February 24, 2020

The Honorable Mitch McConnell               The Honorable Chuck Schumer
Majority Leader                              Minority Leader
United States Senate                         United States Senate
Washington, DC 20510                         Washington, DC 20510

The Honorable Nancy Pelosi                   The Honorable Kevin McCarthy
Speaker                                     Minority Leader
United States House of Representatives       United States House of Representatives
Washington, DC 20515                         Washington, DC 20515

Dear Leaders McConnell and Schumer, Speaker Pelosi and Leader McCarthy:

In response to the U.S. Department of Health and Human Services (HHS) secretary’s declaration that the 2019 novel coronavirus (COVID-19) outbreak is a public health emergency, leaders of national public health organizations, 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), request that the administration propose and Congress pass a Fiscal Year 2020 supplemental appropriations bill to expand and strengthen global, federal, state, territorial, tribal, and local capacity and coordination to adequately respond to this infectious disease outbreak.

While it is too early to reliably predict the additional cost burden and supplemental needs of the COVID-19 response, our organizations seek to work with the administration and Congress to share information so that sufficient funds can be appropriated to optimally respond, stay “ahead of the curve,” and perhaps pursue a strategy to enact multiple appropriations on an as-needed basis as the situation unfolds. We anticipate that an initial supplemental is warranted to respond to public health agencies’ critical need to rapidly detect changes and control the outbreak.

We strongly urge that a supplemental provide:

• A separate appropriation for the Centers for Disease Control and Prevention (CDC), “CDC-Wide Activities,” which should include:
  o A set-aside of a minimum or floor appropriation for state, local, tribal, and territorial public health organizations that can quickly be apportioned by the Office of Management and Budget to reach the field to support initial preparedness and response activities
  o Additional funds to support the Global Health Security Agenda.

• In addition to CDC needs, an appropriation for the relevant offices and programs under the Public Health and Social Services Emergency Fund to support the Assistant Secretary
for Preparedness and Response, including transfer authority to support activities of other HHS operating divisions, such as the National Institutes of Health, the U.S. Food and Drug Administration, and the Health Resources and Services Administration, as needed.

- Authority to reimburse uncompensated care for state and local costs, as has been done in past supplementals for other outbreaks. This should include obtaining and maintaining quarantine and isolation housing capacity and staffing the proper personnel to stand them up and provide wraparound services.

- Provisions to ensure that (1) funding should not be offset by cutting other public health programs and that (2) any existing programs or grants from which funds are diverted or transferred in the near-term response should be replenished by the supplemental appropriation.

International, federal, state, territorial, tribal, and local health agencies are on the front lines of the response to this virus, and major investments are needed to assist in this global health security challenge, which is directly impacting our nation’s health. Moreover, while the current focus is on the seven states that have reported a total of 15 confirmed COVID-19 cases, preparedness and response efforts are currently underway and necessary throughout the rest of the country. The public health response to COVID-19 is broad and demonstrates that public health is the keystone to our nation's health security.

While all public health agencies appreciate the federal government’s annual funding support and partnership, the burden of a public health emergency response quickly exhausts the financial resources of routine, budgeted preparedness activities. For example, the COVID-19 outbreak represents the first time in 50 years that the United States has established a quarantine program in response to a public health threat. Isolating and quarantining individuals and maintaining critical supplies, such as new lab tests and reagents, are beyond the scope of current federal grants. These paramount, labor-intensive functions to safeguard health can only continue if public health programs are adequately resourced. Additional examples of needs beyond what existing resources can cover are provided in the attachment to this letter.

While supplemental funding will support critical activities to rapidly respond to the COVID-19 outbreak, it should not preclude the need for Congress to provide sustained, continued, and increased investments through the annual appropriations process for HHS to expand capacity to address other existing and future public health threats.

We look forward to working with the administration and Congress to address this global outbreak that has the potential to spread throughout our communities, disrupting families, workplaces, and the U.S. economy.
For additional information, please review the attached comprehensive document and contact Carolyn Mullen, ASTHO’s senior vice president of government affairs and public relations, at cmullen@astho.org.

Sincerely,

Michael Fraser, PhD, MS, CAE, FCPP
Chief Executive Officer
Association of State and Territorial Health Officials

Lori Freeman, MBA
Chief Executive Officer
National Association of County and City Health Officials

Jeffrey P. Engel, MD
Executive Director
Council of State and Territorial Epidemiologists

Scott J. Becker, MS
Chief Executive Officer
Association of Public Health Laboratories
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.
The public health workforce is the backbone of our nation’s governmental public health system at the county, city, and state levels. Skilled professionals are the primary resource necessary to deliver public health programs and services: they lead efforts to ensure the safety of the air we breathe, the food we eat, and the water we drink. They prepare and respond to disasters like hurricanes, floods, and wildfires. And they are on the front lines of addressing complex and emerging issues, like the opioid crisis, the spread of novel coronavirus, and the re-emergence of vaccine-preventable diseases like measles.

However, governmental public health 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 (23%) of their workforce since 2008, shedding over 50,000 jobs across the country.

This deficiency is compounded by the age of the public health workforce — 55% of local public health professionals are over age 45, and almost a quarter of health department staff are eligible for retirement. Between those who plan to retire or pursue jobs in the private sector, projections suggest that nearly half of the local and state health department workforce might leave in coming years. At the same time, competition with the private sector, low pay, and geographic challenges contribute to difficulty recruiting new talent with key public health skills.

Combined, these forces indicate a public health workforce crisis that must be addressed.

The nation is positioned to make incredible progress in addressing longstanding public health problems, but health departments need the people to make a difference. And, as the healthcare system has moved rapidly into an electronic data environment, many public health professionals are not equipped with the technology or the skills to engage with these data systems. Public health is dependent on data to identify trends and target resources where they will have the greatest impact. Federal and state governments have invested heavily in healthcare systems that are able to share data, but these investments will not reach their full potential without public health professionals who can harness their potential to improve their communities.

Congress Can Help

No matter what the public health crisis or opportunity, we need the right people in place to act. That is why we must act to rebuild our public health workforce and prepare it for the future.

Therefore, we call on Congress to take a first step to invest in the public health workforce, by enacting and implementing a loan repayment program for public health professionals who agree to serve two years in a local, state, or tribal health department.
Such a program, modeled off the success of the National Health Service Corps in bringing healthcare providers to communities in need, will help health departments across the country recruit appropriate staff who can tackle 21st century challenges and increase health departments’ capacity, now and in the future, to keep the public healthy and safe.

**Supporting Organizations**

Association of State and Territorial Health Officials
Big Cities Health Coalition
National Association of County and City Health Officials

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**While the public health workforce has been cut, serious public health challenges are on the rise:**

- The deadliest flu season in a generation occurred in 2017–2018 with 80,000 deaths.
- 2019 saw 1,276 individual cases of measles in 31 states, the most since 1992.
- Syphilis and other STIs are skyrocketing with a 185% increase in congenital syphilis since 2014.
- Vaping among high schoolers has ballooned from 1.5% in 2011 to 27.5% in 2019, reversing the gains made in reducing youth smoking.

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**For more information, please contact:**

**Adriane Casalotti, MPH, MSW**
Chief, Government and Public Affairs
National Association of County and City Health Officials (NACCHO)
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**Is the workforce sustainable?**

Health departments face a high rate of turnover. Nearly half of the workforce is considering leaving their organization in the next five years.

**Nearly half**

- **22%** plan to retire in the next five years
- **25%** plan to leave in the next year for reasons other than retirement

Since 2014, there has been a 41% increase in those planning to leave their organization

**Source:** Public Health Workforce Interests and Needs Survey, 2017

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**Data Sources**

3. 2016 National Profile of Local Health Departments

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The mission of the National Association of County and City Health Officials (NACCHO) is to be a leader, partner, catalyst, and voice with local health departments.

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While American life expectancy increased for the first time in four years, more work must be done to further prevent heart disease, stroke, diabetes, suicides, and drug overdoses. CDC funds state and local public health efforts to prevent these diseases—and more, not less, is needed. Federal investment in public health has not kept pace with inflation nor the considerable challenges posed by infectious disease outbreaks, extreme weather events, and other emergencies, such as the Flint water crisis. According to a 2017 report by the Trust for America’s Health, of the $3.5 trillion spent annually on health care, only three percent of all health spending is directed to public health, which includes federal, state, and local resources. That equates to an average of $280 per person. By contrast, total health care spending is $10,739 per person.

Reductions in the public health workforce strain the ability of state and local public health departments to protect and promote population health. From 2012-2016, the estimated number of full-time health agency employees decreased by three percent. By 2020, the percentage of health agency employees who are eligible for retirement will reach 25 percent.

Congress Must Act to Increase Funding for
CDC 22% by 2022

22 by 22 is a campaign urging Congress to increase funding for the Centers for Disease Control and Prevention (CDC) 22 percent by fiscal year 2022 (FY22). The CDC’s Bold Promise to the Nation highlights the importance of the agency in protecting and promoting health. By increasing investments in five core capabilities (data, laboratories, workforce, domestic and global preparedness) CDC and its state and local public health partners will be better equipped to saves lives every day by promoting optimal health for all, protecting against disease, and helping to prevent other crises. With the many health threats and challenges our nation faces today, now is the time to adequately fund CDC.

Increasing CDC’s budget is critical to build healthier, more resilient communities and is the only way to ensure our nation’s health is protected from communicable and non-communicable disease threats.

Why 22 by 22?

While American life expectancy increased for the first time in four years, more work must be done to further prevent heart disease, stroke, diabetes, suicides, and drug overdoses. CDC funds state and local public health efforts to prevent these diseases—and more, not less, is needed.

Federal investment in public health has not kept pace with inflation nor the considerable challenges posed by infectious disease outbreaks, extreme weather events, and other emergencies, such as the Flint water crisis. According to a 2017 report by the Trust for America’s Health, of the $3.5 trillion spent annually on health care, only three percent of all health spending is directed to public health, which includes federal, state, and local resources. That equates to an average of $280 per person. By contrast, total health care spending is $10,739 per person.

Reductions in the public health workforce strain the ability of state and local public health departments to protect and promote population health. From 2012-2016, the estimated number of full-time health agency employees decreased by three percent. By 2020, the percentage of health agency employees who are eligible for retirement will reach 25 percent.
The public health community requests that Congress provide $8.3 billion in FY21—an increase of $326 million in discretionary funding from FY20—to build on the momentum of FY20 to provide predictable, sustained, and increased funding pattern needed to address several public health priorities.

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A $826 million total funding increase over two years will allow CDC to better implement effective programs to address, federal, state, and local public health priorities, such as:

**PREVENTING DRUG OVERDOSES**
More than 192 Americans die every day from opioid-related drug overdoses. Increased investment in prevention is needed to curb this dangerous trend.

**SAVING LIVES AND CURBING COSTS THROUGH CHRONIC DISEASE PREVENTION**
Chronic diseases are the leading causes of death and disability. Preventable illnesses and injuries from smoking, lack of physical activity, inadequate nutrition, and harmful environmental exposures are literally killing Americans every day.

**ENHANCING DISASTER PREPAREDNESS, RESPONSE, AND RECOVERY**
From 2015-2019, the cost for weather-related disasters exceeded $525 billion. Public health, in coordination with emergency preparedness, plays a critical role in disaster prevention, response, and recovery—and more is needed.

**PUBLIC HEALTH DATA AND SYSTEMS MODERNIZATION**
Public health data systems are antiquated, in dire need of upgrades, and rely on obsolete surveillance methods. As public health threats continue to evolve, so to must the public health’s surveillance system.

**COMBATING INFECTIOUS DISEASES**
Communicable disease control is a core function of the CDC and other governmental public health entities. The United States is experiencing daily infectious disease outbreaks and sexually transmitted diseases are rising at alarming rates. In 2018, reported cases of gonorrhea, syphilis, and chlamydia increased for the fifth consecutive year. These diseases, in addition to emerging infectious outbreaks, such as Zika, Ebola, and MERS, drain resources and challenge an already fragile public health infrastructure.

**PREVENTING AND REMEDIATING ENVIRONMENTAL HEALTH HAZARDS**
Complex emergencies associated with drinking water, sanitation, and hygiene trigger immediate responses due to the potential for community-wide harm and significant economic loss. Public health plays a role in preventing and responding to these crises.

**ENDING THE HIV EPIDEMIC**
To reduce new HIV infections in five years by 75 percent increased investments are needed for communities to diagnose, treat, prevent, and respond quickly to new HIV outbreaks.

For more information about 22x22 contact Carolyn Mullen SVP of Government Affairs and Public Relations at the Association of State and Territorial Health Officials at cmullen@astho.org
The 22x22 campaign is endorsed by 100 organizations:

Academy of Nutrition and Dietetics
AcademyHealth
Adult Congenital Heart Association
Advocates for Better Children’s Diets
American Academy of Family Physicians
American Association for Dental Research
American Association for the Study of Liver Diseases
American Association of Colleges of Pharmacy
American Association of Poison Control Centers
American Cancer Society Cancer Action Network
American Academy of Preventive Medicine
American Diabetes Association
American Heart Association
American Lung Association
American Public Health Association
American School Health Association
American Sexual Health Association
American Society for Microbiology
American Society of Hematology
Arthritis Foundation
Asian and Pacific Islander American Health Forum
Association of Women’s Health, Obstetric and Neonatal Nurses
Association for Professionals in Infection Control and Epidemiology
Association of American Veterinary Medical Colleges
Association of Immunization Managers
Association of Maternal & Child Health Programs
Association of Public Health Laboratories
Association of State and Territorial Dental Directors
Association of State and Territorial Health Officials
Association of University Centers on Disabilities (AUCD)
Autism Society of America
Big Cities Health Coalition
Campaign for Tobacco-Free Kids
Central Michigan District Health Department
Children’s Hospital Colorado
ClearWay Minnesota
Coalition for Health Funding
Colorado Association of Local Public Health Officials
Cooley’s Anemia Foundation
Council of State and Territorial Epidemiologists
Counter Tools
Epilepsy Foundation
GlaxoSmithKline Consumer Healthcare
Health Resources in Action
Healthy Schools Network
Hogg Foundation for Mental Health
Immunize Nevada
Impetus - Let’s Get Started LLC
Infectious Diseases Society of America
Intermountain Public Health Consulting, LLC
Jeffrey Modell Foundation
Kansas Association of Local Health Departments
Kymn Ballard Consulting
LIVESTRONG
Maine State Breastfeeding Coalition
March of Dimes
Maryland Public Health Association
Michigan Association for Local Public Health
NACDD
NAPHSIS
NASADAD
NASTAD
National Association for Health and Fitness
National Association of County and City Health Officials
National Association of Epilepsy Centers
National Association of School Nurses
National Coalition of STD Directors
National Hemophilia Foundation
National Network of Public Health Institutes
National Recreation and Parks Association
North American Association of Central Cancer Registries
Pitkin County Public Health
Prevent Blindness
Prevent Cancer Foundation
Prevention Institute
Public Health Institute
Redstone Global Center for Prevention and Wellness
Research!America
Respiratory Health Association
RMC Health
Sage Transformations
SAS
School-Based Health Alliance
Signature Pediatrics
Society for Healthcare Epidemiology of America
Society for Public Health Education
Society of State Leaders of Health and Physical Education
Stewards of Change
The AIDS Institute
The Ayuda Foundation/Island Girl Power GUAM
The Immunization Partnership
The Institute for Family Health/Bronx Health REACH
The National REACH Coalition
The Society for Healthcare Epidemiology of America
Tobacco Control Network
Triage Cancer
Trust for America’s Health
West Virginia Breastfeeding Alliance
WomenHeart
YMCA of the USA

Updated February 2020
Local health departments at the city and county level are on the front lines in ensuring the health of the public. The public may not always see the work they do, but communities are safer and healthier because of it.

Emergency Preparedness  
(Federal Agencies: CDC/ASPR)

Local health departments are on-call 24 hours a day, seven days a week to protect their communities quickly and efficiently from all types of public health emergencies. They develop emergency plans, train their workforce and conduct exercises to test plans, and use lessons learned from trainings and exercises to improve those plans. Local health departments secure life-saving medicines and resources including shelter supplies, vaccinations, and first-aid equipment. They know how to quickly respond and deploy these resources during public health emergencies as the result of preparedness planning, training, and exercises.

Immunization  
(Federal Agencies: CDC/CMS)

Local health departments vaccinate people in their communities, providing one of the most successful and cost-effective services to prevent disease and death. Most local health departments provide direct immunization services and promote the importance of immunizations through education and policy. Local health departments use immunization information registries to record and track vaccine administration, provide immunization outreach, and educate providers within their communities.

Infectious Disease Prevention  
(Federal Agencies: CDC/HRSA)

Despite the extraordinary successes generated by immunizations, pharmaceuticals, and evidence-based public health interventions, the spread of infectious diseases remains a critical issue. Sexually transmitted infections, vaccine-preventable diseases, and emerging threats like Ebola and Zika all demonstrate the need for strong infectious disease prevention and control programs. When a disease outbreak occurs in a community, local health departments conduct investigations and collect and analyze data to track and prevent the spread of infectious diseases. Local health departments rely on surveillance and monitoring to detect outbreaks to prevent more people from being infected.

Chronic Disease Prevention  
(Federal Agency: CDC)

Local health departments work with a wide range of community partners to create conditions and policies that help people make healthy choices, such as avoiding tobacco use and eating healthier foods. Local health department staff work to advance policy changes at the local level, such as bans on trans-fats in food served by restaurants, and to sponsor and host screenings to identify people with chronic diseases, such as diabetes and heart disease, and connect them with services and tools to help them manage their diseases. Proactive measures like these ensure there are safe spaces to exercise and play, and contribute to the prevention of chronic diseases and risk factors like obesity, diabetes, and heart disease.
Environmental Health
(Federal Agency: CDC/EPA)
Local health departments create disease control and prevention plans targeted to reduce bacterial and viral diseases transmitted by mosquitoes, ticks, rodents, and other emerging vectors. Local health departments ensure communities have clean water and air and educate residents about air pollution. This is especially important for citizens with chronic diseases, as well as healthy adults who exercise or work outdoors, and people with limited economic resources without access to medical care. Local health departments investigate, plan for, respond to, and educate the community and key partners about water-, food-, and insect-borne diseases.

Food Safety
(Federal Agencies: CDC/FDA)
Local health departments are an essential part of the process to ensure that food is safe to eat at home, at community events, in restaurants, and in schools. They work with state, local, and national partners to prevent, identify, and respond to outbreaks of food-borne illness. They inspect restaurants, grocery stores, daycare facilities, hospitals, schools, and some food manufacturing plants to ensure safe food handling practices and sanitary conditions. When necessary, a local health department will take action to ensure that a food establishment complies with sanitation standards.

Injury and Violence Prevention
(Federal Agency: CDC/SAMHSA)
Local health departments have an important position in coordinating the broader public health system’s efforts to address the causes of injury and violence. They implement and support key interventions to prevent prescription drug misuse and overdose, motor-vehicle related injuries, violence against children and youth, and falls among older adults. Local health departments develop and implement policies to prevent prescription drug misuse and overdose. Local health departments are key partners for states as they are responsible for ensuring the health of communities and serve on the front lines of the opioid epidemic. Local health departments look to curb the epidemic by increased prescription drug monitoring and access to life-saving Naloxone or Naltrexone.

Maternal and Child Health
(Federal Agency: HRSA/CDC)
Local health departments protect and promote the health, safety, and security of women, children, youth, and families. They act as safety-net providers and connect family members to support programs that provide parenting support; home visiting services; newborn screening; lead screening and assessment; supplemental nutrition for women, infants, and children; injury and violence prevention; and intimate partner violence screening as well as services such as HIV/STI testing and screening, immunizations, and oral health screening.

Tobacco Control
(Federal Agency: CDC/FDA)
Tobacco use is the leading cause of preventable death and disease in the United States. Local health departments institute policies to raise the minimum age of tobacco sales to minors, implement smoke-free multiunit housing, and restrict use of electronic cigarettes and other new products. Local health departments communicate with the public through anti-smoking advertising campaigns to decrease smoking and target high-risk groups. They provide or refer people for counseling and medications and educate health care providers about available local resources that support tobacco cessation.

Key: Federal Agency Acronyms
ASPR – Assistant Secretary for Preparedness and Response
CDC – Centers for Disease Control and Prevention
CMS – Centers for Medicare and Medicaid Services
FDA – Food and Drug Administration
HRSA – Health Resources and Services Administration
SAMHSA – Substance Abuse and Mental Health Services Administration

About NACCHO
The National Association of County and City Health Officials is the voice of more than 3,000 local health departments across the country. These city, county, metropolitan, district, and tribal departments work every day to ensure the safety of the water we drink, the food we eat, and the air we breathe.

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The mission of the National Association of County and City Health Officials (NACCHO) is to improve the health of communities by strengthening and advocating for local health departments.

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As community health strategists, local health departments make it easier for people to be healthy and safe. They collaborate with community and private-sector partners to ensure the safety of the water we drink, the food we eat, and the air we breathe. Local health departments are a critical part of every community's first response to disease outbreaks, emergencies, and natural disasters. They educate the public and combat the rising cost of healthcare due to ailments like diabetes and heart disease. They promote immunizations to reduce infectious diseases like measles and work with community partners to address the opioid epidemic. These government agencies report to a mayor, city council, county board of health, or county commission.

What is NACCHO?

The National Association of County and City Health Officials (NACCHO) represents the country's nearly 3,000 local health departments including city, county, metropolitan, district, and tribal agencies across the country. NACCHO subject matter expertise and resources help local health department leaders to develop public health policies, programs, and services to ensure that people in their communities are protected from disease and disaster.

NACCHO’s nearly 40 advisory groups, comprising experts from the field, provide on-the-ground perspectives on public health practice issues in the areas of community health, environmental health, emergency preparedness, and public health infrastructure and systems.

**FAST FACT:** NACCHO is the national non-profit association representing the nearly 3,000 local health departments in the United States, including city, county, metro, district, and tribal agencies.
National Leader in Public Health Policy

NACCHO has more than 120 policy statements on an array of important public health topics. Position statements are developed by local health officials, peer reviewed, and approved by NACCHO’s board of directors. NACCHO and local health departments use these policy statements to educate key stakeholders and urge action by federal officials, state public health officials, elected officials at all levels, partner organizations, the media, and the public.

Authoritative Source for Local Health Department Data

NACCHO has a robust research and evaluation function that provides important understanding of the work of local health departments and the issues facing local communities. NACCHO regularly conducts a national survey of all local health departments. The National Profile of Local Health Departments (Profile) study is the only national source of critical information on local health department infrastructure and public health practices at the local level. Profile offers a wealth of data about local health department activities that address community-based public health issues, including governance, financing, workforce, emergency preparedness and response, chronic disease, environmental health, performance and quality improvement, and health information technology.

Since 2008, NACCHO has also been a source of firsthand data from local health departments about budget cuts and job losses. During this time, more than 51,000 state and local jobs have been lost. This represents nearly 19% of the total state and local health department workforce.

NACCHO’s Work in the Field

- With funding from the Assistant Secretary for Preparedness and Response, NACCHO has developed the Medical Reserve Corps (MRC) Deployment Readiness Resource Guide, which provides a common set of tools for MRC units to develop the capabilities of their volunteers to support medical and public health emergency responses.

- With funding from the Centers for Disease Control and Prevention (CDC), NACCHO has supported local health department tobacco control efforts including providing mini-grants to help implement CDC’s Tips From Former Smokers® Campaign and hosting a series of technical assistance webinars focused on vaping, raising the age to purchase tobacco products to 21, and smoke-free housing.

- Supported by the CDC, NACCHO’s drug overdose prevention and response program is currently providing funding and technical assistance to over 60 communities across the country as they initiate or improve upon programs to address their local drug overdose epidemic. Particular areas of focus include drug overdose surveillance, establishing linkages to care, harm reduction, syringe service programs, collaborations between public health and public safety, diversion programs, and jail and prison-based initiatives.

- With funding from the CDC, NACCHO’s “Reducing Disparities in Breastfeeding through Continuity of Care” project is helping communities in over 30 states increase breastfeeding rates among African American and underserved families. Local health departments and health centers in these communities are collaborating with other community partners to ensure that breastfeeding resources are made available to those who need them most.

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