April 23, 2023

The Honorable Mariannette Miller-Meeks
1034 Longworth House Office Building
Washington, DC 20515

Dear Dr. Miller-Meeks:

On behalf of the Big Cities Health Coalition (BCHC), I am writing to provide comment on your Request For Information (RFI) regarding the U.S. Centers for Disease Control and Prevention (CDC). BCHC is comprised of health officials who lead 35 of the nation's largest metropolitan health departments, who together serve more than 61 million – or about one in five – Americans. As you know, large urban health departments work in concert with their state health department – and other locals in neighboring jurisdictions – as well as the CDC, to comprise the nation's governmental public health system.

BCHC and our members work to advance a shared, actionable vision for health, where all governmental agencies, healthcare providers and systems, and community-based organizations work together to promote and produce health, safety, and equity.

Please find our comments to the RFI below. It is also important to note that a well-functioning health system – and any emergency response – must be a whole of government approach. No one agency at the federal level is solely responsible for the nation's health.

CDC's Mission

CDC serves as the command center for our federal, state, and local public health system protecting against emerging and reemerging infectious diseases as well as man-made and natural disasters. It also works to promote health and prevent harm related to non-infectious disease. From playing a leading role in the detection and mitigation of the COVID-19 pandemic in the U.S. and globally, to monitoring and investigating the mpox outbreak and other disease outbreaks, to pandemic flu preparedness, CDC is the nation's – and a global – expert resource and response center, coordinating communications and action and serving as the laboratory reference center for the nation's state and local public health network that keeps our communities safe.

CDC's mission is critical to building a sustainable and resilient public health system that can respond effectively to emerging threats and ongoing public health needs to keep Americans as safe and healthy as possible. Effective research, data, and implementation of programs requires significant connection and collaboration with local and state public health partners.

Strengthening the public's health means protecting people from preventable illness, unnecessary death, and a host of emergent and recurring health threats. CDC must proactively address the foundational elements of wellbeing for all individuals and continue to invest significantly in the nation's public health infrastructure at all levels of government. The U.S. spends more than any other high-income nation on health care per capita, with significantly worse health outcomes. Chronic diseases are the leading causes of death and disability and, along with mental health conditions, account for an estimated 90 percent of the nation's $4.1 trillion annual health costs. If we want to reduce future health spending, we need to invest in prevention and public health.

To do so, Congress should provide at least $11.5 billion for the CDC in the FY 2024 Labor, Health and Human Services, Education and Related Agencies appropriations bill. Strong funding for CDC is critical to supporting all of the agencies activities and programs as well as state and local public health departments, all of which play an essential in protecting the public's health in your communities. Over two-thirds of CDC funding goes to STLT health agencies, non profits, and private organizations; any cuts to CDC has real trickle down effects.

CDC has experts across issues and supports local and state health departments to do the same. Crises like COVID-19 and Zika demonstrated the need for collaboration across multiple program areas. During Zika, for example, CDC employed a cross-agency response that used infectious disease experts and those in birth defects and maternal health to reduce the risk in pregnant women and infants.

Public health approaches led by CDC are also critical to the understanding of the extent of the opioid crisis. The same approaches that CDC uses to detect and respond to infectious disease - monitoring, early identification, and connecting research to action - are needed to respond to the over 100,000 deaths annually from drug overdoses. The spread of infectious disease among intravenous drug users is an issue that relies on expertise from both infectious and non-infectious centers at CDC – working together across silos.

As the pandemic has demonstrated, chronic disease and infectious disease are inextricably linked. Indeed, in the absence of vaccines, good underlying health is the best way to prevent severe infection and death from communicable diseases. The world is continuing to experience greater linkages between infectious and chronic diseases, like with COVID-19 where individuals with a chronic illness are more susceptible to its effects and leaving many patients living with the chronic condition of long COVID. Therefore, any efforts to improve pandemic preparedness and prevent the spread of infectious disease must also include efforts to prevent chronic disease, address health disparities, and ultimately, improve underlying health and wellness for all. BCHC sees CDC's National Center for Chronic Disease Prevention and Health Promotion as a key pillar of our nation's public health security enterprise. Moving or eliminating programs there puts the use of taxpayer dollars and the health of communities at risk.

CDC's *Moving Forward*

CDC *Moving Forward* is an ongoing process to ensure CDC can better deliver on its mission to protect the health, safety, and security of Americans. CDC has acknowledged they needed to take steps to change the culture and processes of the agency to make it a more responsive organization, and we are supportive of these changes.

BCHC has engaged on and been supportive of *Moving Forward* for several key reasons. First, it has put a greater focus on the core infrastructure pieces – workforce, capacity, lab, epidemiology, data - that are integral to CDC and support local and state health departments, which are now directly reporting into the Office of the Director (OD). CDC also created the National Center for State, Tribal, Local, and Territorial Public Health Infrastructure and Workforce (Public Health Infrastructure Center) to support STLT health departments and bring together critical components of that work that was in different Centers across the Agency. The creation of the data office with the OD is an important step for the Agency to also bring many data streams and partners together in one coordinating space.

In addition, BCHC supports the changes in *Moving Forward* to strengthen CDC as a response agency. CDC plays a critical role in the nation's response to everyday threats as well as epidemics and pandemics. However, CDC has not been afforded many of the needed authorities that would enable it to align with the expectation of being a response agency. For example, CDC should be given the authority and flexibility to direct hire for positions that directly provide for, support, and aid preparedness, response, and recovery activities. This would support a nimble response that can quickly surge to address emerging threats and allow the agency to non-competitively hire term employees in certain circumstances.

CDC should also be given flexibility to pay over the salary caps. This authority would allow CDC to establish a flexible pay scale for priority positions, hire surge staffing, and pay surge personnel above the GS scale during a declared PHE, as in other response agencies like FEMA. Similarly, the agency should be afforded an overtime pay cap waiver and the ability to provide danger pay for certain roles. This would allow CDC to appropriately compensate those staff who are responding at a moment's notice and being put in harm's way. Finally, federal action on these challenges would also support local and state health departments' attempts to get these authorities - particularly overtime in an emergency - from their local governing entities.

CDC Guidance

Local (and state) health departments rely on CDC guidance whether during a public health emergency or addressing an everyday health challenge. CDC provides guidance for public health practitioners, health care providers, and the public. For example, CDC develops guidance on HIV prevention, treatment, and testing that are followed by health practitioners, health departments, and community-based organizations. At the local level, it is critical that there is national guidance to ensure there is relative consistency in public health practice within states and localities, and across the country. That CDC guidance does not carry the weight of law and are recommendations meant to aid state and local health officials in decision-making based on the best available science and data.

During COVID-19, in particular, local health departments relied on CDC guidance in educating providers and the public about masking, social distance, and vaccination policies. But that said, local and state health and elected officials still needed to put policies in place to protect their communities. Our members often see CDC guidance as a "floor, not a ceiling" in considering a minimum set of actions that local and state officials might take to protect the public's health. While much has been made of these restrictions, some of our member jurisdictions felt undercut when CDC recommendations did not go far enough, illustrating that we need CDC to set a baseline that allows for local implementation. CDC data and science were important for local use even if policy decisions and implementation varied.

Another critical example is CDC's development of the Clinical Practice Guidelines for Prescribing Opioids for Pain. CDC recognized the overprescribing of opioids and sought input from experts and the public to develop the guidelines in 2016 and again in 2022. Prescribing of opioids for pain has decreased as a result. For both sets of these guidelines, CDC did both a public comment process (not really possible in a true emergency) and interacted with a host of stakeholders to understand how the guidelines would affect different groups both positively and negatively.

What is needed – no matter for an emergent or everyday challenge – are a process that allows for pre-decisional communications and input by local and state health departments, and other stakeholders when/as appropriate. BCHC is pleased to have shared input when asked and will continue to work closely with the Agency – and others across the federal government – to ensure that guidance is actionable at the local level. Again, we are appreciative of CDC thinking through these processes as part of *Moving Forward*.

MMWR

The Morbidity and Mortality Weekly Reports (MMWRs) are a critical source of research and data that are routinely used by health officials and clinicians across the country. We support CDC's efforts through *Moving Forward* to get scientific information and data out in a more timely fashion to support actionable decision making at the local level. The Agency was able to do this during mpox as they issued timely MMWR articles based on trends they were seeing in the data. Additionally, annual MMWR articles on adult & youth tobacco use rates provide an important breakdown of trends in tobacco use from year-to-year. These articles are based off surveys or questions included in surveys that CDC conducts.

It is important to note that MMWRs are just one mechanism through which data and research are disseminated, and the research reports are not meant for a lay audience. While it is important to increase the time with which MMWR findings are released, and share the underlying data when wherever possible, MMWRs were not meant to be a way to share emerging science with those who need this information most. BCHC supports CDC working through processes about how best to share such information through this and other mechanisms. We know that – regardless of how data or findings are disseminated – it is important to get stakeholder input and buy in to translate data and science into action.

Workforce Reform

As you well know, our governmental public health workforce was in a crisis before the pandemic, with local health departments (LHDs) losing over 20 percent of their workforce compared to before the 2008 recession.[i] Over the same period, the nation's population increased by 8 percent.[ii] In 2019, the number of fulltime equivalent governmental public health staff dropped from 5.2 per 10,000 people to 4.1 per 10,000 people.[iii]

We need to invest in a long term, well-funded, well-trained, and diverse health workforce that is reflective of the community and employed by, or detailed long term to, local health departments. This will take sustained and predictable federal funding to create and support jobs that can support core public health functions, work across health department programs (as opposed to being tied exclusively to siloed disease-specific programs), and support the foundational capabilities of health departments,[iv] including assessment and surveillance and access and linkage to health care, so that all Americans can benefit from these efforts no matter where they live.

Key workforce vacancies among local health departments 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 be done in communities across the country. We appreciate that this is starting to change with more recent funding mechanisms and hope Congress will continue to support STLTs to hire for these roles.

A modern, well-resourced, and sustainable health workforce also requires efforts to recruit and retain top talent, whose skillsets are in even higher demand today by those who can pay more than a local government. Employee benefits, competitive salary, and sufficient training, as well as student loan forgiveness, are all critical to achieving this goal. Programs such as the Centers for Disease Control and Prevention's (CDC) Epidemic Intelligence Service (EIS), the Laboratory Leadership Service, the Public Health Informatics Scholarship, and the Public Health Associate Program (PHAP) – as well as a number of HRSA training programs that support a host of health professions – are all critical for building and retaining a talented and skilled health workforce. These programs must be expanded in concert with a broader federal initiative to recruit, train, and retain the next generation of public health and health care professionals.

Ensuring that resources get to the local level in an efficient and timely manner is incredibly important and all-too-often overlooked. Most CDC funding mechanisms – and many of their career programs or fellowships opportunities – have traditionally placed local health departments at the end of the line. We encourage the federal government to enable as many communities as possible to receive direct federal funds (automatically or via application), but where that is not possible, there needs to be guidance to states with specific language and instruction requiring that local communities 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. Further, local leaders, not just states, should be able to request resources and staffing from federal agencies and partners to extend their capacity when needed.

While not a substitute for permanent workforce members 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 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 know-how to supplement the current workforce, and many "graduates" of these programs continue their careers in governmental public health. This is true across the health landscape, not just in public health, as HRSA has a number of similar programs. Unfortunately, low pay scales and earning potential often make it difficult for these trainees to stay in the communities into which they are placed, and additional effort should be made to help those individuals continue their careers in the communities in which they served.

In terms of a more response-ready staff at CDC, BCHC supports giving CDC the authority to use appropriated funds to support a cadre of response-ready staff in each of CDC's 13 different budget accounts. These staff could deploy for any PHE or an event with significant potential to become an emergency. Further, the CDC director should be given the authority to dedicate up to 1% of each account for the purpose of funding these long-term, response-ready detailees/ deployments. Such authority would not only enable CDC to stand up an emergency response, but also support the local and state health departments in standing up their own responses. BCHC urges flexibility with this funding to enable deployment of CDC staff expeditiously.

State Block Grant Programs & Funding to STLT Health Departments

BCHC does not support creating additional block grant mechanism to states. Rather we support mechanisms that increase the number of grantees to include large LHDs. States are exceedingly variable in how and how much they subgrant to local health departments who are responsible for the health and safety of local communities. As such, CDC should be encouraged to broaden its direct grantmaking pool to include, at a minimum, the 107 jurisdictions recently funded under the Public Health Infrastructure and Grant Program. This universe of grantees includes the 50 states and Washington, D.C.; eight territories/freely associated states; and 48 local health departments that either serve cities with a population of at least 400,000 or counties with a population of at least 2,000,000 based on the most recent U.S. Census numbers.

Congress should also include the following strategies to reduce administrative burdens on STLT public health agencies for non-emergency federal funds:

- Multi-year funding awards with 24-month budget periods and the ability to redirect funds during the budget period. This would reduce the administrative burden of processing carryover and no-cost extension requests.

- Notwithstanding existing provisions, formally allow STLT public health staff funded through any federal categorical cooperative agreements and grants to adopt federal teleworking rules and standards with approval from the STLT public health authority.

BCHC also believes non-disease specific funding is critical. We are incredibly grateful that the FY2022 Consolidate Appropriations Act included an important new investment in core public health infrastructure and support. The pandemic exposed the deadly consequences of chronic underfunding of basic public health capacity. The "boom and bust" cycle on which we fund the public health system is not conducive to sustaining a high level of preparedness or health services and will not build or support lasting capacity needed to fully protect and promote the public's health. Funds must be predictable and sustained so that staffing can be planned for and hired on a "permanent" basis, not always based on the lifetime of a grant.

Because public health departments at all levels of government are largely funded by specific disease or condition, there has been little investment in cross-cutting capabilities that are critical for effective public health. These capabilities include: assessing a community's health needs; preparedness and response; policy development and support; communications; community partnership development; organizational competencies; and accountability. Governmental public health infrastructure requires sustained investments over time, and we believe new investments in core public health infrastructure is an important start.

Data and Surveillance

CDC's Data Modernization Initiative (DMI) is working to create modern, interoperable, and real-time public health data and surveillance systems at the state, local, tribal, and territorial levels. These efforts will ensure public health officials on the ground are prepared to address any emerging threat to public health—whether it be COVID-19, measles, a foodborne outbreak like e coli, or another crisis. COVID-19 exposed the gaps in our public health data systems and since then Congress has provided funding for DMI. We are thankful for those investments as they have been a critical lifeline, but the public health surveillance systems must live beyond COVID-19 and be ready for any and all future threats. This requires long-term, sustained investment to build capacity not just at the federal and state level, but also at health departments in cities and counties across the country.

BCHC also supports the Improving *Data Accessibility Through Advancements in Public Health Act* or *Improving DATA in Public Health Act* (H.R. 5376, 117th Congress) that promotes coordination between federal agencies to share critical public health data used to prepare for and respond to public health emergencies. The bill also creates standards to improve and secure the transfer of electronic health information and establishes an Advisory Committee to ensure that public health data reporting processes are carried out effectively. Every effort must be made to strengthen public health data systems as an essential component of emergency preparedness.

In addition, BCHC believes giving CDC the authority to effectively collect and coordinate public health data is necessary to serve its mission and address known blind spots. The current framework for collecting and sharing public health data has resulted in fragmented and inconsistent reporting to CDC, and to state and local public health partners. Expanded data authority for CDC will allow for more complete and timely data sharing to support decisions at the federal, state, and local levels, while also reducing burden on providers. For example, authority included in the CARES Act requiring COVID-19 laboratory test reporting during the PHE greatly improved the availability of laboratory data. We support CDC having the authority to require reporting of minimum necessary data to serve a range of public health and other mission-critical use cases.

CDC Authorization

CDC's programs are authorized by general and program-specific laws, mostly through the Public Health Service Act (PHSA). CDC has general authorizations and program specific authorizations. BCHC believes these existing authorities have allowed CDC to evolve to address new and emerging health threats and challenges. We do support, as we have stated previously, giving CDC additional authorities to enhance its response-ready and data collection capabilities.

CDC Foundation

The CDC Foundation (CDCF) was created by Congress and began its operations in 1995 to support and carry out activities for the prevention and control of diseases, disorders, injuries, and disabilities, and for the promotion of public health. CDCF is focused on vital efforts that support CDC in improving and saving the lives. During its history, the Foundation has worked across Presidential Administrations and Congresses, and it does so in a nonpartisan way with a clear focus on actions, partnerships and programs that improve health and save lives.

CDCF carries out its work to address large-scale health challenges across core public health protection activities, with the majority of its funding focused on infectious diseases and emergency response (representing more than 70 percent of funding received since its inception). The Foundation's work is playing a critical, strategic, and essential role in protecting and promoting the health of Americans. Importantly, CDCF funding has helped CDC and organizations working in support of the public's health make progress on health challenges by, for instance, working in communities to address infectious disease threats like measles and HIV; working with veteran-serving groups to bolster veteran's suicide prevention; and helping to strengthen our nation's fragile public health protection system.

As such, BCHC supports the CDC Foundation as a partner to CDC and to local and state health departments. The Foundation played a critically important role at the height of the COVID-19 pandemic helping place public health surge staff in local and state health departments. CDCF rapidly hired more than 4,000 staff during the pandemic who were placed in health departments across the country. These staff included epidemiologists, communications professionals, school nurses, and more. BCHC is grateful that the Foundation could facilitate these essential activities, and it should be used a model in future emergencies.

In closing, I want to reiterate how integral a strong, well resourced Centers for Disease Control and Prevention is to the public's health. Across federal, state, and local governmental enterprises we should be working together to restore trust in government generally and public health leaders more specifically.

Thank you for the opportunity to comment on the RFI. Please do not hesitate to contact me at juliano@bigcitieshealth.org if BCHC can be of further assistance.

Sincerely,

Chrissie Juliano, MPP
Executive Director

[i] NACCHO's 2019 Profile Study: Changes in Local Health Department Workforce and Finance Capacity Since 2008. https://www.naccho.org/uploads/downloadable-resources/2019-ProfileWorkforceand-Finance-Capacity_final-May-2020.pdf

[ii] Population Reference Bureau, The U.S. Population Is Growing at the Slowest Rate Since the 1930s. https://www.prb.org/the-u-s-population-is-growing-at-the-slowest-rate-since-the-1930s

[iii] NACCHO's 2019 Profile Study: Changes in Local Health Department Workforce and Finance Capacity Since 2008. https://www.naccho.org/uploads/downloadable-resources/2019-ProfileWorkforceand-Finance-Capacity_final-May-2020.pdf

[iv] Transforming Public Health through the FPHS, 2022. Alexandria, VA: Public Health National Center for Innovations (PHNCI), a division of the Public Health Accreditation Board. https://phnci.org/transformation/fphs