NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

Comments Submitted to Rural Working Group Related to Rural Infrastructure
April 2021

Thank you, Senators Smith, Baldwin, Rounds and Fischer and other members of the Senate Rural Working Group, for the opportunity to provide input about rural infrastructure needs. The following comments are submitted on behalf of the National Association of County and City Health Officials (NACCHO), the association that represents our nation's nearly 3,000 local health departments. NACCHO and local health departments appreciate your long-standing support of rural public health.

Public Health Workforce
The infrastructure of rural public health relies on people, day in and day out, pandemic or not. In rural areas, many local health departments perform more clinical services than in non-rural communities, due in part to a lack of health care providers. Rural public health department staff know their communities and have strong relationships with residents and community partners. Unfortunately, a lack of sufficient, predictable funding has led to challenges in supporting rural public health professionals, recruiting top talent, and retaining this expertise. At the same time, public health challenges have increased. Impending retirements, staff that do not reflect all facets of the demographics of their communities, and positions tied only to specific ailments/funding streams have led to both a shortage in people power and a lack of flexibility to meet new challenges.

We are incredibly grateful the Congress included specific funds in the American Rescue Plan focused on building the public health workforce. NACCHO urges Congress to take this opportunity to leverage this time to build out the systems and funding needed to improve the recruitment and retention of the governmental public health workforce for the long-term so that we can meet our national public health goals in all communities.

Local Health Department Workforce Reductions Over Time
The work of governmental public health—and local public health in particular—has long been under resourced, and local health departments were hit particularly hard by the 2008 recession. Prior to COVID-19, local health departments had already seen decreases in available funding amid increasing threats to the public's health. The Great Recession of 2008 hit all sectors of local government hard, but whereas other sectors were able to bounce back, funding for local public health did not recover. As a result, local health departments began the pandemic response down 21% of their workforce capacity from 2008, with the number of full-time equivalent employees dropping from 5.2 per 10,000 people in 2008 to 4.1 per 10,000 people in 2019.[1] In 2019 alone, just prior to the most deadly public health emergency in a century, nearly a quarter of local health departments reported losing jobs.[1] In the smallest health departments (serving populations of less than 50,000) small gains were recorded in 2018

and 2015, but this does not erase the impact of losses in 2011 and 2012 (1,800 jobs).[1] These figures are also pre-COVID-19, which has further decreased local and state government budgets. In addition, rural health departments often have a small number of staff, each wearing multiple hats. They may not have the grantwriting resources to take advantage of funding opportunities or to be successful in being funded for grants. Rural health departments entered the COVID-19 pandemic without the necessary resources to protect their communities from the deadliest disease outbreak in 100 years.

The types of jobs lost also matter. We have seen a huge reduction in public health nurses on staff—the key utility player in the COVID-19 response — with a loss more than one third since 2008. Similarly, key roles that work across programs were also lost. For example, public information officers were difficult to train with decreased budgets, but their importance as lead communicators to help get information to the public in a clear and consistent way is a critical component of a public health response built on the actions of individuals to properly social distance and use masks. Individuals who perform core functions of the health department are often not included in disease-specific grants and therefore challenging to retain without targeted investment.

The types of workforce available to local health departments vary widely due to the size of the health department and its budget. Almost all local health departments employ registered nurses and office and administrative support staff. Small agencies (serving populations less than 50,000) are much less likely than to employ epidemiologists or statisticians, information systems specialists, public information professionals, and public health physicians than local health departments serving populations greater than 500,000.[1] Professionals who are trained to assess data and information coming from health care and other sectors has been particularly critical in the COVID-19 response. Less than 10% of the smallest health departments employ epidemiologists/statisticians or public information officers, which affects the ability of these agencies to adequately track the spread of disease and communicate timely, science-based information to the public.[1]

The Impact of COVID-19 on Public Health Programs

These workforce shortages pre-pandemic have significantly impacted the ability of local health departments not only to respond to the crisis, but to keep other public health problems at bay. Preliminary findings from NACCHO's 2020 Forces of Change survey show that 80.5% of local health departments reassigned existing staff from their regular duties to the agency's COVID-19 response. In situations where staff were reassigned, 72.9% reported that employees performed fewer of their regular duties, and nearly half (46.6%) indicated their regular duties were not performed at all. The programmatic areas most impacted by service reduction include obesity prevention (74.7%); maternal and child health services (60.1%); tobacco, alcohol or other drug prevention (64.6%); and screening activities for blood lead (58.8%), high blood pressure (63.0%), and diabetes (66.0%). This highlights the importance of strong staffing levels not just to respond to the pandemic or future large-scale crises, but also to rebuild the many other health department priorities that have been impacted by the response.

Workforce Recommendations

- **Provide Incentives for the Recruitment and Retention of Public Health Professionals**

A lack of public health workforce capacity has real world implications that expand the human cost of the pandemic beyond the astronomical number of lives lost to the virus and will continue to impact their day-to-day operations long after the pandemic is over.
The public health workforce crisis needs our attention now—not just to get through the pandemic, but also to pick up the pieces of the many other public health issues that have not gotten their needed attention. To do so, we must focus on the three key factors to building a strong rural health department workforce: retaining trained staff, recruiting top talent, and expanding the workforce overall with predictable, sustainable, flexible funding.

We must act to create a comprehensive approach to increasing available jobs to grow the public health workforce, recruiting key professionals, and retaining them for the long term. That is why over the past year, NACCHO has organized and led over 100 stakeholders in a call to create a federal loan repayment program for public health professionals who complete a term of service in a local, state, or tribal health department that would help to fill these workforce gaps. This is particularly relevant now, as new staff and volunteers are being brought into the field for the COVID-19 response on a temporary basis. A public health loan repayment program, modelled after the successful National Health Service Corps that currently bolsters the rural health care workforce, would provide an added incentive to retain them long term and help ensure that their experience is harnessed and available to address current as well as future public health emergencies. Bipartisan legislation was introduced in the last Congress to stand up this program by Senators Smith (D-MN) and Booker (D-NJ) and Representatives Crow and Burgess (S. 3737/H.R. 6578), and we urge Congress to move forward to create and fund this initiative as quickly as possible so that the program can be stood up in time to help the pandemic response and recovery.

While we work to increase staffing and capacity at public health departments, we must also look to increase salaries and increase benefits to make these positions more competitive and offer those already in the pipeline a career ladder to stay in the field.

- **Investment in Public Health Workforce and Infrastructure over the Long Term**

The importance of strong, predictable federal investment in the public health system is even more vital now as the economic and social impacts of the pandemic are felt nationwide, and as local and state budgets contend with lost tax revenue. During summer 2020 we saw some local health departments furlough staff in the middle of the pandemic due to budget challenges related to the economic impact of COVID-19 on local and state budgets, and similar constraints are likely in the coming months and years, especially as COVID supplemental funds run out.

The reality is that we need to do more to ensure that every American, regardless of geography, is protected and supported by a strong public health system, as the resources, staffing, and capacity of local health departments greatly vary across the country. We applaud legislation introduced by Health, Education, Labor, and Pensions Committee Chair Patty Murray (D-WA) –

the Public Health Infrastructure Saves Lives Act – which would provide a sustained investment in the basic infrastructure of the governmental public health system at all levels. If enacted, this investment would help support staff to deliver the core capabilities necessary for all health departments to be successful. By building the core public health infrastructure of localities, states, tribal governments, and territories, as well as the Centers for Disease Control and Prevention (CDC), the nation will be better prepared for emerging threats in ways that will more meaningfully address the health inequities magnified by such threats.

Recently, NACCHO developed recommendations in coordination with the Big Cities Health Coalition in response to EO 13996 and the American Rescue Plan (ARP); that document is attached. Below we share some key principles that must be considered in any current or future attempts to strengthen the rural public health workforce:

- **Federal Funding Must be Sustained and Predictable**
  The "boom and bust" cycle on which we fund the public health system is not conducive to sustainability, particularly in public health preparedness, and will not build back the lasting capacity needed to protect and promote the public health's health. This has proven to be painfully evident in our country's pandemic response to date. Funds must be predictable and sustained so that health departments can plan for and hire the staffing they need on a "permanent" basis, not based on the lifetime of a grant, which could be a year, for example. In these instances, staff are hired and trained by local health departments, but not retained for the long term.

  We also must ensure that these funds get to the core needs of local health departments, which includes, but is not limited to, public health preparedness. For example, health departments' critical work on preventing chronic disease cannot be separated from the pandemic as these diseases have been shown to be a dangerous pre-existing condition for COVID (and so many other costly outcomes). Similarly, the pandemic has highlighted the need to also support LHD staff, and the community as a whole, to continue to address health disparities and build a more equitable health system for all.

- **Resources, Both People and Dollars, Must Get to the Ground Level Quickly**
  Ensuring that resources get to the local level in an efficient and timely manner is incredibly important and all-too-often overlooked. Local health departments are the front line and, in their communities in particular, the face of the governmental public health enterprise. However, traditionally most CDC funding mechanisms place them at the end of the line for possible resources, often without meaningful inclusion to ensure sufficient funds are made available in a timely manner.

  While we urge the federal government to enable as many communities as possible to receive funds directly (automatically or via application), where that is not possible, there needs to be guidance to states with specific language *and instruction* requiring that local health departments receive an appropriate portion of the funds in a timely manner

without additional requirements beyond the federal guidelines. In the past, despite federally allocated funds for local response, state channeled funds have been slow to arrive to the local health departments, which can significantly impact their ability to hire and train needed staff. Ideally, local health departments, not just states, should be able to request these resources and staff from federal agencies and partners.

Finally, the US Office of Management and Budget (OMB) and/or HHS must ensure that federal funds are publicly tracked, including information about how much has been sent by states to the local level and the timeframe for receipt to both identify best practices as well as better understand the historical challenges of getting money to the front lines.

- **Mechanisms for Local Support**
  We need to have flexible approaches to help local health departments hire directly. A variety of options should be employed depending on what works for the individual health department: staff may be employed by the health department, long-term embedded staff (that can be directly requested from the federal government by a local agency), or allowing small health departments to come together to hire shared professionals that they may not be able to afford alone, such as an epidemiologist or informatician.

- **Leverage Existing Infrastructure at Health Departments and Across Workforce Programs**
  While not a substitute for permanent workforce employed at the local level, workforce programs based at the CDC, such as the Public Health Associate Program (PHAP) and the Epidemic Intelligence Service (EIS), as well as other detailed federal employees, have been used for years to extend the capacity of health departments and key partners at all levels of government. This should continue, and the PHAP and EIS programs should be expanded. They provide critical capacity and public health training provided by the CDC to supplement the current workforce, and many "graduates" of these programs continue their careers in governmental public health. Unfortunately, low pay often makes it difficult for these trainees to join their health department after their traineeship has ended. Additional consideration should be given to efforts to help them continue their career in local public health departments.

  Where utilized, staffing placements and/or detailees, including federal employees, should be integrated within the health department to which they are detailed, to maximize effective functioning and promote connection and collaboration with existing public health prevention and response efforts. For any staff details, placements, or deployments, it is critical that local health departments be able to request these staff directly from the federal programs. Moreover, outreach should be conducted to help lower resourced health departments apply so that they can be competitive for this important assistance.

- **Diversify the Workforce to Reflect the Community**
  All public health workforce programs should consider how to best support efforts to increase diversity, open doors of opportunity for all, and make every effort to ensure that staff reflect the community. The growth and retention of the public health workforce should contain a specific focus on racial and ethnic diversity to address issues of trust, confidence, and representation of the diversity of the residents served by the health department. This should include diversity and inclusion resources, as well as implicit bias training for the current workforce.

- **Priority Governmental Public Health Workforce Positions and Functions**
  Key workforce positions most in need by local health departments essential for COVID response (and beyond) include informaticians, molecular lab specialists, public health nurses, and epidemiologists, as well as policy, outreach, communications, and administrative support. The latter, which includes legal, human resource, and finance and contract management positions are often excluded from federal grant mechanisms and are an integral part of ensuring that the work can done in communities across the country.

  While highlighting specific occupations is helpful to show the range of positions needed, it is also important to ensure flexibility so that health departments can staff up not just based on title but based on functions and skillsets. This is particularly important for smaller health departments where individual staff must fill numerous roles.

  Sustainability and flexibility in the use of workforce funds is critical to build legitimate capacity in governmental public health. While we must hire positions now that can respond to COVID-19, we must also shift to preparing for future public health emergencies, building a trained, ready, workforce.

Data Modernization

In addition to workforce capacity, the data infrastructure of rural health departments is sorely in need of upgrading in order to allow health departments, health care providers including hospitals, and the federal government to seamlessly and quickly exchange data. In an emergency, as we have seen with COVID-19, delays of minutes and hours can result in severe consequences and lost lives. In the smallest local health departments – those serving populations of less than 50,000 – only about half have implemented electronic health records (53%) and electronic lab reporting (44%).[1]

The Data Modernization Initiative (DMI) at the CDC is helping to create a standards-based interoperable public health infrastructure, ensuring all systems can communicate and share data with one another; advancing standards so that information can be stored and shared across systems; and facilitating complete and timely reporting so that our public health system has essential data on race, ethnicity, pregnancy status, treatments, and co-morbidities that are critical for achieving equity in public health response.

NACCHO urges Congress to appropriate at least $250 million in Fiscal Year (FY) 2022 towards the DMI, which represents a commitment to building the world-class data workforce and data systems that are ready for the next public health emergency. NACCHO is grateful to Congress for providing nearly $1 billion to date for CDC's DMI through annual and supplemental appropriations. Now, we need robust, sustained, annual funding to complete the foundational investment of $1 billion and to ensure we are investing in public health systems and infrastructure, including at rural local and state health departments, that will keep pace with evolving technology.

Rapidly evolving technology demands that public health keep pace with advancements by continually upgrading data systems and ensuring cybersecurity. The COVID-19 pandemic has shown starkly that public health has fallen behind over the past decade because of eroding infrastructure in data science and information technology. We cannot allow our foundational investments to become obsolete—we must build upon them and provide adequate sustained resources for public health to develop, implement, and maintain the data systems and technologies needed to train the next generation of data scientists.

In conclusion, a robust, sustained commitment to transform today's public health surveillance and workforce will ultimately improve America's rural health and security.

For additional information, please contact Eli Briggs, NACCHO's Senior Government Affairs Director, at ebriggs@naccho.org.

[1] NACCHO. 2019 Profile of Local Health Departments. Retrieved April 14, 2021 from https://www.naccho.org/resources/lhd-research/national-profile-of-local-health-departments.