FEDERAL INTERNET SITE ON BIOTERRORISM.—It is the recommendation of Congress that there should be established an official Federal Internet site on bioterrorism, either directly or through provision of a grant to an entity that has expertise in bioterrorism and the development of websites, that should include information relevant to diverse populations (including messages directed at the general public and such relevant groups as medical personnel, public safety workers, and agricultural workers) and links to appropriate State and local government sites.

[(e) GRANTS.—

[(1) IN GENERAL.—The Secretary, in coordination with the working group established under subsection (b)¹, shall, on a competitive basis and following scientific or technical review, award grants to or enter into cooperative agreements with eligible entities to enable such entities to increase their capacity to detect, diagnose, and respond to acts of bioterrorism upon the civilian population.

[(2) ELIGIBILITY.—To be an eligible entity under this subsection, such entity must be a State, political subdivision of a State, a consortium of two or more States or political subdivisions of States, or a hospital, clinic, or primary care facility².

[(3) USE OF FUNDS.—An entity that receives a grant under this subsection shall use such funds for activities that are consistent with the priorities identified by the working group under subsection (b)³, including—

[(A) training health care professionals and public health personnel to enhance the ability of such personnel to recognize the symptoms and epidemiological characteristics of exposure to a potential bioweapon;

[(B) addressing rapid and accurate identification of potential bioweapons;

[(C) coordinating medical care for individuals exposed to bioweapons; and

[(D) facilitating and coordinating rapid communication of data generated from a bioterrorist attack between national, State, and local health agencies, and health care providers.

[(4) COORDINATION.—The Secretary, in awarding grants under this subsection, shall—

[(A) notify the Director of the Office of Justice Programs, and the Director of the National Domestic Preparedness Office annually as to the amount and status of grants awarded under this subsection; and

[(B) coordinate grants awarded under this subsection with grants awarded by the Office of Emergency Preparedness and the Centers for Disease Control and Prevention for the purpose of improving the capacity of health care providers and public health agencies to respond to bioterrorist attacks on the civilian population.

[(5) ACTIVITIES.—An entity that receives a grant under this subsection shall, to the greatest extent practicable, coordinate

activities carried out with such funds with the activities of a local Metropolitan Medical Response System.

[(f) FEDERAL ASSISTANCE.—The Secretary shall ensure that the Department of Health and Human Services is able to provide such assistance as may be needed to State and local health agencies to enable such agencies to respond effectively to bioterrorist attacks.

[(g) EDUCATION; TRAINING REGARDING PEDIATRIC ISSUES.—

[(1) MATERIALS; CORE CURRICULUM.—The Secretary, in collaboration with members of the working group described in subsection (b)¹, and professional organizations and societies, shall—

[(A) develop materials for teaching the elements of a core curriculum for the recognition and identification of potential bioweapons and other agents that may create a public health emergency, and for the care of victims of such emergencies, recognizing the special needs of children and other vulnerable populations, to public health officials, medical professionals, emergency physicians and other emergency department staff, laboratory personnel, and other personnel working in health care facilities (including poison control centers);

[(B) develop a core curriculum and materials for community-wide planning by State and local governments, hospitals and other health care facilities, emergency response units, and appropriate public and private sector entities to respond to a bioterrorist attack or other public health emergency; and

[(C) develop materials for proficiency testing of laboratory and other public health personnel for the recognition and identification of potential bioweapons and other agents that may create a public health emergency; and

[(D) provide for dissemination and teaching of the materials described in subparagraphs (A) through (C) by appropriate means, which may include telemedicine, long-distance learning, or other such means.

[(2) CERTAIN ENTITIES.—The entities through which education and training activities described in paragraph (1) may be carried out include Public Health Preparedness Centers, the Public Health Service's Noble Training Center, the Emerging Infections Program, the Epidemic Intelligence Service, the Public Health Leadership Institute, multi-State, multi-institutional consortia, other appropriate educational entities, professional organizations and societies, private accrediting organizations, and other nonprofit institutions or entities meeting criteria established by the Secretary.

[(3) GRANTS AND CONTRACTS.—In carrying out paragraph (1), the Secretary may carry out activities directly and through the award of grants and contracts, and may enter into interagency cooperative agreements with other Federal agencies.

[(4) HEALTH-RELATED ASSISTANCE FOR EMERGENCY RESPONSE PERSONNEL TRAINING.—The Secretary, in consultation with the Attorney General and the Director of the Federal Emergency Management Agency, may provide technical assistance with respect to health-related aspects of emergency response per-

sonnel training carried out by the Department of Justice and the Federal Emergency Management Agency.】

“(c) *EXPANSION OF EPIDEMIC INTELLIGENCE SERVICE PROGRAM.*—The Secretary may establish 20 officer positions in the Epidemic Intelligence Service Program, in addition to the number of the officer positions offered under such Program in 2006, for individuals who agree to participate, for a period of not less than 2 years, in the Career Epidemiology Field Officer program in a State, local, or tribal health department that serves a health professional shortage area (as defined under section 332(a)), a medically underserved population (as defined under section 330(b)(3)), or a medically underserved area or area at high risk of a public health emergency as designated by the Secretary.

(d) *CENTERS FOR PUBLIC HEALTH PREPAREDNESS; CORE CURRICULA AND TRAINING.*—

(1) *IN GENERAL.*—The Secretary may establish at accredited schools of public health, Centers for Public Health Preparedness (hereafter referred to in this section as the “Centers”).

(2) *ELIGIBILITY.*—To be eligible to receive an award under this subsection to establish a Center, an accredited school of public health shall agree to conduct activities consistent with the requirements of this subsection.

(3) *CORE CURRICULA.*—The Secretary, in collaboration with the Centers and other public or private entities shall establish core curricula based on established competencies leading to a 4-year bachelor’s degree, a graduate degree, a combined bachelor and master’s degree, or a certificate program, for use by each Center. The Secretary shall disseminate such curricula to other accredited schools of public health and other health professions schools determined appropriate by the Secretary, for voluntary use by such schools.

(4) *CORE COMPETENCY-BASED TRAINING PROGRAM.*—The Secretary, in collaboration with the Centers and other public or private entities shall facilitate the development of a competency-based training program to train public health practitioners. The Centers shall use such training program to train public health practitioners. The Secretary shall disseminate such training program to other accredited schools of public health, health professions schools, and other public or private entities as determined by the Secretary, for voluntary use by such entities.

(5) *CONTENT OF CORE CURRICULA AND TRAINING PROGRAM.*—The Secretary shall ensure that the core curricula and training program established pursuant to this subsection respond to the needs of State, local, and tribal public health authorities and integrate and emphasize essential public health security capabilities consistent with section 2802(c)(2).

(6) *ACADEMIC-WORKFORCE COMMUNICATION.*—As a condition of receiving funding from the Secretary under this subsection, a Center shall collaborate with a State, local, or tribal public health department to—

(A) define the public health preparedness and response needs of the community involved;

(B) assess the extent to which such needs are fulfilled by existing preparedness and response activities of such school

or health department, and how such activities may be improved;

(C) prior to developing new materials or trainings, evaluate and utilize relevant materials and trainings developed by other Centers; and

(D) evaluate community impact and the effectiveness of any newly developed materials or trainings.

(7) **PUBLIC HEALTH SYSTEMS RESEARCH.**—In consultation with relevant public and private entities, the Secretary shall define the existing knowledge base for public health preparedness and response systems, and establish a research agenda based on Federal, State, local, and tribal public health preparedness priorities. As a condition of receiving funding from the Secretary under this subsection, a Center shall conduct public health systems research that is consistent with the agenda described under this paragraph.

[(h)](e) ACCELERATED RESEARCH AND DEVELOPMENT ON PRIORITY PATHOGENS AND COUNTERMEASURES.—

(1) **IN GENERAL.**—* * *

* * * * *

(f) **AUTHORIZATION OF APPROPRIATIONS.**—

(1) **FISCAL YEAR 2007.**—There are authorized to be appropriated to carry out this section for fiscal year 2007—

(A) to carry out subsection (a)—

(i) \$5,000,000 to carry out paragraphs (1) through (4); and

(ii) \$7,000,000 to carry out paragraph (5);

(B) to carry out subsection (c), \$3,000,000; and

(C) to carry out subsection (d), \$31,000,000, of which \$5,000,000 shall be used to carry out paragraphs (3) through (5) of such subsection.

(2) **SUBSEQUENT FISCAL YEARS.**—There are authorized to be appropriated such sums as may be necessary to carry out this section for fiscal year 2008 and each subsequent fiscal year.

[(i) GENERAL ACCOUNTING OFFICE REPORT¹.—Not later than 180 days after the date of the enactment of this section, the Comptroller General shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate and the Committee on Commerce and the Committee on Appropriations of the House of Representatives a report that describes—

[(1) Federal activities primarily related to research on, preparedness for, and the management of the public health and medical consequences of a bioterrorist attack against the civilian population;

[(2) the coordination of the activities described in paragraph (1);

[(3) the amount of Federal funds authorized or appropriated for the activities described in paragraph (1); and

[(4) the effectiveness of such efforts in preparing national, State, and local authorities to address the public health and medical consequences of a potential bioterrorist attack against the civilian population.

[(j) SUPPLEMENT NOT SUPPLANT.—Funds appropriated under this section shall be used to supplement and not supplant other

Federal, State, and local public funds provided for activities under this section.】

* * * * *

SEC. 319I. EMERGENCY SYSTEM FOR ADVANCE REGISTRATION OF HEALTH PROFESSIONS VOLUNTEERS.

【(a) **IN GENERAL.**—The Secretary shall, directly or through an award of a grant, contract, or cooperative agreement, establish and maintain a system for the advance registration of health professionals for the purpose of verifying the credentials, licenses, accreditations, and hospital privileges of such professionals when, during public health emergencies, the professionals volunteer to provide health services (referred to in this section as the “verification system”). In carrying out the preceding sentence, the Secretary shall provide for an electronic database for the verification system.

【(b) **CERTAIN CRITERIA.**—The Secretary shall establish provisions regarding the promptness and efficiency of the system in collecting, storing, updating, and disseminating information on the credentials, licenses, accreditations, and hospital privileges of volunteers described in subsection (a).】

(a) IN GENERAL.—Not later than 12 months after the date of enactment of the Pandemic and All-Hazards Preparedness Act, the Secretary shall link existing State verification systems to maintain a single national interoperable network of systems, each system being maintained by a State or group of States, for the purpose of verifying the credentials and licenses of health care professionals who volunteer to provide health services during a public health emergency (such network shall be referred to in this section as the “verification network”).

(b) REQUIREMENTS.—The interoperable network of systems established under subsection (a) shall include—

(1) with respect to each volunteer health professional included in the system—

(A) information necessary for the rapid identification of, and communication with, such professionals; and

(B) the credentials, certifications, licenses, and relevant training of such individuals; and

(2) the name of each member of the Medical Reserve Corps, the National Disaster Medical System, and any other relevant federally-sponsored or administered programs determined necessary by the Secretary.

(c) **OTHER ASSISTANCE.**—The Secretary may make grants and provide technical assistance to States and other public or nonprofit private entities for activities relating to the verification 【system】 network developed under subsection (a).

【(d) **COORDINATION AMONG STATES.**—The Secretary may encourage each State to provide legal authority during a public health emergency for health professionals authorized in another State to provide certain health services to provide such health services in the State.】

(d) ACCESSIBILITY.—The Secretary shall ensure that the network established under subsection (a) is electronically accessible by State, local, and tribal health departments and can be linked with the identification cards under section 2813.

(e) *CONFIDENTIALITY.*—The Secretary shall establish and require the application of and compliance with measures to ensure the effective security of, integrity of, and access to the data included in the network.

(f) *COORDINATION.*—The Secretary shall coordinate with the Secretary of Veterans Affairs and the Secretary of Homeland Security to assess the feasibility of integrating the verification network under this section with the VetPro system of the Department of Veterans Affairs and the National Emergency Responder Credentialing System of the Department of Homeland Security. The Secretary shall, if feasible, integrate the verification network under this section with such VetPro system and the National Emergency Responder Credentialing System.

(g) *UPDATING OF INFORMATION.*—The States that are participants in the network established under subsection (a) shall, on at least a quarterly basis, work with the Director to provide for the updating of the information contained in such network.

(h) *CLARIFICATION.*—Inclusion of a health professional in the verification network established pursuant to this section shall not constitute appointment of such individual as a Federal employee for any purpose, either under section 2812(c) or otherwise. Such appointment may only be made under section 2812 or 2813.

(i) *HEALTH CARE PROVIDER LICENSES.*—The Secretary shall encourage States to establish and implement mechanisms to waive the application of licensing requirements applicable to health professionals, who are seeking to provide medical services (within their scope of practice), during a national, State, local, or tribal public health emergency upon verification that such health professionals are licensed and in good standing in another State and have not been disciplined by any State health licensing or disciplinary board.

[(e)] (j) *RULE OF CONSTRUCTION.*—This section may not be construed as authorizing the Secretary to issue requirements regarding the provision by the States of credentials, licenses, accreditations, or hospital privileges.

[(f)] (k) *AUTHORIZATION OF APPROPRIATIONS.*—For the purpose of carrying out this section, there are authorized to be appropriated \$2,000,000 for fiscal year 2002, and such sums as may be necessary for each of the fiscal years 2003 through [2006] 2011.

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PART D—PRIMARY HEALTH CARE

Subpart I—Health Centers

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Subpart III—Scholarship Program and Loan Repayment Program

NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM

SEC. 338A. * * *

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SEC. 338I. GRANTS TO STATES FOR LOAN REPAYMENT PROGRAMS.

(a) IN GENERAL.—

(1) AUTHORITY FOR GRANTS.—* * *

* * * * *

(i) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—* * *

* * * * *

(j) PUBLIC HEALTH LOAN REPAYMENT.—

(1) IN GENERAL.—*The Secretary may award grants to States for the purpose of assisting such States in operating loan repayment programs under which such States enter into contracts to repay all or part of the eligible loans borrowed by, or on behalf of, individuals who agree to serve in State, local, or tribal health departments that serve health professional shortage areas or other areas at risk of a public health emergency, as designated by the Secretary.*

(2) LOANS ELIGIBLE FOR REPAYMENT.—*To be eligible for repayment under this subsection, a loan shall be a loan made, insured, or guaranteed by the Federal Government that is borrowed by, or on behalf of, an individual to pay the cost of attendance for a program of education leading to a degree appropriate for serving in a State, local, or tribal health department as determined by the Secretary and the chief executive officer of the State in which the grant is administered, at an institution of higher education (as defined in section 102 of the Higher Education Act of 1965), including principal, interest, and related expenses on such loan.*

(3) APPLICABILITY OF EXISTING REQUIREMENTS.—*With respect to awards made under paragraph (1)—*

(A) the requirements of subsections (b), (f), and (g) shall apply to such awards; and

(B) the requirements of subsection (c) shall apply to such awards except that with respect to paragraph (1) of such subsection, the State involved may assign an individual only to public and nonprofit private entities that serve health professional shortage areas or areas at risk of a public health emergency, as determined by the Secretary.

(4) AUTHORIZATION OF APPROPRIATIONS.—*There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2007 through 2010.*

SEC. 338L. DEMONSTRATION PROJECT.

(a) PROGRAM AUTHORIZED.* * *

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SEC. 338M. PUBLIC HEALTH DEPARTMENTS.

(a) IN GENERAL.—*To the extent that funds are appropriated under subsection (e), the Secretary shall establish a demonstration project to provide for the participation of individuals who are eligible for the Loan Repayment Program described in section 338B and who agree to complete their service obligation in a State health department that provides a significant amount of service to health professional shortage areas or areas at risk of a public health emergency, as determined by the Secretary, or in a local or tribal health depart-*

ment that serves a health professional shortage area or an area at risk of a public health emergency.

(b) *PROCEDURE.*—To be eligible to receive assistance under subsection (a), with respect to the program described in section 338B, an individual shall—

(1) comply with all rules and requirements described in such section (other than section 338B(f)(1)(B)(iv)); and

(2) agree to serve for a time period equal to 2 years, or such longer period as the individual may agree to, in a State, local, or tribal health department, described in subsection (a).

(c) *DESIGNATIONS.*—The demonstration project described in subsection (a), and any healthcare providers who are selected to participate in such project, shall not be considered by the Secretary in the designation of health professional shortage areas under section 332 during fiscal years 2007 through 2010.

(d) *REPORT.*—Not later than 3 years after the date of enactment of this section, the Secretary shall submit a report to the relevant committees of Congress that evaluates the participation of individuals in the demonstration project under subsection (a), the impact of such participation on State, local, and tribal health departments, and the benefit and feasibility of permanently allowing such placements in the Loan Repayment Program.

(e) *AUTHORIZATION OF APPROPRIATIONS.*—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2007 through 2010.

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[TITLE XXVIII—NATIONAL PREPAREDNESS FOR BIOTERRORISM AND OTHER PUBLIC HEALTH EMERGENCIES]

TITLE XXVIII—NATIONAL ALL-HAZARDS PREPAREDNESS FOR PUBLIC HEALTH EMERGENCIES

[Subtitle A—National Preparedness and Response Planning, Coordinating, and Reporting

[SEC. 2801. NATIONAL PREPAREDNESS PLAN.

[(a) IN GENERAL.—

[(1) PREPAREDNESS AND RESPONSE REGARDING PUBLIC HEALTH EMERGENCIES.—The Secretary shall further develop and implement a coordinated strategy, building upon the core public health capabilities established pursuant to section 319A, for carrying out health-related activities to prepare for and respond effectively to bioterrorism and other public health emergencies, including the preparation of a plan under this section. The Secretary shall periodically thereafter review and, as appropriate, revise the plan.

[(2) NATIONAL APPROACH.—In carrying out paragraph (1), the Secretary shall collaborate with the States toward the goal of ensuring that the activities of the Secretary regarding bio-

terrorism and other public health emergencies are coordinated with activities of the States, including local governments.

[(3) EVALUATION OF PROGRESS.—The plan under paragraph (2) shall provide for specific benchmarks and outcome measures for evaluating the progress of the Secretary and the States, including local governments, with respect to the plan under paragraph (1), including progress toward achieving the goals specified in subsection (b).

[(b) PREPAREDNESS GOALS.—The plan under subsection (a) should include provisions in furtherance of the following:

[(1) Providing effective assistance to State and local governments in the event of bioterrorism or other public health emergency.

[(2) Ensuring that State and local governments have appropriate capacity to detect and respond effectively to such emergencies, including capacities for the following:

[(A) Effective public health surveillance and reporting mechanisms at the State and local levels.

[(B) Appropriate laboratory readiness.

[(C) Properly trained and equipped emergency response, public health, and medical personnel.

[(D) Health and safety protection of workers responding to such an emergency.

[(E) Public health agencies that are prepared to coordinate health services (including mental health services) during and after such emergencies.

[(F) Participation in communications networks that can effectively disseminate relevant information in a timely and secure manner to appropriate public and private entities and to the public.

[(3) Developing and maintaining medical countermeasures (such as drugs, vaccines and other biological products, medical devices, and other supplies) against biological agents and toxins that may be involved in such emergencies.

[(4) Ensuring coordination and minimizing duplication of Federal, State, and local planning, preparedness, and response activities, including during the investigation of a suspicious disease outbreak or other potential public health emergency.

[(5) Enhancing the readiness of hospitals and other health care facilities to respond effectively to such emergencies.

[(c) REPORTS TO CONGRESS.—

[(1) IN GENERAL.—Not later than one year after the date of the enactment of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, and biennially thereafter, the Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives, and the Committee on Health, Education, Labor, and Pensions of the Senate, a report concerning progress with respect to the plan under subsection (a), including progress toward achieving the goals specified in subsection (b).

[(2) ADDITIONAL AUTHORITY.—Reports submitted under paragraph (1) by the Secretary (other than the first report) shall make recommendations concerning—

[(A) any additional legislative authority that the Secretary determines is necessary for fully implementing the

plan under subsection (a), including meeting the goals under subsection (b); and

[(B) any additional legislative authority that the Secretary determines is necessary under section 319 to protect the public health in the event of an emergency described in section 319(a).

[(d) **RULE OF CONSTRUCTION.**—This section may not be construed as expanding or limiting any of the authorities of the Secretary that, on the day before the date of the enactment of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, were in effect with respect to preparing for and responding effectively to bioterrorism and other public health emergencies.]

Subtitle A—National All-Hazards Preparedness and Response Planning, Coordinating, and Reporting

SEC. 2801. PUBLIC HEALTH AND MEDICAL PREPAREDNESS AND RESPONSE FUNCTIONS.

(a) **IN GENERAL.**—*The Secretary of Health and Human Services shall lead all Federal public health and medical response to public health emergencies and incidents covered by the National Response Plan developed pursuant to section 502(6) of the Homeland Security Act of 2002, or any successor plan.*

(b) **INTERAGENCY AGREEMENT.**—*The Secretary, in collaboration with the Secretary of Veterans Affairs, the Secretary of Transportation, the Secretary of Defense, the Secretary of Homeland Security, and the head of any other relevant Federal agency, shall establish an interagency agreement, consistent with the National Response Plan or any successor plan, under which agreement the Secretary of Health and Human Services shall assume operational control of emergency public health and medical response assets, as necessary, in the event of a public health emergency.*

SEC. 2802. NATIONAL HEALTH SECURITY STRATEGY.

(a) **IN GENERAL.**—

(1) **PREPAREDNESS AND RESPONSE REGARDING PUBLIC HEALTH EMERGENCIES.**—*Beginning in 2009 and every 4 years thereafter, the Secretary shall prepare and submit to the relevant Committees of Congress a coordinated strategy and any revisions thereof, and an accompanying implementation plan for public health emergency preparedness and response. The strategy shall identify the process for achieving the preparedness goals described in subsection (b) and shall be consistent with the National Preparedness Goal, the National Incident Management System, and the National Response Plan developed pursuant to section 502(6) of the Homeland Security Act of 2002, or any successor plan.*

(2) **EVALUATION OF PROGRESS.**—*The National Health Security Strategy shall include an evaluation of the progress made by Federal, State, local, and tribal entities, based on the evidence-based benchmarks and objective standards that measure levels of preparedness established pursuant to section 319C–1(g). Such evaluation shall include aggregate and State-specific breakdowns of obligated funding spent by major category (as defined*

by the Secretary) for activities funded through awards pursuant to sections 319C-1 and 319C-2.

(3) *PUBLIC HEALTH WORKFORCE.*—In 2009, the National Health Security Strategy shall include a national strategy for establishing an effective and prepared public health workforce, including defining the functions, capabilities, and gaps in such workforce, and identifying strategies to recruit, retain, and protect such workforce from workplace exposures during public health emergencies.

(b) *PREPAREDNESS GOALS.*—The strategy under subsection (a) shall include provisions in furtherance of the following:

(1) *INTEGRATION.*—Integrating public health and public and private medical capabilities with other first responder systems, including through—

(A) the periodic evaluation of Federal, State, local, and tribal preparedness and response capabilities through drills and exercises; and

(B) integrating public and private sector public health and medical donations and volunteers.

(2) *PUBLIC HEALTH.*—Developing and sustaining Federal, State, local, and tribal essential public health security capabilities, including the following:

(A) Disease situational awareness domestically and abroad, including detection, identification, and investigation.

(B) Disease containment including capabilities for isolation, quarantine, social distancing, and decontamination.

(C) Risk communication and public preparedness.

(D) Rapid distribution and administration of medical countermeasures.

(3) *MEDICAL.*—Increasing the preparedness, response capabilities, and surge capacity of hospitals, other health care facilities (including mental health facilities), and trauma care and emergency medical service systems with respect to public health emergencies, which shall include developing plans for the following:

(A) Strengthening public health emergency medical management and treatment capabilities.

(B) Medical evacuation and fatality management.

(C) Rapid distribution and administration of medical countermeasures.

(D) Effective utilization of any available public and private mobile medical assets and integration of other Federal assets.

(E) Protecting health care workers and health care first responders from workplace exposures during a public health emergency.

(4) *AT-RISK INDIVIDUALS.*—

(A) Taking into account the public health and medical needs of at-risk individuals in the event of a public health emergency.

(B) For purpose of the Pandemic and All-Hazards Preparedness Act, the term “at-risk individuals” means children, pregnant women, senior citizens and other individ-

uals who have special needs in the event of a public health emergency, as determined by the Secretary.

(5) *COORDINATION.—Minimizing duplication of, and ensuring coordination between Federal, State, local, and tribal planning, preparedness, and response activities (including the State Emergency Management Assistance Compact). Such planning shall be consistent with the National Response Plan, or any successor plan, and National Incident Management System and the National Preparedness Goal.*

(6) *CONTINUITY OF OPERATIONS.—Maintaining vital public health and medical services to allow for optimal Federal, State, local, and tribal operations in the event of a public health emergency.*

SEC. 2804. ENHANCING MEDICAL SURGE CAPACITY.

(a) *STUDY OF ENHANCING MEDICAL SURGE CAPACITY.—As part of the joint review described in section 2812(b), the Secretary shall evaluate the benefits and feasibility of improving the capacity of the Department of Health and Human Services to provide additional medical surge capacity to local communities in the event of a public health emergency. Such study shall include an assessment of the need for and feasibility of improving surge capacity through—*

(1) *acquisition and operation of mobile medical assets by the Secretary to be deployed, on a contingency basis, to a community in the event of a public health emergency; and*

(2) *other strategies to improve such capacity as determined appropriate by the Secretary.*

(b) *AUTHORITY TO ACQUIRE AND OPERATE MOBILE MEDICAL ASSETS.—In addition to any other authority to acquire, deploy, and operate mobile medical assets, the Secretary may acquire, deploy, and operate mobile medical assets if, taking into consideration the evaluation conducted under subsection (a), such acquisition, deployment, and operation is determined to be beneficial and feasible in improving the capacity of the Department of Health and Human Services to provide additional medical surge capacity to local communities in the event of a public health emergency.*

(c) *USING FEDERAL FACILITIES TO ENHANCE MEDICAL SURGE CAPACITY.—*

(1) *ANALYSIS.—The Secretary shall conduct an analysis of whether there are Federal facilities which, in the event of a public health emergency, could practicably be used as facilities in which to provide health care.*

(2) *MEMORANDA OF UNDERSTANDING.—If, based on the analysis conducted under paragraph (1), the Secretary determines that there are Federal facilities which, in the event of a public health emergency, could be used as facilities in which to provide health care, the Secretary shall, with respect to each such facility, seek to conclude a memorandum of understanding with the head of the Department or agency that operates such facility that permits the use of such facility to provide health care in the event of a public health emergency.*

* * * * *

Subtitle B—*All-Hazards* Emergency Preparedness and Response

SEC. 2811. COORDINATION OF PREPAREDNESS FOR AND RESPONSE TO ALL-HAZARDS PUBLIC HEALTH EMERGENCIES.

(a) *IN GENERAL.*—There is established within the Department of Health and Human Services the position of the Assistant Secretary for Preparedness and Response. The President, with the advice and consent of the Senate, shall appoint an individual to serve in such position. Such Assistant Secretary shall report to the Secretary.

(b) *DUTIES.*—Subject to the authority of the Secretary, the Assistant Secretary for Preparedness and Response shall carry out the following functions:

(1) *LEADERSHIP.*—Serve as the principal advisor to the Secretary on all matters related to Federal public health and medical preparedness and response for public health emergencies.

(2) *PERSONNEL.*—Register, credential, organize, train, equip, and have the authority to deploy Federal public health and medical personnel under the authority of the Secretary, including the National Disaster Medical System, and coordinate such personnel with the Medical Reserve Corps and the Emergency System for Advance Registration of Volunteer Health Professionals.

(3) *COUNTERMEASURES.*—

(A) *OVERSIGHT.*—Oversee advanced research, development, and procurement of qualified countermeasures (as defined in section 319F-1) and qualified pandemic or epidemic products (as defined in section 319F-3).

(B) *STRATEGIC NATIONAL STOCKPILE.*—Maintain the Strategic National Stockpile in accordance with section 319F-2, including conducting an annual review (taking into account at-risk individuals) of the contents of the stockpile, including non-pharmaceutical supplies, and make necessary additions or modifications to the contents based on such review.

(4) *COORDINATION.*—

(A) *FEDERAL INTEGRATION.*—Coordinate with relevant Federal officials to ensure integration of Federal preparedness and response activities for public health emergencies.

(B) *STATE, LOCAL, AND TRIBAL INTEGRATION.*—Coordinate with State, local, and tribal public health officials, the Emergency Management Assistance Compact, health care systems, and emergency medical service systems to ensure effective integration of Federal public health and medical assets during a public health emergency.

(C) *EMERGENCY MEDICAL SERVICES.*—Promote improved emergency medical services medical direction, system integration, research, and uniformity of data collection, treatment protocols, and policies with regard to public health emergencies.

(5) *LOGISTICS.*—In coordination with the Secretary of Veterans Affairs, the Secretary of Homeland Security, the General Services Administration, and other public and private entities, provide logistical support for medical and public health aspects of Federal responses to public health emergencies.

(6) *LEADERSHIP.*—Provide leadership in international programs, initiatives, and policies that deal with public health and medical emergency preparedness and response.

(c) *FUNCTIONS.*—The Assistant Secretary for Preparedness and Response shall—

(1) have authority over and responsibility for the functions, personnel, assets, and liabilities of the following—

(A) the National Disaster Medical System (in accordance with section 301 of the Pandemic and All-Hazards Preparedness Act);

(B) the Hospital Preparedness Cooperative Agreement Program pursuant to section 319C-2; and

(C) the Public Health Preparedness Cooperative Agreement Program pursuant to section 319C-1;

(2) exercise the responsibilities and authorities of the Secretary with respect to the coordination of—

(A) the Medical Reserve Corps pursuant to section 2813;

(B) the Emergency System for Advance Registration of Volunteer Health Professionals pursuant to section 319I;

(C) the Strategic National Stockpile; and

(D) the Cities Readiness Initiative; and

(3) assume other duties as determined appropriate by the Secretary.

* * * * *

SEC. [2811.] 2812.[COORDINATION OF PREPAREDNESS FOR AND RESPONSE TO BIOTERRORISM AND OTHER PUBLIC HEALTH EMERGENCIES] NATIONAL DISASTER MEDICAL SYSTEM

[(a) ASSISTANT SECRETARY FOR PUBLIC HEALTH EMERGENCY PREPAREDNESS.—

[(1) IN GENERAL.—There is established within the Department of Health and Human Services the position of Assistant Secretary for Public Health Emergency Preparedness. The President shall appoint an individual to serve in such position. Such Assistant Secretary shall report to the Secretary.

[(2) DUTIES.—Subject to the authority of the Secretary, the Assistant Secretary for Public Health Emergency Preparedness shall carry out the following duties with respect to bioterrorism and other public health emergencies:

[(A) Coordinate on behalf of the Secretary—

[(i) interagency interfaces between the Department of Health and Human Services (referred to in this paragraph as the “Department”) and other departments, agencies, and offices of the United States; and

[(ii) interfaces between the Department and State and local entities with responsibility for emergency preparedness.

[(B) Coordinate the operations of the National Disaster Medical System and any other emergency response activities within the Department of Health and Human Services that are related to bioterrorism and other public health emergencies.

[(C) Coordinate the efforts of the Department to bolster State and local emergency preparedness for a bioterrorist attack or other public health emergency, and evaluate the progress of such entities in meeting the benchmarks and

other outcome measures contained in the national plan and in meeting the core public health capabilities established pursuant to 319A.

[(D) Any other duties determined appropriate by the Secretary.]

[(b)](a) NATIONAL DISASTER MEDICAL SYSTEM.—

(1) IN GENERAL.—The Secretary shall provide for the operation in accordance with this section of a system to be known as the National Disaster Medical System. The Secretary shall designate the [Assistant Secretary for Public Health Emergency Preparedness] *Assistant Secretary for Preparedness and Response* as the head of the National Disaster Medical System, subject to the authority of the Secretary.

(2) FEDERAL AND STATE COLLABORATIVE SYSTEM.—

(A) IN GENERAL.—* * *

(B) PARTICIPATING FEDERAL AGENCIES.—The Federal agencies referred to in subparagraph (A) are the Department of Health and Human Services, the [Federal Emergency Management Agency] *Department of Homeland Security*, the Department of Defense, and the Department of Veterans Affairs.

(3) PURPOSE OF SYSTEM.—

(A) IN GENERAL.—* * *

* * * * *

(C) TEST FOR MOBILIZATION OF SYSTEM.—During the one-year period beginning on the date of the enactment of the [Public Health Security and Bioterrorism Preparedness and Response Act of 2002] *Pandemic and All-Hazards Preparedness Act*, the Secretary shall conduct an exercise to test the capability and timeliness of the National Disaster Medical System to mobilize and otherwise respond effectively to a bioterrorist attack or other public health emergency that affects two or more geographic locations concurrently. Thereafter, the Secretary may periodically conduct such exercises regarding the National Disaster Medical System as the Secretary determines to be appropriate.

[(c)](b) [CRITERIA] MODIFICATIONS.—

[(i) IN GENERAL.—The Secretary shall establish criteria for the operation of the National Disaster Medical System.

(1) IN GENERAL.—*Taking into account the findings from the joint review described under paragraph (2), the Secretary shall modify the policies of the National Disaster Medical System as necessary.*

(2) JOINT REVIEW AND MEDICAL SURGE CAPACITY STRATEGIC PLAN.—*Not later than 180 days after the date of enactment of the Pandemic and All-Hazards Preparedness Act, the Secretary, in coordination with the Secretary of Homeland Security, the Secretary of Defense, and the Secretary of Veterans Affairs, shall conduct a joint review of the National Disaster Medical System. Such review shall include an evaluation of medical surge capacity, as described by section 2804(a). As part of the National Health Security Strategy under section 2802, the Secretary shall update the findings from such review and further modify the policies of the National Disaster Medical System as necessary.*

[(2)](3) PARTICIPATION AGREEMENTS FOR NON-FEDERAL ENTITIES.—* * *

(A) Provisions relating to the custody and use of Federal personal property by such entities, which may in the discretion of the Secretary include authorizing the custody and use of such property to respond to emergency situations for which the National Disaster Medical System has not been activated by the Secretary pursuant to [subsection (b)] *subsection (a)(3)(A)*. Any such custody and use of Federal personal property shall be on a reimbursable basis.

* * * * *

[(d)](c) INTERMITTENT DISASTER-RESPONSE PERSONNEL.—

(1) IN GENERAL.—* * *

(2) LIABILITY.—For purposes of section 224(a) and the remedies described in such section, an individual appointed under paragraph (1) shall, while acting within the scope of such appointment, be considered to be an employee of the Public Health Service performing medical, surgical, dental, or related functions. With respect to the participation of individuals appointed under paragraph (1) in training programs authorized by the [Assistant Secretary for Public Health Emergency Preparedness] or *Assistant Secretary for Preparedness and Response* or a comparable official of any Federal agency specified in [subsection (b)] *subsection (2)(B)*, acts of individuals so appointed that are within the scope of such participation shall be considered within the scope of the appointment under paragraph (1) (regardless of whether the individuals receive compensation for such participation).

[(e)](d) CERTAIN EMPLOYMENT ISSUES REGARDING INTERMITTENT APPOINTMENTS.—

(1) INTERMITTENT DISASTER-RESPONSE APPOINTEE.—For purposes of this subsection, the term “intermittent disaster-response appointee” means an individual appointed by the Secretary under [subsection (d)] *subsection (c)*.

(2) COMPENSATION FOR WORK INJURIES.—An intermittent disaster-response appointee shall, while acting in the scope of such appointment, be considered to be an employee of the Public Health Service performing medical, surgical, dental, or related functions, and an injury sustained by such an individual shall be deemed “in the performance of duty”, for purposes of chapter 81 of title 5, United States Code, pertaining to compensation for work injuries. With respect to the participation of individuals appointed under [subsection (d)] *subsection (c)* in training programs authorized by the [Assistant Secretary for Public Health Emergency Preparedness] *Assistant Secretary for Preparedness and Response* or a comparable official of any Federal agency specified in [subsection (b)] *subsection (2)(B)*, injuries sustained by such an individual, while acting within the scope of such participation, also shall be deemed “in the performance of duty” for purposes of chapter 81 of title 5, United States Code (regardless of whether the individuals receive compensation for such participation). In the event of an injury to such an intermittent disaster-response appointee, the Secretary of Labor shall be responsible for making determina-

tions as the whether the claimant is entitled to compensation or other benefits in accordance with chapter 81 of title 5, United States Code.

(3) EMPLOYMENT AND REEMPLOYMENT RIGHTS.—

(A) IN GENERAL.—Service as an intermittent disaster-response appointee when the Secretary activates the National Disaster Medical System or when the individual participates in a training program authorized by the [Assistant Secretary for Public Health Emergency Preparedness] *Assistant Secretary for Preparedness and Response* or a comparable official of any Federal agency specified in [subsection (b)] *subsection (2)(B)* shall be deemed “service in the uniformed services” for purposes of chapter 43 of title 38, United States Code, pertaining to employment and reemployment rights of individuals who have performed service in the uniformed services (regardless of whether the individual receives compensation for such participation). All rights and obligations of such persons and procedures for assistance, enforcement, and investigation shall be as provided for in chapter 43 of title 38, United States Code.

* * * * *

[(f)(e)] RULE OF CONSTRUCTION REGARDING USE OF COMMISSIONED CORPS.—* * *

[(g)(f)] DEFINITION.—For purposes of this section, the term “auxiliary services” includes mortuary services, veterinary services, and other services that are determined by the Secretary to be appropriate with respect to the needs referred to in [subsection (b)] *subsection (a)(3)(A)*.

[(h)(g)] AUTHORIZATION OF APPROPRIATIONS.—For the purpose of providing for the [Assistant Secretary for Public Health Emergency Preparedness] *Assistant Secretary for Preparedness and Response* and the operations of the National Disaster Medical System, other than purposes for which amounts in the Public Health Emergency Fund under section 319 are available, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years [2002 through 2006] *2007 through 2011*.

* * * * *

SEC. 2813. VOLUNTEER MEDICAL RESERVE CORPS.

(a) IN GENERAL.—*Not later than 180 days after the date of enactment of the Pandemic and All-Hazards Preparedness Act, the Secretary, in collaboration with State, local, and tribal officials, shall build on State, local, and tribal programs in existence on the date of enactment of such Act to establish and maintain a Medical Reserve Corps (referred to in this section as the “Corps”) to provide for an adequate supply of volunteers in the case of a Federal, State, local, or tribal public health emergency. The Corps shall be headed by a Director who shall be appointed by the Secretary and shall oversee the activities of the Corps chapters that exist at the State, local, and tribal levels.*

(b) STATE, LOCAL, AND TRIBAL COORDINATION.—*The Corps shall be established using existing State, local, and tribal teams and shall not alter such teams.*

(c) *COMPOSITION.*—*The Corps shall be composed of individuals who—*

(1)(A) *are health professionals who have appropriate professional training and expertise as determined appropriate by the Director of the Corps; or*

(B) *are non-health professionals who have an interest in serving in an auxiliary or support capacity to facilitate access to health care services in a public health emergency;*

(2) *are certified in accordance with the certification program developed under subsection (d);*

(3) *are geographically diverse in residence;*

(4) *have registered and carry out training exercises with a local chapter of the Medical Reserve Corps; and*

(5) *indicate whether they are willing to be deployed outside the area in which they reside in the event of a public health emergency.*

(d) *CERTIFICATION; DRILLS.*—

(1) *CERTIFICATION.*—*The Director, in collaboration with State, local, and tribal officials, shall establish a process for the periodic certification of individuals who volunteer for the Corps, as determined by the Secretary, which shall include the completion by each individual of the core training programs developed under section 319F, as required by the Director. Such certification shall not supercede State licensing or credentialing requirements.*

(2) *DRILLS.*—*In conjunction with the core training programs referred to in paragraph (1), and in order to facilitate the integration of trained volunteers into the health care system at the local level, Corps members shall engage in periodic training exercises to be carried out at the local level.*

(e) *DEPLOYMENT.*—*During a public health emergency, the Secretary shall have the authority to activate and deploy willing members of the Corps to areas of need, taking into consideration the public health and medical expertise required, with the concurrence of the State, local, or tribal officials from the area where the members reside.*

(f) *EXPENSES AND TRANSPORTATION.*—*While engaged in performing duties as a member of the Corps pursuant to an assignment by the Secretary (including periods of travel to facilitate such assignment), members of the Corps who are not otherwise employed by the Federal Government shall be allowed travel or transportation expenses, including per diem in lieu of subsistence.*

(g) *IDENTIFICATION.*—*The Secretary, in cooperation and consultation with the States, shall develop a Medical Reserve Corps Identification Card that describes the licensure and certification information of Corps members, as well as other identifying information determined necessary by the Secretary.*

(h) *INTERMITTENT DISASTER-RESPONSE PERSONNEL.*—

(1) *IN GENERAL.*—*For the purpose of assisting the Corps in carrying out duties under this section, during a public health emergency, the Secretary may appoint selected individuals to serve as intermittent personnel of such Corps in accordance with applicable civil service laws and regulations. In all other cases, members of the Corps are subject to the laws of the State in which the activities of the Corps are undertaken.*

(2) *APPLICABLE PROTECTIONS.*—Subsections (c)(2), (d), and (e) of section 2812 shall apply to an individual appointed under paragraph (1) in the same manner as such subsections apply to an individual appointed under section 2812(c).

(3) *LIMITATION.*—State, local, and tribal officials shall have no authority to designate a member of the Corps as Federal intermittent disaster-response personnel, but may request the services of such members.

(i) *AUTHORIZATION OF APPROPRIATIONS.*—There is authorized to be appropriated to carry out this section, \$22,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.

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HOMELAND SECURITY ACT OF 2002

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TITLE V—EMERGENCY PREPAREDNESS AND RESPONSE

SEC. 501. * * *

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SEC. 502. RESPONSIBILITIES.

* * * * *

(3) providing the Federal Government’s response to terrorist attacks and major disasters, including—

(A) managing such response;

(B) directing the Domestic Emergency Support Team[, the National Disaster Medical System,] and (when operating as an organizational unit of the Department pursuant to this title) the Nuclear Incident Response Team;

* * * * *

SEC. 503. FUNCTIONS TRANSFERRED.

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(5) The Office of Emergency Preparedness[, the National Disaster Medical System,] and the Metropolitan Medical Response System of the Department of Health and Human Services, including the functions of the Secretary of Health and Human Services and the Assistant Secretary for Public Health Emergency Preparedness relating thereto.

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SOCIAL SECURITY ACT

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AUTHORITY TO WAIVE REQUIREMENTS DURING NATIONAL EMERGENCIES

SEC. 1135. (a) PURPOSE.—* * *

* * * * *

(b) SECRETARIAL AUTHORITY.—* * *

(1)(A)* * *

* * * * *

(3) * * *

(A) * * *

[(B) the direction or relocation of an individual to receive medical screening in an alternate location pursuant to an appropriate State emergency preparedness plan;]

(B) the direction or relocation of an individual to receive medical screening in an alternative location—

(i) pursuant to an appropriate State emergency preparedness plan; or

(ii) in the case of a public health emergency described in subsection (g)(1)(B) that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan or a plan referred to in clause (i), whichever is applicable in the State;

* * * * *

(7) * * *

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Insofar as the Secretary exercises authority under paragraph (6) with respect to individuals enrolled in a Medicare+Choice plan, to the extent possible given the circumstances, the Secretary shall reconcile payments made on behalf of such enrollees to ensure that the enrollees do not pay more than would be required had they received services from providers within the network of the plan and may reconcile payments to the organization offering the plan to ensure that such organization pays for services for which payment is included in the capitation payment it receives under part C of title XVIII. A waiver or modification provided for under paragraph (3) or (7) shall only be in effect if such actions are taken in a manner that does not discriminate among individuals on the basis of their source of payment or of their ability to pay, [and shall be limited to] and, except in the case of a waiver or modification to which the fifth sentence of this subsection applies, shall be limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. A waiver or modification under such paragraph (7) shall be withdrawn after such period and the provider shall comply with the requirements under such paragraph for any patient still under the care of the provider. If a public health emergency described in subsection (g)(1)(B) involves a pandemic infectious disease (such as pandemic influenza), the duration of a waiver or modification under paragraph (3) shall be determined in accordance with subsection (e) as such subsection applies to public health emergencies.

* * * * *

UNITED STATES CODE

TITLE 38

§ 8117. Emergency preparedness

(a) **READINESS OF DEPARTMENT MEDICAL CENTERS.**—(1) The Secretary shall take appropriate actions to provide for the readiness of Department medical centers to protect the patients and staff of such centers from **[chemical or biological attack]** *a public health emergency (as defined in section 2801 of the Public Health Service Act)* or otherwise to respond to such **[an attack]** *such an emergency* so as to enable such centers to fulfill their obligations as part of the Federal response to **[public health emergencies]** *such emergencies*.

(2) Actions under paragraph (1) shall include—

(A) the provision of decontamination equipment and personal protection equipment at Department medical centers **[and]**;

(B) the provision of training in the use of such equipment to staff of such centers**[.]**;

(C) organizing, training, and equipping the staff of such centers to support the activities carried out by the Secretary of Health and Human Services under section 2801 of the Public Health Service Act in the event of a public health emergency and incidents covered by the National Response Plan developed pursuant to section 502(6) of the Homeland Security Act of 2002, or any successor plan; and

(D) providing medical logistical support to the National Disaster Medical System and the Secretary of Health and Human Services as necessary, on a reimbursable basis, and in coordination with other designated Federal agencies.

(b) * * *

* * * * *

(c) **Tracking of pharmaceuticals and medical supplies and equipment.**—The Secretary shall develop and maintain a centralized system for tracking the current location and availability of pharmaceuticals, medical supplies, and medical equipment throughout the Department health care system in order to permit the ready identification and utilization of such pharmaceuticals, supplies, and equipment for a variety of purposes, including responses to **[a chemical or biological attack or other terrorist attack.]** *a public health emergency. The Secretary shall, through existing medical procurement contracts, and on a reimbursable basis, make available as necessary, medical supplies, equipment, and pharmaceuticals in response to a public health emergency in support of the Secretary of Health and Human Services.*

(d) **TRAINING.**—The Secretary, shall ensure that the Department centers, in consultation with the accredited medical school affiliates of such medical centers, **[develop and]** implement curricula to train resident physicians and health care personnel in medical matters relating to **[biological, chemical, or radiological attacks]** *public health emergencies* or attacks from an incendiary or other explosive weapon *consistent with section 319F(a) of the Public Health Service Act.*

(e) PARTICIPATION IN NATIONAL DISASTER MEDICAL SYSTEM.—(1) The Secretary shall establish and maintain a training program to facilitate the participation of the staff of Department medical centers, and of the community partners of such centers, in the National Disaster Medical System established pursuant to section **【2811(b)】 2812** of the Public Health Service Act (42 U.S.C. 300hh–11(b)).

(2) The Secretary shall establish and maintain the training program under paragraph 91) in accordance with the recommendations of the working group on the prevention, preparedness, and response to **【bioterrorism and other】** public health emergencies established under section **【319F(a)】 319F** of the Public Health Service Act (42 U.S.C. 247d–6(a)).

* * * * *

(g) AUTHORIZATION OF APPROPRIATIONS.—*There are authorized to be appropriated, such sums as may be necessary to carry out this section for each of fiscal years 2007 through 2011.*

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