

June 26, 2020

The Honorable Lamar Alexander  
Chairman  
Senate Health, Education, Labor, and Pensions Committee  
Washington, DC 20510

Dear Chairman Alexander:

Thank you for your attention to and past support of public health emergency preparedness. The white paper, *Preparing for the Next Pandemic* – published June 9, 2020, highlights strides made in pandemic preparedness and challenges faced by the nation in being adequately prepared.

The National Association of County and City Health Officials (NACCHO) appreciates the opportunity to provide comments on the white paper and on the challenges local health departments continue to face with response to COVID-19 as well as public health emergencies like wildfires, severe weather events, and non-COVID infectious diseases. NACCHO represents nearly 3,000 local health departments across the country that are committed to protecting their communities every day and have been engaged in COVID-19 response nonstop since the outbreak emerged in the United States.

The white paper raised many important issues and questions for preparing for a future pandemic. NACCHO and local health departments appreciate this strategic approach. However, it cannot be overstated that we are still in the midst of the current emergency. Rates of COVID-19 are rising across the nation. Testing and tracing for the disease are still not at optimal levels. It is critically important that Congress continue to demonstrate leadership, conduct oversight on the Administration's response, and provide a consistent flow of resources to local health departments across the country to allow all communities to get to the point of recovery from this pandemic.

The federal government, in partnership with local and state governments, should do everything possible to make sure that we can emerge from the current pandemic with the lowest possible loss of life as well as a strengthened ability to get back to school and work, restart the economy, and get on the path to return to normal operations. Below are some recommendations about how to do that most effectively.

### *Importance of Public Health Guidance*

In an emergency, the public relies on trusted public health officials and health care providers to provide unbiased guidance based on scientific evidence. At the federal level, the Centers for Disease Control and Prevention (CDC) is the agency with decades of public health expertise and world-renowned experts dedicated to emergency preparedness, infectious disease, immunization, and other disciplines within public health. CDC should be front and center in the pandemic response. COVID-19 was unknown to scientists until a few months ago and new evidence about the disease is emerging every day. In order to make sure the public understands the intricacies of COVID-19, and how to remain safe, experts from the CDC should have been highly visible in communications from the Trump Administration. Unfortunately, this did not happen. Even guidance documents have been censored or delayed, and often published



without any wide-scale communication to the public about what our national guidelines should be. Now there is vast misinformation and mistrust of public health authority across the country.

During the COVID-19 response, public health department officials and staff across the country have been physically threatened and politically scapegoated. Too many have lost their jobs for trying to protect and defend the health of their community in responding to COVID-19. Many others have stepped down, interrupting their careers, to protect themselves and their loved ones from actual or perceived threats. The nation is losing expertise, experience, and most importantly, leadership, at a time when we need it most.

NACCHO and local health departments are also concerned about recent reports of potential “restructuring” of CDC, leading to the loss of the agency’s authority and stature during the COVID-19 pandemic. Similar rumors about efforts to reduce the scope of CDC’s mission would also be problematic, as there is a clear connection between the impact of infectious disease and the importance of reducing chronic disease and making all communities healthier. CDC continues to be the world’s premiere public health institution and should be treated as such. It is a scientific organization that functions best as an apolitical agency trusted to guide the strategy of our nation to be healthier and safer. The core mission of the CDC is clear, and it is replicated in every local, state, tribal, and territorial public health agency: prevent illness and injury and save lives. Now more than ever we need them to accomplish their mission.

**NACCHO calls on the Health, Education, Labor, and Pensions Committee and its members individually to speak up in support of CDC and local, state, tribal, and territorial public health officials and their staff and to urge the public and elected officials at all levels to heed science-based public health recommendations to keep the public safe.**

It is also critical to ensure strong inclusion of the local health department voice at all levels of decision making to ensure that national or state-level plans are informed by and can be executed successfully in local communities. Local health officials are experts in their communities about how to respond to a pandemic and have developed extensive plans detailing how different sectors in society can most effectively prevent illness and deaths. **The federal government through the Department of Health and Human Services (HHS) and its agencies and the Federal Emergency Management Administration (FEMA) should always include local health officials and their staff in pandemic planning and response efforts and provide material and financial support for their activities.** NACCHO has catalogued examples during the COVID-19 response where local health departments have been left out of these efforts. For example, in some communities FEMA-HHS community-based testing centers instructed people being tested to contact their local health department for their results when these agencies weren’t part of the system and did not even have access to the test results. In addition, the federal government has asked hospitals to send testing data directly to them, bypassing local and state authorities who need access to the data to conduct surveillance. There have also been duplicative information/data-collection efforts from the federal government of information that state and local health departments are already asking of their community stakeholders. If local health departments are expected to implement federal guidance, then they need to be more a part of the overall federal planning and coordination effort.

*Public Health Emergency Preparedness Funding*

As the white paper describes, funding for public health emergency preparedness at the local, state, and federal level has declined precipitously in the past two decades. At its height, funding for the public health emergency preparedness program at the CDC was nearly \$1 billion; currently it is \$675 million. NACCHO research found that in 2019, more than 80% of local health departments experienced either a decrease in their preparedness budget or flat funding for preparedness compared to the previous fiscal year.<sup>1</sup> This is during a period where local health departments have seen increased demands on their emergency preparedness staff – even before COVID-19—due to increased severe weather, wildfires, severe flu seasons, and measles outbreaks to name a few challenges.

In 2019, nearly three-quarters of local health departments relied on federal funding for emergency preparedness, while only a quarter received local or state funding.<sup>1</sup> Federal funding is expected to become even more critical as local and state sources of funding sharply decrease due to the economic downturn and loss of tax revenue associated with COVID-19. By the time they reach the local level, these funds are often quite modest, not even enough to hire a full-time preparedness coordinator, let alone to support the wide variety of activities and exercises needed to truly keep communities prepared for all possible crises.

NACCHO recommends increased funding for public health emergency preparedness so that communities have adequate planning and trained personnel to respond to any type of public health emergency, including a pandemic. **NACCHO recommends at least \$824 million for the public health emergency preparedness program at CDC in FY2021.** While more money is certainly necessary to really move the needle at the local health department level, this request takes into account the difficult budgetary situation Congress is in for FY2021.

That is why we strongly support the proposal from former CDC Director Thomas Frieden, MD, MPH and others to **create a Health Defense Operations (HDO) budget designation to increase investments in public health and pandemic preparedness before the next pandemic occurs.**<sup>2</sup> Congress would determine which health functions in CDC, Assistant Secretary for Preparedness and Response (ASPR) and other public health agencies would be included in a HDO designation. Future health and economic security can best be achieved by a permanent budget cap exemption for critical public health functions to prevent, detect and respond to health threats both globally and domestically.

It is critical that the entire governmental public health system is strong in order to achieve our national goals in preparedness and response. Even as local health departments rely on the federal government for support of public health emergency preparedness, there is vast inconsistency in the amount of federal funding that is specifically authorized and appropriated for use by local health departments that reaches local communities. Four city health departments (Washington, DC, New York City, Chicago, and Los Angeles) have traditionally received direct funding for emergency preparedness from CDC; the other nearly 3,000 local health departments are reliant on state health departments, who determine if they will pass through any funding, how much they will pass on, and which local health departments will receive it.

While not new to the COVID-19 response, the challenges in tracking these dollars and ensuring that local health departments benefit from federal investments have been magnified during this pandemic response. During the COVID-19 response, only 6 city health departments have received direct funding from CDC. Other than that, there is no public tracking of federal funds designated for both state and local health departments down to the local health department level. This makes oversight and

accountability incredibly difficult, but it also presents a challenge in identifying best practices in state-local funding that could be modeled in other regions. NACCHO has collected data showing that there are entire states where no federal funds have made it to local health departments to support their months-long response. By contrast, some states were seen to split funds allocated by CDC early in the response 50/50 with local communities. It is important that Congress receives information about how much of the federal funding allocated for COVID-19 reaches local communities and acts to ensure that Congressional intent is followed by supporting the full governmental public health system in this response as well as the preparation for others.

**NACCHO recommends that Congress require CDC to provide a state-by-state report at least annually showing how much federal emergency preparedness funding, including COVID-19 response funding, is reaching the local level via state health departments. NACCHO also recommends specific guidance to ensure that federal COVID-19 response dollars are adequately reaching all local health departments.**

#### *Public Health Workforce*

The public health workforce is the backbone of our nation's governmental public health system at the county, city, state, and tribal levels. These skilled professionals are the primary resource necessary to deliver public health programs and services: they lead efforts to ensure the tracking and surveillance of infectious disease outbreaks such as COVID-19, prepare for and respond to natural or man-made disasters, and ensure the safety of the air we breathe, the food we eat, and the water we drink. Health departments employ full-time nurses, behavioral health staff, community health workers, environmental health workers, epidemiologists, health educators, nutritionists, lab workers and others who use their unique skill sets to do all they can to keep people in their communities healthy and safe. While the current COVID-19 outbreak has raised the profile of public health workers, they have a long track record of protecting our communities out of the spotlight, preventing illness and harm.

While the importance of these professionals cannot be understated, health departments across the country face significant workforce challenges to maintaining robust staffing levels and recruiting and retaining needed professionals. The public health workforce was hit hard by the Great Recession, and whereas much of the rest of the public sector workforce has recovered or grown, local and state health departments have not. In fact, local and state health departments have lost nearly a quarter of their workforce since 2008, shedding over 50,000 jobs across the country. The deficiency is compounded by the age of the public health workforce – nearly 55% of public health professionals are over the age of 45 and almost a quarter of health department staff are eligible for retirement. Between those who plan to retire and those who plan to pursue opportunities in the private sector (often due to low wages), nearly half of the local and state health department workforce might leave over the next several years.

**NACCHO recommends passage of and \$200 million in funding for the Strengthening the Public Health Workforce Act (S. 3737),** which would provide up to \$35,000 per year in loan repayment per health professional in exchange for a two-year commitment to serve in a local, state, or tribal health department.<sup>3</sup> As new staff and volunteers are brought into the field for the COVID-19 response, this is an added incentive to keep them long term. This program could help ensure that their experience is harnessed and available before the next crisis hits.

#### *Public Health Infrastructure Funding*

The COVID-19 experience thus far shows that prevention and containment of a deadly virus is ONLY possible when a robust, well-resourced governmental public health system comprised of career professionals is in place. The health care system is necessary, but not sufficient, to address an outbreak such as this. It takes a host of public health interventions to form a robust response.

**NACCHO calls on Congress to provide \$4.5 billion in annual mandatory funding for CDC, state, local, tribal, and territorial core public health infrastructure to pay for essential public health activities.**

Essential activities include disease surveillance; epidemiology; laboratory capacity, all-hazards preparedness and response; policy development and support; communications; community partnership development; and organizational competencies. This funding should be in addition to the annual discretionary appropriations, designed to strengthen the entirety of the governmental public health system.

Below are specific comments on some of the questions included in the white paper.

*Tests, Treatments, and Vaccines – Accelerate Research and Development*

The infrastructure used for the COVID-19 response today is the same infrastructure that was built to address seasonal and pandemic flu. The federal government must strengthen our public health sector and modernize the vaccines, preventives, diagnostics, and treatments needed to end the threat of seasonal flu and protect us from the next influenza pandemic.

As the 2020-2021 influenza season will coincide with the COVID-19 pandemic, Congress should support efforts by local health departments and health care providers to increase vaccination rates among populations at higher risk of complications, including older adults, health care workers, underserved communities, people with chronic health conditions, and school-aged children.

1. What incentives can the federal government offer to the private sector to encourage development of more medical countermeasures with no commercial market?

A strong pipeline of antibiotics is critical to preparedness efforts, but the antibiotics market is on the verge of collapse. Because antibiotics are typically used for a short duration and must be used judiciously to preserve their effectiveness, it is extremely difficult for innovators to earn a return on investment in new antibiotic research and development. As a result, most large pharmaceutical companies are no longer engaged in antibiotic R&D, and the small companies responsible for the vast majority of current antibiotic innovation are struggling to remain in business. Two such companies filed for bankruptcy in 2019. While federal funding has been critical to bring new antibiotics to market, it is insufficient to spur the thriving antibiotics market necessary to ensure our nation's preparedness capacity. NACCHO joins the Infectious Diseases Society of America recommending that preparedness legislation specifically include post-market incentives to help antibiotic innovators earn a fair and reasonable return on investments. We also emphasize the importance of diagnostic tests to guide optimal antibiotic use and of vaccines to prevent infections and obviate the need for antibiotic use.

4. How can the federal, state, and private sector work together to more effectively distribute and administer treatments and vaccines?

The distribution of medical countermeasures (MCMs) and therapeutics is most successful in saving lives and protecting health when implemented through local, state, and federal coordination and

collaboration. NACCHO recommends that the immunization infrastructure in the US, both private and public, should be strengthened. While the existing public health preparedness and response and immunization program infrastructure in the United States provides a solid foundation, gaps in capacity and capability across public health and health care systems must be addressed to ensure that our nation is prepared to engage in a timely, comprehensive, and equitable vaccination campaign for COVID-19. Infrastructure investments must be made now to further strengthen, enhance, and scale up the ability of public health agencies, primary care physicians, pharmacists, and other health care providers in the community who currently provide immunization to meet demand for a future COVID-19 vaccine. This important work will be a multi-phase process that requires resources for planning, prioritization, expanding the public health workforce, clear communication highlighting the safety and effectiveness of the vaccine, and close collaboration between public health and existing primary care physicians, pharmacists and other health care providers within the immunization neighborhood to strengthen and enhance our immunization infrastructure and surveillance systems in anticipation of a new vaccine.

Concurrently, communication with, and engagement of, the public through ongoing education and outreach efforts on what to expect when a COVID-19 vaccine becomes available is critical and must have a heightened focus on addressing vaccination hesitancy and increasing public confidence in the safety and efficacy of vaccines as a potentially lifesaving medical countermeasure.

During the H1N1 flu pandemic, there was a need for communication and coordination across the federal, state and local levels. This became clear when delays and less than anticipated amounts of vaccine were available at the local level. The result was the loss of credibility and trust at the local level with lasting impacts. The need for clear guidance and identified prioritized populations—developed in partnership with all levels of the governmental public health system—will be important for efficient vaccine deployment.

9. What the lessons learned from the current fast tracking of tests, treatments, and vaccines to make them available even more rapidly?

Regarding Recommendation 1.4 in the white paper, supplies need to be distributed in a uniform fashion in an emergency such as COVID-19 that impacts multiple communities and states simultaneously. NACCHO members report that their communities had to compete with neighboring jurisdictions for testing supplies and personal protective equipment, which cost valuable time, inflated prices, and resulted in an increase in COVID-19 deaths.

#### *Disease Surveillance – Expand Ability to Detect, Identify, Model, and Track Emerging Infectious Diseases*

1. What other barriers, in addition to limited testing capacity, and insufficient and outdated technology, make it difficult to detect and conduct public health surveillance of emerging infectious diseases?

Please see information above regarding the need to bolster the public health workforce and pass the Strengthening the Public Health Workforce Act (S. 3737).

NACCHO has also joined with other public health associations to advocate for sufficient funding for a contact tracing workforce at the local level to identify and appropriately isolate and support people who are infected with (or who have been exposed to) COVID-19.<sup>4</sup>

NACCHO recommends that Congress provide the following for staff at the local and state level:

- Tier 1 at least 100,000 Contact Tracers: at least \$4.8 billion.
- Tier 2 at least 10,000 Disease Intervention Specialist (DIS) Supervisors: at least \$1.3 billion.
- Tier 3 at least 1,600 Epidemiologists: at least \$240 million.

Congress should also support interoperable immunization information systems (IIS) to enable bi-directional data exchange between states and community immunization providers, to reduce administrative burden, and to ensure tracking of vaccination status for both flu and COVID-19.

The federal government should encourage the development and dissemination of sufficient flu diagnostic tests, including to distinguish flu diagnoses from COVID-19 diagnoses. Congress must also provide adequate support for labs that will be tasked with balancing higher demand for testing during pandemics.

Congress should also instruct the CDC to evaluate the current electronic lab reporting system. Demographic data was, and still remains, challenging to collect, which, according to some, is due to existing electronic lab reporting systems. CDC should report to Congress the status of these systems, and funding should be provided to upgrade the systems as necessary. HHS has required that labs collect data on race/ethnicity as of August 1, 2020; however, it is unclear what the penalty will be for labs that fail to collect this data. In addition, there have been months of data collected largely without demographic information.

Additionally, CDC must work to better coordinate and align state and local testing recommendations and case reporting. Particularly at the beginning of this pandemic, the federal recommendations around testing eligibility were too limited and did not take local experiences into account. This greatly hindered early response and surveillance, resulting in a large amount of COVID-19 cases that were undetected and contributed to unmitigated community spread.

## 2. What appropriate role can innovative technologies play to improve public health surveillance?

Innovative technologies should be used in conjunction with public health department efforts to engage in contact tracing. Technology can add to, but cannot replace, the human element in collecting information about contacts who may potentially be exposed to COVID-19. Culturally competent contact tracers are currently needed to gather information and encourage people who test positive for COVID-19 to take the appropriate precautions including isolation and quarantine as necessary. Epidemiologists are needed to analyze data and identify trends in the spread of disease. Public health professionals are also needed to help connect people with housing, food, and other supports that may be necessary for them to follow public health guidance.

## 6. How can the private sector innovations to support and modernize federal and state surveillance be better leveraged?

NACCHO supports Recommendation 2.4 in the white paper and supports passage of the Public Health Data Systems Modernization Act, included in the Lower Health Care Costs Act. For many years, the antiquated nature of public health data systems has been documented. NACCHO has consistently called attention to the need for CDC's data systems to seamlessly connect with state and local systems and to allow interoperable access to data in order to increase the speed and effectiveness with which disease outbreaks can be detected, tracked, and prevented.

NACCHO urges that local- and state-reported data in integrated surveillance systems be equally accessible to local, state, and federal jurisdictions and that local health departments have access to other relevant datasets developed within their locale (e.g., healthcare associated infections data available from the national healthcare safety network from hospitals in their jurisdictions; school performance and attendance databases; and, community health needs assessment data from local public hospitals or other organizations).

*Stockpiles, Distribution, and Surges – Rebuild and Maintain State and Federal Stockpiles and Improve Medical Supply Surge Capacity and Distribution*

1. How can the Strategic National Stockpile be better managed and how can Congress increase oversight and accountability?

Federal agencies and officials including the ASPR and the CDC are critical to the effective functioning of the MCM enterprise. Currently, CDC expertise on public health emergency preparedness from the Center for Preparedness and Response plays an integral role to the operations of the Strategic National Stockpile (SNS). CDC experts provide guidance and technical assistance to help health departments develop, test, operationalize, and improve preparedness and medical countermeasure plans and evaluation to standardize approaches and tools to measure the readiness of health departments to get life-saving medicines and supplies to the public. **NACCHO recommends that SNS remain in HHS and that the collaboration between ASPR and CDC in SNS administration be continued to ensure that there is necessary coordination and efficiency of operations of the SNS.**<sup>5</sup>

2. How can states and hospitals improve their ability to maintain a reserve of supplies in the future to ensure the Strategic National Stockpile is the backup and not the first source of supplies during emergencies?

The COVID-19 response has shown the importance of strong preparedness and coordination at the national level. NACCHO is concerned that due to funding cuts at the local, state, and federal level, many local communities and states do not currently have the necessary supplies and products stockpiled to support pandemic response particularly as it relates to COVID-19 but also for other public health emergencies. ASPR recently released a document containing a vision of the Strategic National Stockpile (SNS) as a “short-term, stopgap buffer,” which is only effective if local and state resources are sufficient to meet the needs of most of the people in their jurisdiction.<sup>5</sup>

4. As states and hospitals establish or build their own stockpiles, how will they know what supplies to stockpile? What guidance should the federal government provide on what medical supplies are appropriate?

Local communities depend on the leadership of the federal government in maintaining the SNS. As demonstrated in COVID-19, MCMs and other supplies from the SNS are critical to timely and effective response in a public health emergency. The SNS has been the catalyst for operational readiness for local communities and states to be capable of handling public health emergencies including a pandemic, other outbreak, or terrorist event, and previous training and advised plans have been used in the COVID-19 response.<sup>5</sup>

*Public Health Capabilities – Improve State and Local Capacity to Respond*



1. What specific changes to our public health infrastructure (hospitals, health departments, laboratories, etc.) are needed at the federal, state, and local levels?

As noted above, NACCHO supports a new annual mandatory funding stream in addition to the annual discretionary appropriations to support the CDC, local, state, tribal, and territorial core public health infrastructure to support essential public health activities. Essential activities include disease surveillance; epidemiology; laboratory capacity, all-hazards preparedness and response; policy development and support; communications; community partnership development; and organizational competencies. These cross-cutting needs are key to ensuring that all Americans can be confident that they have a strong public health infrastructure working to keep them healthy and safe. They are also critical to keep health departments strong in the face of the economic impacts of COVID-19, which are likely to cause service disruptions and workforce reductions at local health departments despite their critical role in the pandemic response.

2. What changes can be made to Public Health Emergency Preparedness and Hospital Preparedness Program to help states prepare and respond more quickly?

As described above, funding for the public health emergency preparedness program (PHEP) at CDC is far from optimal. Many local health departments have difficulty performing all their emergency preparedness functions with current funding; much less respond to an emergency like COVID-19. Funding for the Hospital Preparedness Program (HPP) has fallen by over 60% since FY2003 when accounting for inflation. The impact of these cuts has had devastating effects in the COVID-19 pandemic, as health departments have tried to track the disease with out-of-date surveillance systems and hospitals in disease “hot spots” have quickly become overwhelmed.<sup>6</sup> NACCHO calls on Congress to provide additional funding for PHEP and HPP in FY2021 as well as additional emergency funding to respond to COVID-19. Our request numbers for PHEP and HPP before COVID-19 hit were at least \$824 million and \$474 million respectively.

3. How can the federal government ensure all states are adequately prepared without infringing on states’ rights and recognizing states have primary responsibility for response?

Regarding Recommendation 4.4 in the white paper, NACCHO recommends several improvements to how funds are allocated from CDC in an emergency.

In the response to COVID-19 thus far, funding has flowed through the Crisis Cooperative Agreement and through the Epidemiology and Lab Capacity Program to states and 6 large city health departments. Thanks to Congressional direction, funding was sent in an expeditious manner to these recipients. However, NACCHO has found that depending on the state, local health departments received varying degrees of financial assistance for COVID-19. For those who have received some amount of funding from state governments; many are unsure if the funding provided will be able to last throughout the pandemic or even through the summer. Unfortunately, there are also entire states where no local health departments have received federal funds via the state health department for their activation. Unfortunately, this information is not publicly reported by CDC. As stated above, NACCHO recommends that Congress require CDC to report on how much federal funding reaches local health departments via state health departments.

4. How should the federal government ensure agencies like CDC maintain an appropriate mission focus on infectious diseases in the periods between emergencies to strengthen readiness to respond when a new threat arises?

The challenges with COVID-19 are not due to CDC not maintaining an appropriate mission focus on infectious diseases. CDC's funding has not kept pace with inflation and with the vast array of issues that the agency oversees. CDC is faced with unprecedented challenges and responsibilities ranging from combating the opioid, tobacco, vaping and obesity epidemics to emergency preparedness and chronic disease prevention. CDC funds programs for injury control and violence prevention; global health security; health promotion in schools and workplaces; the prevention of diabetes, heart disease, stroke, cancer, lung disease and other chronic diseases; tobacco prevention and control; nutrition and physical activity; immunizations; HIV/AIDS prevention; environmental health, including the prevention of childhood lead poisoning; oral health; reducing health disparities; preventing infant mortality and birth defects; preventing antimicrobial resistance; preventing prescription drug overdose; improving the health and quality of life of individuals with disabilities; vision and eye health and public health research and health statistics. In order to ensure that the agency is able to respond to emergencies and address everyday health threats, adequate funding needs to be allocated by Congress to support it and the rest of the governmental public health system.

*Who Is on the Flagpole? – Improve Coordination of Federal Agencies During a Public Health Emergency*

1. Is the Assistant Secretary for Preparedness and Response the right position to coordinate a whole-of-government response to a pandemic?

NACCHO supports the leadership of HHS, and specifically the CDC and ASPR, in preparing for and responding to a public health emergency. It is essential to respect that numerous thorough and evidence-based plans have existed for years leading up to the COVID-19 pandemic and that these plans be followed.

In terms of interagency coordination during a whole-of-government response, the White House should restore a permanent health security directorate within the National Security Council. The White House should ensure these senior advisors to the President have a strong background in public health and that senior-level interagency cooperation is progressing before, during, and after public health emergencies. The White House, HHS, CDC, ASPR, Department of Homeland Security, FEMA, and the Food and Drug Administration should work together to clarify roles and responsibilities to improve the nation's emergency preparedness and response capacity

While the White House must play a coordinating role across departments in any response, the agencies with technical and public health expertise should lead during a public health emergency.

6. How can federal departments and agencies more effectively work together to respond to public health emergencies?

Regarding Recommendation 5.2, we agree that more training as well as opportunities to exercise plans and processes is needed. Without adequate funding, local health departments are unable to provide training and conduct exercises. As noted above, funding for public health emergency preparedness has steadily been cut over time. However, the work of preparing for an emergency takes consistent exercising and activity to truly be ready for disaster. Reversal of this trend is

necessary to allow public health professionals to have adequate training and exercises of preparedness plans.

In addition to these issues regarding COVID-19 and other pandemics, NACCHO recognizes that animal, human, and environmental health are inextricably linked, and future pandemic legislation must direct and require coordination among federal agencies to achieve a level of preparedness that will safeguard public health and the food supply against infectious disease outbreaks.

**NACCHO recommends that the Senate HELP Committee pass the Advancing Emergency Preparedness through One Health Act of 2019, (S. 1903)** to direct HHS and the Department of Agriculture (USDA) to develop a coordinated One Health framework across the entire federal government. Such sustained and permanent inter-agency coordination will integrate and leverage federal assets at USDA, HHS, and other agencies to prepare for and prevent the next zoonotic disease outbreak. This urgently needed coordination would increase government economic efficiency by allowing collaborative projects and responses rather than each agency operating alone and often in a vacuum.

In conclusion, thank you for the opportunity to respond to the white paper, *Preparing for the Next Pandemic*. NACCHO and local health departments look forward to continuing to work with you to keep the public safe and healthy. Please contact Eli Briggs, NACCHO Senior Government Affairs Director, at [ebriggs@naccho.org](mailto:ebriggs@naccho.org) with any questions or for any additional information you need.

Sincerely,



Lori Tremmel Freeman, MBA  
CEO

cc: Members of the HELP Committee

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#### References

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<sup>2</sup> Resolve to Save Lives. Health Defense Operations Funding Factsheet. Retrieved on June 24, 2020 from <https://preventepidemics.org/wp-content/uploads/2020/05/HDO-1-pager.pdf>.

<sup>3</sup> NACCHO. Keep Communities Healthy by Investing in the Public Health Workforce Factsheet. Retrieved on June 24, 2020 from <https://www.naccho.org/uploads/downloadable-resources/Workforce-COALITION-2020-4-30-20.pdf>.

<sup>4</sup> NACCHO. Public Health Organizations Contact Workforce Emergency Supplemental Funding Request. Retrieved on June 24, 2020 from <https://www.naccho.org/uploads/full-width-images/Joint-Public-Health-Contact-Tracing-Workforce-Request-4.30.20-FINAL.pdf>

<sup>5</sup> NACCHO. Response to ASPR Request for Information Regarding the Strategic National Stockpile. Retrieved on June 24, 2020 from [https://www.naccho.org/uploads/downloadable-resources/2020\\_05\\_27\\_ASPR-SNS-RFI.pdf](https://www.naccho.org/uploads/downloadable-resources/2020_05_27_ASPR-SNS-RFI.pdf).

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