



Public Health Federal Funding Request to Address the COVID-19 Outbreak

In response to HHS Secretary Alex Azar declaring COVID-19 as a public health emergency, public health leaders including the Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), Council of State and Territorial Epidemiologists (CSTE), and Association of Public Health Laboratories (APHL) are requesting that Congress provide resources to expand and strengthen state, territorial, and local capacity to respond to the coronavirus outbreak. State, territorial, and local health departments need major investments to assist in this global health security matter, which is now directly impacting the public health of our nation. Moreover, while the focus may be on the seven states that have reported a total of 15 confirmed cases, preparedness and response efforts are currently underway throughout the rest of the country. The infectious disease response to COVID-19 is broad and demonstrates that public health is the keystone to our nation's health security.

As of Feb. 19, 2020, it is our understanding limited funding from Infectious Disease Rapid Response Reserve Fund (IDRRF) may be distributed to state and local health departments, who are currently on the front lines in our nation's response to the 2019 novel coronavirus (COVID-19). However, to date, no official announcement of that has been made that these will be made available to the states and localities that need them, and even with limited funding current efforts by state and local health departments to halt the outbreak exceed existing funding and resources.

Six essential facts about containment of COVID-19:

- Public health serves as a first responder, once at-risk people enter the United States and serves as a trusted community resource to provide timely, accurate, and culturally sensitive public information and risk communications.
- Currently, there are no medical countermeasures (antivirals or vaccines); in their absence, containment will solely rely on public health's ability to identify, quarantine, and monitor those at high and medium risk for COVID-19, isolate and test those with symptoms consistent with COVID-19, and quickly identify potential cases with our healthcare partners.
- Public health, alone, has the necessary legal authority to implement voluntary and mandatory isolation and quarantine, through its public health authority.
- Codified by state laws and regulations, public health, individually, holds the authority to collect identifiable patient information necessary to investigate cases and contacts necessary to respond.
- Public health works closely with healthcare to provide vanguard, frontline guidance to ensure effective, consistent infection control and occupational health protection (i.e. personal protective equipment) is implemented.
- Public health plays a central role in readying and providing expertise to healthcare systems, emergency medical services, businesses, schools, elected officials, law enforcement, and other pertinent sectors for implementing guidance and community mitigation measures.

These paramount, labor intensive functions to safeguard health will only continue if public health is adequately resourced. While all non-federal governmental public health agencies appreciate the annual federal funding support and partnership with the federal government, the burden of a public health emergency response quickly exhausts the financial resources of routine, budgeted preparedness activities.

Leading public health organizations request that Congress begin immediate work to provide supplemental emergency appropriations directly to the Centers for Disease Control and Prevention (CDC), with a guaranteed base amount for state, territorial, and local health departments. While it is difficult to predict the level of supplemental funding needed this early in the U.S. response, all indications are pointing to a pandemic with broad scale population impacts. Therefore, it is important to initiate supplemental appropriations funding, before the outbreak worsens, that anticipates and funds the response, after existing resources and the transfer authority of the Secretary of HHS have been utilized. Delays in supplemental funding will severely impact the necessary response to this public health emergency and delay efforts to appropriately secure the public health of our nation.

As the public health boots on the ground working with our federal partners, we anticipate the following needs:

Immediate Response and Preventing the Spread of COVID-19

As state and local health departments, public health labs, and other similar state/local functions work to address current outbreaks and prevent additional spread, there are specific immediate needs that federal funding should support:

- **Isolation/quarantine related activities, including securing and standing up facilities, transportation and lodging and wrap around services like behavioral health services/support, counseling, or even necessities like food, toiletries, etc.**
- **Testing and monitoring patients that are currently under investigation (PUIs), rapidly investigating cases, and obtaining information on their close contacts.**
- **Outreach to the general public, including media buys, collaboration with community organizations, printing, phone banks, updating web information, and translating materials into appropriate languages.**
- **Engagement with hospital, healthcare system, and health plan leaders to monitor healthcare staffing and supplies; implement plans to reduce demands on the healthcare system, increase surge capacity in our systems, and implement alternate standards of care to conserve limited supplies.**
- **Acquisition of personal protective equipment (PPE) including N95 masks, face shields, gowns, and secure fit testing resources by third party vendors for respiratory protection.**
- **Other equipment, such as infection control supplies, digital thermometers, and other equipment costs associated with quarantine and isolation.**
- **Funds to cover the clinic visits or mobile home testing teams for uninsured/underinsured persons meeting case definition who need testing to confirm infection.**
- **Funds to cover medical transport and hospitalization for uninsured/underinsured persons with symptoms for medical evaluation.**

Congress should also ensure that the Infectious Disease Rapid Response Reserve Fund is replenished for future emergencies. This fund is critical to support short-term immediate needs such as the COVID-19 initial response. We know the fund does not adequately support a sustained response or all phases of

a response (which it was not intended to do), as it does not directly fund states to cover the resources they need to invest in a sustained response.

Further, in response to COVID-19, short-term staffing capacity is needed to assist states and localities responsible for assessing the person(s) under isolation/quarantine at regular intervals to determine if the person(s) has signs and/or symptoms of illness. Additional staffing is also needed for:

- **Increased epidemiology and surveillance, case/contact investigation, data analysis, infection control and prevention, laboratory services, pharmaceutical and non-pharmaceutical interventions, patient care and management activities.**
- **Incident management emergency operations coordination, at-risk population planning, healthcare worker safety, patient transportation, public information, and environmental services.**
- **Staffing and volunteer management, financial reporting systems, information system management, physical infrastructure and equipment management, contracting, supply and material procurement, and workforce training required to respond to an emergent disease.**
- **Increased staff within the CDC's Division of Global Migration and Quarantine at airports, seaports, and crossings to strengthen day-to-day operations, capacity and preparedness efforts.**

Laboratory Capacity

Response to COVID-19 has been swift because of CDC's public health laboratory capacity and complementary support from states and territories. CDC developed a diagnostic polymerase chain reaction (PCR) within a week of the virus being recognized by public health authorities in China, because of its world-class laboratories and a cadre of skilled laboratorians capable of utilizing genomic sequencing data and developing assays. Moreover, state, territorial and local health departments rely upon CDC for expert consultation and capacity to supplement laboratories in states, local, and territorial health departments. **An investment of funding is needed at the state and local level to purchase the equipment necessary to provide rapid diagnosis of the COVID-19. In addition, the following supplies and staff are needed:**

- **Specimen tracking and transport.**
- **Laboratory testing reagents, supplies, and consumables.**
- **Laboratory equipment for sample extraction.**
- **Laboratory packing, shipping materials, and supplies.**
- **Clerical assistance and/or laboratory assistant to support laboratory testing and other related functions.**

Workforce

Public health professionals are our biggest asset, and governmental public health departments need to be able to accelerate their expansion of a workforce of expert practitioners to serve as disease investigators and health ambassadors here in the United States and around the world. In addition, CDC's Epidemic Intelligence Service (EIS) officers have been instrumental in responding to every modern public health emergency in recent history. EIS officers are critical to federal, state, tribal, and local capacity to detect and respond to health threats and yet we are training fewer officers today than ever due to funding reductions (at its height, CDC trained 80 disease detectives a year). Currently, there are only 62 available slots in next year's cohort. Likewise, cuts at the state and local level have resulted in fewer public health professionals across all functional areas, including public health preparedness experts, epidemiologists, disease investigation specialists, and many others. Additional staffing is already needed

to eliminate uneven response capacity and readiness that will compromising our nation's health security at a time when it is needed the most.

Data Analytics/Surveillance System Rapid Case Detection and Response

Public health surveillance is the interactive system of government public health departments at the international, federal, state, local, tribal, and territorial levels working with healthcare providers and the public at-large to detect, report, respond to, and prevent illness and death. Every day—often unbeknownst to most Americans—public health surveillance is saving lives by detecting and facilitating the response to health threats.

Advancing surveillance data systems and analytics to support rapid COVID-19 detection, response, and public health decision-making is vital to our nation's health security in this response. Outdated manual methods such as faxes, phone calls, and electronic systems that are not interoperable will not adequately address the data needs given the pace of this response. Instantaneous data and information are needed to be collected on cases, their contacts, persons suspect of infection, and to rapidly communicate with persons under quarantine to identify the first signs of symptoms. The data and analytics used to support public health decision making is the cornerstone to disease surveillance and all phases of response activities. Current processes and modes of data sharing are slow, cumbersome, and curb efforts to respond effectively to the speed and intensity with the outbreak demands. To halt this outbreak, we need more, better, faster, and secure data to adequate protect the public's health. It is important to acknowledge that some of this work requires a sustained commitment of resources across all five stages of response (prevention, preparedness, response, recovery and mitigation). **Funds are needed to:**

- **Connect the laboratory test data from the new CDC COVID-19 Real-Time Reverse Transcriptase PCT Diagnostic Panel with the public health disease surveillance systems where disease information case investigations will occur. Data system changes will need to be made to ensure rapid, secure electronic standards-based sharing of test results from testing performed at public health laboratories (state/local public health laboratories, CDC laboratories) and likely soon, commercial laboratories.**
- **Improve data analytics and epidemiological surveillance system capacity and support at the state and local public health level for secure, electronic seamless reporting and information sharing of COVID-19 case information from healthcare facilities to public health. This will ensure optimal isolation and management of cases and their contacts.**
- **Implement seamless, interoperable data sharing *across* the public health infrastructure (from state/local/tribal/territorial *to or from* the federal level): Even after data are linked and stored at the state/local/tribal/territorial level, the siloed fragmented national surveillance infrastructure does not allow the data to be immediately shared with (to or from) CDC. Lack of an established enterprise process for jurisdictions to share data electronically with CDC leads to duplicative time-consuming processes at CDC to aggregate and organize data despite it being already stored electronically at the state/local/tribal/territorial level.**
- **Improve seamless data collection and sharing of and transmission of data for persons under quarantine and persons under investigation. Current processes are reliant on large amounts of manual work: pen and paper, excel spreadsheets, phone calls to healthcare providers and laboratories and from state/local public health to CDC.**
- **Support additional staffing from skilled data scientists to rapidly modify data systems to support the changing needs of the response to securely collect, receive, integrate and analyze data from multiple healthcare sources. Thousands of new data points must be received, rapidly integrated and turned into information for public health action and decision making.**

Domestic Preparedness

The threat of events, both non-domestic and domestic, increase the importance of ensuring that our nation has the adequate resources to support public health departments and our nation's healthcare system both before and during outbreaks and other emergencies. The following programs are critical to this work, but have not been fully funded in recent years:

- CDC's Public Health Emergency Preparedness (PHEP) cooperative agreement grants support 62 state, territorial, and local grantees to develop core public health capabilities, including in the areas of public health laboratory testing, health surveillance and epidemiology, community resilience, countermeasures and mitigation, incident management, and information management. While these funds are critical to build the framework for public health preparedness across the country, appropriations for the program have been significantly reduced over time from \$940 million to \$675 million between FY2002 and FY2020. The funding through PHEP is used to help health departments build and strengthen their abilities to effectively respond to public health threats, however it cannot be used to respond to potential or actual outbreaks.
- ASPR's Hospital Preparedness Program (HPP) is the only source of federal funding that supports regional healthcare system preparedness. HPP promotes a sustained national focus to improve patient outcomes. HPP's highest appropriation was \$515 million in FY2004 and funding has decreased to \$275.5 million in FY2020. Current responses to novel viruses reflect the critical need for these programs to maintain active exercising and response readiness. Increased community preparedness and response reduces financial burden in the long term by improving immediate response capability at the community level.
- The Regional Treatment Network for Ebola and Other Special Pathogens and National Ebola Training and Education Center (NETEC) are also a critical component of domestic healthcare preparedness. They are focused on screening, transfer, and treatment for many highly pathogenic diseases, not just Ebola. This program works collaboratively with the ASPR Hospital Preparedness Program and CDC to prepare and support a broad system of healthcare facilities to better respond to these diseases.

Additional funding for domestic preparedness, that supplements current resources, will ensure that the federal, states, territorial and local agencies can respond to and adequately prepare for the COVID-19. We also support additional funding for:

- Additional programs under the Assistant Secretary for Preparedness and Response, including the Strategic National Stockpile, Biomedical Advanced Research and Development Authority, and others. We can anticipate that there may be additional needs for the National Institutes of Health, the Food and Drug Administration and other federal agencies but are not in a position at this point to assess those potential budgetary needs.
- Obtaining and maintaining quarantine and isolation housing capacity. This also includes staffing the proper personnel to stand them up and provide wrap around services.

Expand CDC Capacity to Respond Globally at Outbreak Source

The many infectious diseases that pose a threat to the United States occur outside the country and it remains critical that our response to such threats occur at the source, and not when they arrive on our shores. **Funding to expand CDC's ability and capacity to respond to global threats at their origin is important to protecting the health security and public health of our nation.** Furthermore, this would also increase coordination between CDC and other pertinent U.S. government agencies in promoting a coordinated response across the federal government.