Statement of the
NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS
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Submitted for the record to the U.S. Senate Committee on Appropriations
For the Full Committee Hearing
"U.S. Government Response: Fighting Ebola and Protecting America"

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The National Association of County and City Health Officials (NACCHO) is the voice of the 2,800 local health departments across the country. NACCHO appreciates the opportunity to provide input to the Senate Appropriations Committee on the public health response to Ebola in the United States. Local health departments are on the front lines of public health. You may not always see the work they do, but communities are safer and healthier because of it. For example, they detect and stop outbreaks of diseases like measles, tuberculosis and food-borne illnesses; protect children and adults from infectious diseases through immunization; and provide public health information and education in the aftermath of hurricanes, tornadoes, and other natural and human caused disasters.

All disasters strike locally and local health departments are a critical part of any community's first response to disease outbreaks, emergencies, and acts of terrorism. When an infectious disease outbreak is suspected or occurs in a community, local health departments contribute in many ways. They slow the spread of disease by advising local leaders when to close schools, day care facilities, and other public places. They educate the public about how to protect themselves from getting sick. They dispense medications or vaccinations to slow the spread of illness.

Since late July 2014, NACCHO has been monitoring the outbreak of Ebola in West Africa and working with the Centers for Disease Control and Prevention (CDC) and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to support a coordinated national preparedness and response effort. NACCHO strongly supports the President's Supplemental Appropriations request for emergency funding for CDC and ASPR to combat the Ebola virus in West Africa and strengthen the domestic response. Additional resources are needed to improve Ebola readiness within state and local public health departments, because these agencies are on the front lines of protecting the public, calming anxiety and identifying any potentially symptomatic Ebola patients.

With the first case of imported Ebola in Dallas announced on September 30, the CDC escalated its domestic response to Ebola and engaged NACCHO and several other public health partners to assist in the response. NACCHO's partnership with the CDC and ASPR allows near-real time input from local health departments to be included as part of the coordinated national response. By hearing the "boots on the ground" experiences of local health departments, the federal government is able to draft appropriate guidance for scenarios that are likely to occur if local

health departments and their community partners are faced with a suspected or confirmed case of Ebola.

NACCHO began sharing Ebola preparedness resources with local health departments in early August, helping them to prepare for potential cases of Ebola in their communities. Local health departments are using their time-tested capability to respond to infectious disease and protect the public. Local health departments, under guidance from CDC and ASPR, are monitoring travelers from nations that have had widespread Ebola virus transmissions. Local health departments are determining when to isolate and potentially quarantine individuals who are at risk of becoming contagious, which stops transmission of the disease. They investigate people who may have come in contact with a contagious Ebola patient. This requires local health departments to interview patients on all their activities to identify others that may have been exposed (i.e. contact tracing). Exposed individuals must also be interviewed, informed of their risk, and monitored appropriately according to national guidance. When a symptomatic person has been to a crowded public setting, then the local health department may issue health alerts or other notices to help identify potentially exposed individuals. Local health departments also work with hospital officials, emergency management, emergency medical services and law enforcement to encourage adherence to rigorous infection control practices, including procedures for putting on and taking off personal protective equipment.

But what is especially unique to local health departments is the critical role they play in health risk communication. It is their job to educate and inform the public about how to protect themselves from getting sick during an outbreak, like advising when it is necessary to engage in health protection activities such as when to wear masks, avoid mass gatherings, and stay at home. In the case of Ebola, the risk to the public is extremely low and none of these precautions are currently necessary for those that have not had direct contact with a symptomatic Ebola patient. However, increased media attention and misinformation have significantly contributed to public angst about Ebola. Local health departments are trusted and credible sources for disseminating health risk information that provides a calm path forward for an anxious and worried public. Recently, local health departments have also been an essential voice in providing science-based information to the public in an effort to educate and dispel misinformation that has led to Ebola-related stigma against people from West African countries and returning healthcare workers that were deployed to the affected locations. The preparedness and response activities required of public health agencies protect public safety if performed correctly, but come at a high human resource and financial cost.

The domestic response to Ebola also highlights the need for interoperable health information technology (IT) systems that facilitate sharing of data between health care providers and public health agencies. This has the ability to support contact tracing and disease surveillance and allow quicker targeting of suspect cases. Some jurisdictions may bear a disproportionate burden for monitoring individuals. Technological solutions such as call centers, video monitoring, and data reporting systems will ease this burden and keep local health department capacity from becoming strained. New and available data sources also need to be available to local health departments to facilitate contact tracing, particularly when data on an individual is incorrect or incomplete.

A lot of attention has been focused on whether the electronic health record system in Dallas helped or hindered hospital personnel in diagnosing the first imported Ebola patient. However, NACCHO urges the Committee to also recognize the importance of building a health IT system that allows the public health and health care sectors to communicate and share information in a timely fashion to slow and stop the spread of disease. Currently, in many communities across the nation, such a system does not exist. In a larger outbreak, there could be dire consequences to this lack of readily accessible information.

While supplemental funding is needed in the short term, a sustained federal investment in public health emergency preparedness is critical to maintaining this capacity at the local level. After 9/11 and Hurricane Katrina, there was national momentum to improve public health preparedness. This momentum was matched with increased federal spending to improve preparedness at all levels of government: local, state, and federal. The increase in federal funds allowed for local health departments to increase the number of staff dedicated to public health preparedness, form healthcare coalitions in their communities, develop and exercise plans, and increase coordination with other agencies, as well as purchase medications, supplies, and other equipment that might be needed during a public health emergency.

More than half of local health departments rely solely on the federal government for emergency preparedness funding. The federal government provides three sources of funding that support the preparedness capabilities of local health departments. The first is CDC's Public Health Emergency Preparedness (PHEP) program that has provided over $7 billion in funding to state, local, and territorial public health departments to build and strengthen their abilities to respond effectively to public health emergencies including terrorist attacks, infectious disease outbreaks, natural disasters, and biological, chemical, nuclear, and radiological incidents. While there are only four directly funded cities (Chicago, Los Angeles, New York City, Washington DC) many local health departments receive funding through subcontracts with their state health department.

The second is ASPR's Hospital Preparedness Program (HPP) that provides grants to states and four directly funded cities that in turn fund local health departments, healthcare facilities, and other partners to build capabilities and capacities that strengthen the preparedness, response, recovery, and resilience of the public health and healthcare system. HPP supports health department preparedness coordinators to organize coalitions of public health and healthcare providers to plan and prepare for public health emergencies. This coordination is extremely important in response to an emergency like Ebola where the local health department and the affected healthcare facilities must work together to protect the community.

Under the federal government's National Hospital Preparedness Program (HPP), local health departments are encouraged to develop healthcare coalitions within their communities to improve coordination between the healthcare and public health communities. Healthcare coalitions that respond to Ebola may need to be broader than just a partnership with the local hospital. Local health departments may need to work closely with agencies and private organizations that support law enforcement, the judicial system, emergency management, EMS, medical examiners, medical waste management, veterinary services, volunteers, and others.

Lastly, the Office of the Surgeon General provides $9 million in annual funding to support the nation's 1,000 Medical Reserve Corps units, with two-thirds of these units housed at local health departments that support staff to manage volunteer coordination during disaster response. Many local health departments rely on these funding sources to support activities such as dispensing vital medications during a pandemic or other infectious disease outbreaks, conducting disease surveillance, providing accurate and up-to-date risk information to their communities, and staffing shelters for those displaced by a disaster.

However, PHEP grants have been cut by 33 percent over the last decade (FY2004-FY2014). In FY2014, HPP was cut by $100 million. In total HPP has been cut by 54 percent over the last decade (FY2004-FY2014). These three federal funding sources work together to support local health departments, and cuts to one have a ripple effect on the preparedness capabilities of communities across the country. Many local health departments, especially those in rural areas, have had to cut staff and have been relying more and more on volunteers such as those in Medical Reserve Corps units to fill the gap.

NACCHO's 2013 *National Profile of Local Health Departments* found that per capita spending on public health preparedness went from a median of $2.07 per person in 2010 to $1.15 per person in 2013. NACCHO's 2014 *Forces of Change Survey* found that 48,300 jobs have been lost in local health departments from 2008 – 2013, representing 15% of the local health department workforce. Many local health departments are operating at a diminished capacity due to budget cuts from all levels of government. In the area of preparedness that means there is less staff to prepare for and respond to disasters, fewer restaurant inspectors to protect the community from foodborne illnesses, and fewer trained professionals to detect the release of deadly biological or chemical agents resulting from terrorist attacks.

It is also important to note that Ebola is not the only preparedness priority right now for many of NACCHO's members. Other infectious diseases such as Enterovirus D-68 and seasonal influenza are also top priorities. Local health departments are also responding to natural disasters such as tornados or flooding and, very soon, winter storms.

Despite funding cuts, the public health workforce stands ready to do whatever is necessary to stop Ebola from spreading. But those cuts have put deep dents in the public health shield that protects the lives of all Americans and make it more likely that local health departments faced with even a few cases of Ebola would significantly strain their already thinly stretched workforce and financial resources during the response.

NACCHO appreciates the Committee's attention to the need to protect public health both domestically and abroad and to shore up the U.S. public health system. NACCHO urges Congress to provide emergency funding to CDC and ASPR for global and domestic Ebola preparedness and response. In addition, NACCHO urges Congress to pass an FY2015 Omnibus appropriations bill that provides sustained funding for state and local health department preparedness programs through PHEP, HPP, and the MRC.