

January 31, 2022

The Honorable Richard Hudson  
Healthy Future Task Force  
Security Subcommittee  
2112 Rayburn House Office Building  
Washington, DC 20515

The Honorable Jim Banks  
Healthy Future Task Force  
Security Subcommittee  
1713 Longworth House Office Building  
Washington, DC 20515

The Honorable Tom Cole  
Healthy Future Task Force  
Security Subcommittee  
2207 Rayburn House Office Building  
Washington, DC 20515

Dear Representatives Hudson, Banks, and Cole:

On behalf of the National Association of County and City Health Officials (NACCHO) and the nearly 3,000 local health departments across the country, thank you for the opportunity to provide comment on your Request for Information (RFI) on pandemic preparedness, public health, and supply chains.

Local health departments have led the nation's COVID-19 response for two years and will continue to do so for the foreseeable future. However, they also work each day to prevent and address other public health problems that do not make the headlines. As community chief 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 natural disasters, emergencies, and acts of terrorism. 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.

NACCHO has provided feedback on the RFI questions that are most relevant to the work of our members and appreciates the Taskforce's inclusion of the local health department perspective in its work.

**Question 1.** *In its Public Health Emergency Medical Countermeasures Enterprise Multi Year Budget: Fiscal Years 2018-2022, the Department of Health and Human Services acknowledged the Strategic National Stockpile (SNS) "faces the challenge of maintaining a stockpile of [medical countermeasures] against a plethora of low-probability, high-consequence threats, while continuing to develop important countermeasures against other threats, and maintaining the capacity to rapidly respond to novel threats like emerging or re-emerging infectious diseases."*



- a. *What steps can Congress take to ensure the sustainability of our medical countermeasure (MCM) response capabilities?*
- b. *Are there additional flexibilities and authorities the SNS needs to adequately stockpile MCMs and to act nimbly in response to emerging infectious diseases and during public health emergencies?*
- c. *To stretch scarce Federal resources further, what additional authorities or flexibilities does the SNS require to transfer expiring stockpile items to other Federal agencies, State governments, or non-governmental entities and use profits from these transfers to acquire new MCMs?*
- d. *What challenges does the SNS face when distributing MCMs to State and local partners? What steps can Congress take to fix these challenges?*

It is critical that the roles, responsibilities, and expectations for the Strategic National Stockpile (SNS) are clarified so that localities, states, and tribal governments know what to expect in a crisis. NACCHO recommends that the SNS serve as an asset to local, state, and tribal governments available in emergencies to deliver medical countermeasures and supplies using point-to-point distribution. Without sufficient support from the federal SNS, jurisdictions must compete for needed supplies on the open market, creating an “every jurisdiction for itself” dynamic, which can disadvantage more rural or less resourced communities, and result in artificially inflated prices and an inefficient use of limited time and resources during a crisis response. The federal government should facilitate the equitable use of the SNS by all jurisdictions, and not contribute to a situation, such as during COVID-19, where jurisdictions had to compete for scarce supplies.

Further, local health department perspective should be included in implementation considerations for the SNS and other medical countermeasures from the outset (e.g., distribution, dispensing, public communications, community engagement). This includes early coordination with both local *and* state health departments involved with critical public health actions.

**Question 2.** *The Coronavirus Aid, Relief, and Economic Security (CARES) Act explicitly required the SNS to maintain, in addition to already enumerated items, supplies of “personal protective equipment, ancillary medical supplies, and other applicable supplies required for the administration of drugs, vaccines and other biological products, medical devices, and diagnostic tests in the stockpile.”*

- a. *Are there other products and MCMs Congress should explicitly require the SNS to stock?*
- b. *What challenges might the Federal government encounter to maintaining this stockpile?*
- c. *Are the SNS’s current annual review procedures sufficient for evaluating inventory needs and manufacturing, procurement, and deployment challenges?*
- d. *Should additional Federal (or even non-Federal) entities be included in the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE), which provides input on SNS stockpiling decisions? Are there shortcomings in the SNS’s coordination with current PHEMCE members? If so, how best can these shortcomings be fixed?*

Additional supplies that should be considered for pandemic response include shoe covers, hand sanitizer, disinfectants, body bags, and ancillary supplies for vaccine clinics (e.g., disposal containers for sharps, alcohol swabs, band-aids). During the COVID-19 response, we have also seen shortages of respirators/masks, gloves, and other ancillary supplies for both testing and vaccination. This is important as commodities needed for crisis response may be the same as those needed in other routine sectors,

meaning that supply shortages have a greater impact across the full workings of health department activities.

**Question 3.** *Operation Warp Speed was an unquestionable success, delivering the fastest vaccine developed and approved on record. Much of its success is due to accelerated pathways for development, testing, and approval of vaccine candidates.*

- a. *What changes to the vaccine development and approval process proved most beneficial to the timely development of COVID-19 vaccines? What changes might the federal government have made that would prove more beneficial still?*
- b. *As Congress looks toward the reauthorization of the Pandemic and All-Hazards Preparedness and Advancing Innovation Act, how might Congress codify what worked during the COVID-19 pandemic for future pandemics?*

The federal government rightly invested a lot of funding and agency capacity in the development of COVID-19 vaccines. Concurrent clinical trial research, Food and Drug Administration review, and manufacturing allowed for vaccines to be available for use less than a year after SARS-CoV-2 first emerged.

Unfortunately, the same amount of attention and resources was not invested in preparing for vaccine distribution, administration, and communication. Therefore, when vaccines were made available, systems and processes were not in place to ensure vaccinations could be administered in a timely and efficient manner. Moreover, very little could be done in advance to lay the groundwork to educate and build confidence in the broader population, allowing mis- and disinformation to spread and impacting vaccine demand.

With adequate resources, public health and health care partners could have concurrently built administration and communication capacity to ensure successful vaccine roll-out and uptake. All aspects of the vaccination lifespan – from development to distribution to administration (including both getting shots in arms, but also driving consumer confidence and demand for vaccination) – must be considered. Planning must also take into account how to ensure equitable access and distribution.

Health departments have long prepared for and practiced their response for pathogens similar to COVID-19, including pandemic flu, which included plans and exercises for mass vaccinations. Health departments play a critical role as a clinical point for vaccination, but also as an in-community strategist and coordinator to ensure efficient vaccination efforts in their local area. In the case of the COVID-19 vaccine rollout, the federal government established new routes of vaccine delivery that relied heavily on pharmacies and federally qualified health centers (FQHC) as opposed to leveraging pandemic preparedness plans previously developed at the local level to work in tandem with the newly established routes. While pharmacies and FQHCs are important access points; focusing solely on these two settings was not sufficient for broader distribution of the critical vaccinations. It is vital to ensure an array of settings have the capacity to plan, implement, and deploy mass vaccination sites for future outbreaks and emergency response.

Furthermore, health departments with robust immunization information systems experienced an unnecessary burden of navigating new systems through Operation Warp Speed such as the Vaccine Administration Management System (VAMS,) which created duplicative processes. Finally, local health

departments in many areas lacked access and visibility into where COVID-19 vaccines were distributed within their community. To date, they still do not have guaranteed access to the Tiberius data system, which tracks vaccination distribution and uptake, making it difficult to coordinate efforts within a community or to target resources. As a result, health departments could not ensure efficient deployment and uptake of vaccines in their communities.

**Question 4.** *Supplemental appropriations for the United States' early pandemic response and proposed transfers of funds illustrated the need for the Department of Health and Human Services (HHS) to act quickly and draw upon all available funding, despite the existence of the Infectious Disease Rapid Response Reserve Fund and the Public Health Emergency Fund. How can Congress better equip these funds, and other resources, to provide HHS with the support it needs to act nimbly with dedicated funding and without waiting for Congressional action?*

The federal government, via the Centers for Disease Control and Prevention (CDC), traditionally funds 50 state health departments, 5-6 very large city health departments, and health departments in the territories, often via a formula based on population. From there, in general, states then decide if, what amount, when, and how any of those dollars will go to support the local health departments in their state. However, the majority of local health departments are locally governed and not a function of the states and there is little uniformity in the experience of these dollars once they leave the federal level. As a result, there are varied experiences of how these federal dollars, which were made available by Congress for "state and local health departments," make their way to the local level. The reach of federal public health dollars to the local health department level is generally not well-tracked, providing little system-wide transparency and oversight into if and how funds are supporting critical work at the community level. While Congress directed the federal government to move quickly to disperse funds, NACCHO members report that those funds often stalled at the state level and did not move quickly through to the local level. Congress should consider the importance of federal, state, and local partners in funding conversations to ensure that communities at all levels have access to what they need to respond to a crisis. This is important both in terms of where federal funds are used but also ensuring that the strategy for those funds is informed by the local health department level as well. We greatly appreciate report language included in both the House and Senate Labor-HHS bills for FY22 that draw attention to this issue. Additional ways to improve this issue is to specify percentages of funds that must be directed to local health department level in legislation and publicly tracking the amount, speed, and reach of federal resources intended to reach the local health department level to help identify best practices.

**Question 5.** *The COVID-19 pandemic highlighted the efficacy of removing inefficient regulatory barriers that may stall public health and recovery responses. While many federal barriers to the immediate risk were addressed, long-term impediments remain that could discourage State, local, and private sector investment in pandemic preparedness.*

- a. *What regulatory barriers could be modified, consolidated, harmonized, or repealed to better ensure Federal and State public health agencies are better situated to quickly adapt and efficaciously respond to protect public health in a future PHE?*
- b. *What barriers exist that impede private sector investment in resources and capabilities – such as early warning systems, vaccine development, and domestic manufacturing – which could prove beneficial in future pandemics and public health emergencies?*

- c. *What regulatory barriers and burdens could be allayed, consolidated, repealed, or otherwise modified that would better situate local communities to remain economically viable and resilient in the face of future public health emergencies?*
- d. *What revisions and updates to public health and communicable disease law may be required in light of issues raised during the public health response to the COVID-19 pandemic?*

Federal funds are often released with specific permitted uses and reporting requirements. As these funds flow through state health departments to local health departments, states sometimes add duplicative reporting requirements and restrictions, making it difficult for local health departments to operationalize the funding efficiently. Congress should consider steps to ensure additional burdens are not added to federal dollars as they move through the state level that limit the funding's usefulness.

**Question 6.** *The National Academies of Sciences, Engineering, and Medicine (NASEM) released a study report in November 2021, *Ensuring an Effective Public Health Emergency Medical Countermeasures Enterprise*, that provides recommendations for a re-envisioned Public Health Emergency Medical Countermeasures Enterprise (PHEMCE). Four priority areas of improvement emerged from committee deliberations: (1) articulating PHEMCE's mission and role and explicating the principles guiding PHEMCE's operating principles and processes, (2) revising PHEMCE operations and processes, (3) collaborating more effectively with external public and private partners, and (4) navigating legal and policy issues. Please provide feedback and responses to relevant recommendations in this report.*

Input from local health departments must be solicited and incorporated through all aspects of public health emergency preparedness and response, including medical countermeasures. Local health departments provide strategy and direct service on public health matters in their communities and have a unique perspective that complements that of their counterparts at the state and federal level. Moreover, in terms of preparedness and response, public health, health care, and emergency management are key partners. More must be done to break down silos across these sectors and to strengthen all three.

**Question 7.** *The Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) has historically focused on and invested in strong public-private partnerships, pairing together the foundation and support of the U.S. federal government (USG) with the expertise and on-the-ground, in-the-field experience of the private sector. Throughout the COVID-19 pandemic, we have relied on the success of public-private partnerships such as Operation Warp Speed and Accelerating COVID-19 Therapeutic Interventions and Vaccines (ACTIV).*

- a. *What regulatory barriers could be modified, consolidated, harmonized, or repealed to ensure these public-private partnerships continue to be supported and best utilized to both prepare for and respond to future pandemic and public health emergencies?*
- b. *Are there other barriers that exist that impede private sector interest and investment in public-private partnerships?*
- c. *How can the U.S. federal government better support, encourage, and invest in promoting and advancing public-private partnerships with the private sector?*
- d. *Please identify any specific gaps in issue areas or programs that would benefit from additional support and promotion of public-private partnerships.*

As discussed in the response to question 6, inclusion of the public health perspective, including the unique local health department perspective, is critical throughout planning and implementation of public health emergency preparedness and response activities to ensure communities are well-equipped when public health crises arise.

**Question 8.** *What other policy considerations should Congress examine concerning reauthorization of the Pandemic and All-Hazards Preparedness and Advancing Innovation Act?*

The pandemic has brought to the fore the critical role of governmental public health — especially local health departments — in all aspects of daily life and exposed the consequences of years of underinvestment in our public health system. While emergency funding has enabled local health departments to respond to the COVID-19 crisis at hand, without a sustained investment in public health workforce and infrastructure, the public health system will be under-prepared to face the next emergency.

The public health workforce is facing a crisis that predates COVID-19 but has worsened during the pandemic response. Between those who planned to retire or pursue jobs in the private sector, projections suggest that prior to the pandemic over a third of the local workforce might leave in the coming years. NACCHO calls on Congress to establish and fund a federal loan repayment program for public health professionals who agree to serve three years in a local, state, or tribal health department as envisioned in the Public Health Workforce Loan Repayment Act (H.R. 3297). Such a program is particularly important now to retain staff and volunteers who have been brought into the field for the COVID-19 response, so their experience is harnessed and available to address current as well as future public health challenges.

NACCHO also calls for sustainable, disease-agnostic, predictable funding to support local public health infrastructure, including data modernization and workforce development. Such funding would allow local health departments to focus on certain skillsets that are critically necessary — like communication, outreach, data analysis, and digitalization — but that local health departments largely lack due to funding constraints that typically tie funding to specific disease states. This does not allow the health department to leverage skillsets across the department's efforts or to be nimble to address emerging challenges.

Importantly, funding to support cross-cutting core public health functions should supplement, not supplant the disease-specific funding that currently supports many critical health department activities. Indeed, new capabilities supported by disease-agnostic funding would ultimately enhance the functionality of existing programs.

**Question 11.** *CDC's Public Health Emergency Preparedness (PHEP) Program is comprised of several subprograms, among which are the PHEP cooperative agreement program and CDC Preparedness and Response Capability. PHEP cooperative agreements assist public health departments respond to numerous public health threats, such as infectious diseases; natural disasters; and biological, chemical,*

*and radiological events. Through both real funding decreases and inflation, funding for the PHEP Program has been reduced 48% since FY2003.*

- a. What level of funding is advisable for PHEP? Are there specific program components that should be prioritized for increases?*
- b. What additional activities would this increased funding permit CDC and State, territory, and local grantees to pursue?*
- c. How might a revitalization of PHEP enable the United States to better respond to public health threats and emergencies?*

The CDC's PHEP program should be funded at a minimum of \$1 billion in order to maintain investments in preparedness that have been made over the course of the COVID-19 response. Traditionally, investment in public health preparedness has dropped off as crises abate, meaning that the public health system cannot maintain a consistent level of readiness. PHEP is intended to support health departments in *preparing* for public health emergency and PHEP recipients expend their funding annually to establish and maintain preparedness capability; therefore, when a crisis does arrive, supplemental funds are needed to activate response systems. As with many other federal funding streams, PHEP reaches the local level in variable amounts and for many health departments is not even sufficient to support one full-time employee. Additional PHEP investments should include a requirement that a larger portion of funding makes it to the local level and that *all* local health departments are reached. COVID-19 has shown that no matter the size of the population or geographic location, all areas nationwide are susceptible to public health threats.

**Question 12.** *The COVID-19 pandemic highlighted how chronic medical conditions elevate an individual's risk of severe illness, hospitalization, and death. This elevated risk extends beyond COVID-19 and is tied to poor outcomes on numerous measures of health. Worryingly, 6 in 10 Americans have a chronic medical condition, and 4 in 10 have two or more. The Centers for Disease Control and Prevention (CDC) operates numerous programs and offices dedicated to chronic disease prevention and health promotion.*

- a. What challenges, if any, do CDC's disease-specific programs have in addressing comorbid conditions?*
- b. How might these challenges be better addressed under CDC's current programmatic structure?*
- c. Are there alternatives to current disease-specific programming that address multiple underlying conditions and promote healthy living?*
- d. What flexibilities or authorities would be required to promote such cross-programmatic efforts?*

Programs within the CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) provide funding to support activities and services delivered at the local level. Unfortunately, CDC programs have been consistently underfunded, meaning that sufficient resources have not made their way to the community level. Congress should provide adequate funding so that CDC can enable local health departments to carry out vital chronic disease prevention and health promotion activities.

In addition to strong programmatic support, Congress should provide a sustained investment in disease-agnostic, flexible funding for core public health infrastructure, including data modernization and workforce development.

**Question 14.** *Social determinants of health are another key driver of healthcare spending. Individual behavior and social and environmental factors are estimated to account for 60% of health care costs.*

- a. *To what extent do federal health programs already account for and address social determinants of health?*
- b. *How can Congress best address the factors that influence overall health outcomes in rural, Tribal, and other underserved areas to improve health outcomes in these communities?*
- c. *What flexibilities or authorities are needed to promote the adoption of policies and strategies in federal health programs to address these social determinants?*
- d. *What innovative programs or practices, whether operated by non-governmental entities or local, State, or Tribal governments, might Congress examine for implementation on a national scale?*

Efforts to address social determinants of health (SDOH) must involve governmental public health at all levels: federal, state, local, and tribal. Local health departments are uniquely qualified to serve as the convener of multiple sectors at the local level to address factors outside of the health system that affect individual and community health. It is also important the work to address social determinants of health includes both rural and urban communities.

Local health departments' role as Community Chief Health Strategists should be enacted, leveraging their expertise in data, implementation science, grounding in SDOH and health equity, and cultivating trust with the communities they serve – especially among those populations made marginalized, including BIPOC - and the cross-sectoral partnerships with whom they convene and support. This includes helping communities apply federal frameworks, like Health People 2030 and HI-5 ([High Impact in 5 Years](#)) to make meaningful progress improving health and health equity through SDOH strategies. NACCHO is currently partnering with the Association of State and Territorial Health Officials and the CDC's National Center for Chronic Disease Prevention and Health Promotion on a ground-breaking national initiative, [Improving Social Determinants of Health – Getting Further Faster](#) (GFF). Into its second year, GFF is building the evidence base on how community-based coalitions, in partnership with their local and state health departments, are improving health outcomes through SDOH strategies.

**Question 15.** *The COVID-19 pandemic has called attention to some populations' distrust of public health departments and officials, whether through historical wrongs or because of skepticism of more recent public health measures. How can Congress work to bolster Americans' confidence in public health institutions?*

Congress should invest in public health communication and literacy at the federal, state, and local level. This includes supporting resources for communications professionals and outreach workers from health departments at the local level to build trust and effectively communicate with the different corners of their community. It is also important for Congress and other elected leaders to speak out on behalf of public health colleagues and support them as they make tough but necessary decisions for their community. The politicization of public health is leading to massive losses in the public health workforce as well as unnecessary death and disease in the communities they serve.

**Question 16.** *Vaccines are perhaps the greatest public health tool, yet the COVID-19 pandemic demonstrated how widespread vaccine hesitancy is nationwide, fueled by misinformation campaigns or*

*Americans' lack of knowledge about the importance and efficacy of vaccines. Prior to the pandemic, vaccination rates for numerous vaccine preventable diseases were in decline, resulting in what were previously rare epidemics of measles in some U.S. cities. During the pandemic, lockdowns and hesitancy to visit health care settings has resulted in millions of children, and even adults, missing important routine vaccinations.*

- a. How can the federal government work to reverse both short- and long-term declines in vaccination against vaccine preventable diseases?*
- b. How can the federal government better support State and local partners in educating Americans on the efficacy and safety of vaccines and combating misinformation?*
- c. Some Americans remain unvaccinated for many vaccine preventable diseases, not because of opposition to vaccines, but because of lack of insurance coverage or access to health care services. How can the federal government better address the needs of this population?*

The federal government must invest more resources in a holistic local immunization program including the day-to-day work of vaccine promotion and administration at health departments, as well as outreach to ensure communities receive accurate information. With limited funding, efforts toward vaccine communications and trust building have lacked prior to the pandemic. In NACCHO's 2017 assessment on local health department immunization programs, the most common barrier indicated by respondents was vaccine hesitancy. Unfortunately, we have seen the consequences of that lack of investment manifest as vaccine hesitancy and skepticism during the COVID-19 vaccine rollout impacted vaccine uptake within some communities.

During the pandemic, NACCHO and partner organizations conducted several surveys and focus groups in the *Understanding Diverse Communities and Supporting Equitable and Informed COVID-19 Vaccination Decision-making Project*. The goal was to support health departments and community-based organizations in reaching communities to support people in their decision-making process. Some key takeaways were: 1) the need to understand an individual's lived experience, 2) information needs continued to evolve throughout vaccination rollout, and 3) involving the community in identifying problems and potential solutions could serve for future crisis. All of these require investment of infrastructure, time, and further evaluation to inform vaccine hesitancy. If these issues had been addressed pre-pandemic, the nation would have been better situated for COVID-19 vaccine uptake.

While mis- and disinformation do contribute to low vaccination rates in some communities, access is still a problem for others. Factors like scheduling, available transportation, and ability to take time off work may serve as barriers to receiving wanted vaccines, particularly for working families. In addition, systemic barriers to differing requirements across vaccine stocks can limit the success of vaccine delivery. One important success of the COVID-19 vaccination campaign was its no-cost availability to all, regardless of insurance status, which could also bolster the delivery of other vaccines.

There is a need for better data across the public health enterprise. Increased investments in immunization information systems and any additional real-time data on vaccination would make it easier for health departments to identify who is not vaccinated, why, and what supports they need to make informed vaccination choices. While the state-level systems need to be strengthened, they also must become more interoperable across systems. Vaccination data is particularly difficult to share across state lines, creating challenges for border counties where the state an individual lives and receives health services may be different. A lack of system-wide interoperability makes it hard to target

public health programs effectively and also hinders the consumer's own access to their records when needed. NACCHO has also heard repeatedly from our members that they do not consistently receive good data from the Department of Veterans Affairs or Department of Defense health care systems, making it difficult for local health departments to understand the true scope of vaccinations in their communities and efficiently target their resources accordingly.

**Question 17.** *The beginning of the COVID-19 pandemic illustrated the insufficiency of States' public health laboratory testing capacity and surveillance activities. What specific problems contributed to the challenges many States encountered? Which problems remain to be addressed by Congress, and what solutions might Congress pursue to enhance public health laboratory testing capacity and surveillance?*

Capacity was a challenge for both state and local public health laboratories at the beginning of the COVID-19 pandemic. While laboratory needs are real, challenges extend out to other players in the testing and surveillance process, including staff at health department who participate in testing, data entry, data analysis, and other surveillance activities. To ensure readiness, Congress, in partnership with local, state, and federal partners, should determine how to maintain a baseline level of testing and surveillance capacity so that it is available when needed in times of crisis.

**Question 20.** *The COVID-19 pandemic highlighted the need for agile, adaptable public health agencies unencumbered by activities and actions beyond the scope of their core mission.*

- a. *What reforms can be made to modernize and streamline Federal public health agencies?*
- b. *What reforms, if any, are needed to Federal public health agencies to ensure an unencumbered, agile, and adaptable public health response? What actions covered by such agencies fall outside the scope of their core missions and should be moved, repealed, streamlined, or otherwise addressed?*

The health of individuals and communities are impacted by a multitude of factors, including chronic disease, and a comprehensive approach to population health must address both disease control and prevention. One way to improve federal public health agency response would be to better connect federal policy development and funding to the state *and* local level. As COVID-19 has shown, a crisis response requires activation across all levels of government. If federal policymakers are already closely partnering with state and local jurisdictions (beyond just large cities), they will be better prepared to address federal public health priorities at the community level when an emergency arises.

**Question 22.** *What other policy considerations should Congress examine concerning improving public health and public health infrastructure?*

Congress should provide sustainable, disease-agnostic, mandatory funding to support core public health infrastructure needs. Such funding would allow local health departments to focus on certain skillsets that are critically necessary – like communication, outreach, data analysis, and digitalization – but that local health departments largely lack due to funding constraints that typically tie funding to specific disease states.

It is important that all entities throughout the continuum of governmental public health are empowered and resourced to work together to support our shared mission. Unfortunately, federal funding intended

by Congress to support all levels of the governmental public health enterprise continues to have variable reach (e.g., in amount, timeliness, and requirements) to local public health agencies. Congress should designate funding specifically for local health departments and require public tracking of disbursement of federal public health funds down to the local health department level to identify best practices and address challenges.

The public health workforce is facing a crisis that predates COVID-19 but has worsened during the pandemic response. Prior to COVID-19, between those who planned to retire or pursue jobs in the private sector, projections suggest that prior to the pandemic over a third of the local workforce might leave in coming years. NACCHO calls on Congress to establish and fund a federal loan repayment program for public health professionals who agree to serve three years in a local, state, or tribal health department as envisioned in the Public Health Workforce Loan Repayment Act (H.R. 3297). Such a program is particularly important now to retain staff and volunteers who have been brought into the field for the COVID-19 response, so their experience is harnessed and available to address current as well as future public health challenges.

Thank you again for the opportunity to provide feedback on behalf of our nation's local health departments. commendations and looks forward to working with you bolster the public health workforce. For additional information, please contact Adriane Casalotti, NACCHO's Chief of Government and Public Affairs, at [acasalotti@naccho.org](mailto:acasalotti@naccho.org). NACCHO looks forward to working with the Taskforce to improve preparedness and public health.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori Tremmel Freeman". The signature is fluid and cursive, with a long horizontal flourish at the end.

Lori Tremmel Freeman, MBA  
CEO