astho™

TO: Members of Congress
FROM: Association of State and Territorial Health Officials
Date: April 10, 2020
RE: Contact Tracing Workforce

Background: In order to appropriately address the COVID-19 outbreak and potentially move to gradually reduce community mitigation efforts, we encourage Congress to ensure sufficient national capacity for COVID-19--this includes reagents for COVID-19 testing, personal protective equipment for both rapid COVID-19 tests and point of care and serological testing for COVID antibodies, and electronic data systems to rapidly share and receive laboratory data by public health. We also encourage a robust contact tracing workforce that builds on existing state and territorial health agency disease investigation programs to find COVID-19 cases and isolate them.

Congress must provide flexible long term and emergency supplemental funding to expand the scale of disease investigation specialists (DIS) and the contact tracing workforce within our local, state, territorial, tribal and federal public health agencies.

Principles: Below is an outline of principles Congress should consider when drafting legislative language:

1) Contact tracing workforce should be scaled using existing capacity at the state, local, and territorial public health departments. This workforce exists in health agencies and their communities. The ultimate goal should be to increase DIS and add lay contact investigator support using existing DIS. Commensurate expansion of federal, state and territorial epidemiology and laboratory capacity is also necessary.
2) Congress **should not** set up a system outside of existing public health agency response (i.e. FEMA) for hiring or placing new contact tracing volunteers. Volunteer management systems are in place in state emergency operation centers and new efforts must be integrated with current capabilities and capacity at CDC, federal, state, local, tribal, and territorial health departments to assure coordinated planning of volunteer deployment and consistent implementation of liability protections and safety measures.
3) The federal funding must provide maximum flexibility to enable public health agencies the support needed to recruit and retain staff.
4) The response and recovery will vary city by city and state by state. Workforce capacity cannot be based on a one size fits all approach and must be led by the state and territorial public health departments in partnership with local, federal, and tribal public health and emergency management stakeholders.
5) Workforce capacity must be built for the long-term. COVID-19 will not be the last time the United States experiences an infectious disease outbreak. We encourage recruitment from the existing workforce—this includes MPH students, established public health fellows, community health workers, and medical assistants. Support to forgive student loans for the public health workforce is necessary to recruit and retain existing and new staffing.

Workforce Numbers: Currently only 2,200 DIS are employed throughout the entire country in local and state health agencies. Based on preliminary research generated by Johns Hopkins University, it’s believed an additional 100,000 contact tracing employees are needed to address COVID-19 in the immediate future. Additionally, a minimum of 1,200 new epidemiologist are needed to support full

epidemiologic capacity as document in the 2017 Epidemiology Capacity Survey by the Council of State and Territorial Epidemiologists (CSTE).

Current Challenges: Due to state revenue short falls because of the economic downturn, some health departments furloughed staff which equates to lost capacity at the state and local health departments. These staff must be rehired expeditiously using supplemental and stimulus funding to support public health priorities. Furloughed public health department staff possess technical and content expertise to assist with the immediate COVID-19 response and eventual recovery efforts.

Funding: ASTHO encourages Congress to create three funding streams. One which will provide long term sustainability via a mandatory public health infrastructure fund, a short-term emergency supplemental funding, and finally a loan repayment program to quickly scale up the workforce.

- **Public Health Infrastructure Fund: $4.5 billion** in additional annual mandatory funding for CDC, state, local, tribal and territorial core public health infrastructure to pay for such essential activities. This includes disease surveillance; epidemiology; laboratory capacity, all-hazards preparedness and response; policy development and support; communications; community partnership development; and organizational competencies. This funding should be in addition to the annual discretionary appropriations.
- **Emergency Supplemental Funding:** Based on modeling generated by Johns Hopkins University, approximately **$3.6 billion** at a minimum is needed for state and local health departments to hire this staff. The mechanism to get this funding quickly out the door could be through the CDC Crisis CoAg. Programs at CDC that support this type of work include the Infectious Disease Division, STD, HIV, and TB line items. Again, it is critical that funding is not restrictive and as flexible as possible.
- **Loan Repayment:** Another critical step to invest in the public health workforce is enacting and implementing a loan repayment program at the Health Resources and Services Administration, for public health professionals who agree to serve two years in a local, state, or tribal health department. **$200 million** in appropriations is needed to establish such a program.

Supporting Organizations: The approach outlined in this document is supported by the Association of Public Health Laboratories, the Council of State and Territorial Epidemiologists, and the National Coalition of STD Directors.

Contact: Carolyn Mullen ASTHO's Senior Vice President, Government Affairs & Public Relations
cmullen@astho.org