October 20, 2023

The Honorable Bill Cassidy
Ranking Member
Senate Committee on Health, Education, Labor, and Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

Via CDCModernization@help.senate.gov

Dear Dr. Cassidy:
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 state health departments – and other locals in neighboring jurisdictions – as well as the CDC, to as a key part of the nation's governmental public health system.

BCHC and our members work to advance a shared, actionable vision for health, where all governmental agencies, health 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.

Fostering Innovation and Collaboration

Creating a Culture of Innovation
While we don't disagree that innovation and creativity are needed at the CDC, this is a challenge many government agencies deal with. A critical piece of the Moving Forward work has been to think about how the agency needs to change and adapt to be more nimble, less siloed, and more proactive. Further, it is important to remember that CDC sits within HHS, a huge department with its own set of priorities, which can limit the agency's ability to truly create such a culture.

In-Person Work
Much has been made of CDC staff in Atlanta returning to the office. And while there is a large campus that has real costs to the taxpayers to run, one way that government *can* compete with the private sector is in offering benefits such as telework. In an environment with set pay scales and prescriptive benefits, it is often hard to compete for the best talent. Because of this, BCHC believes Congress should not further hamstring government agencies abilities to do so by demanding full time in person work.

Making Data Work for Everyone

Public Health Data

Gathering and exchanging data defines the foundation of public health detection and response. Starting at the point of patient care, health-related information is collected and reported to state, tribal, local, and territorial (STLT) health departments as governed by state law. Health departments analyze the data to quickly detect possible threats to the public and evaluate and implement local control measures if needed. To provide a nationwide perspective of disease burden, STLT health departments share de-identified data that has been organized and linked with investigation and response information, with CDC, which ultimately informs national public health responses, resource allocation, prevention initiatives, and policy.

The effectiveness of the nation's public health data system relies on efficient and accurate data flow from source to STLT agencies to the federal government. While data at the federal level are essential, it is important to emphasize that individual-level data are collected at the STLT level where immediate public health response happens. STLT health departments have the legal responsibility and authority to protect people living within their jurisdictions; they need timely data to respond immediately, efficiently and effectively "on the ground." Investment in system modernization at the STLT level is essential to support this flow of public health data and ensure the rapid delivery of health care data to public health.

CDC's Data Modernization Initiative

CDC's Data Modernization Initiative (DMI) is working to create modern, interoperable, and real-time public health data and surveillance systems at all STLT 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 critically important investments, but public health data and 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 and our partners in the Data: Elemental to Health campaign, support a robust and sustained federal investment in public health data modernization at CDC and to STLT health departments. Investing in DMI, which the coalition estimates will cost $7.84 billion at the STLT levels in five core pillars (see below) over five years, is the key to improving our public health data infrastructure. These estimates do not include critical dollars at the federal level or expansion beyond the five core pillars—both of which are also ultimately necessary. As a start, Congress should appropriate at least $160 million for DMI in fiscal year (FY) 2024 and commit to making a larger long-term investment as soon as possible. Without sustained funding, neither STLT public health authorities nor CDC will be able to implement, maintain and update the federal data assets necessary to achieve timely public health data to inform public health action and save the lives of babies, children, and adults in this country.

There are five key interconnected pillars essential for public health data modernization. They are: (1) Electronic Case Reporting, (2) the National Notifiable Disease Surveillance System (NNDSS), (3) the Electronic Vital Records System, (4) Syndromic Surveillance, and (5) Laboratory Information Systems including Electronic Laboratory Reporting (ELR). Each of these pillars plays a key role in the modernization of our public health data infrastructure and more information on each is included below.

1. **Electronic Case Reporting (eCR)** is the automatic submission of disease reports directly from electronic health records at clinical care organizations (e.g., hospitals, health systems, community health centers) to STLT public health departments. STLT public health authorities need to fully integrate eCR (across all diseases) to give health care providers an automated, burden-free means to communicate with public health when there is a condition of public health importance. eCR reduces physician time to fulfill their legal responsibility to report to public health and dramatically improves disease and condition reporting, leading to early implementation of interventions and limits the further spread of infectious agents. eCR will help guarantee that when providers see patients—in any setting—patient demographics, clinical information, and test results for reportable conditions are automatically shared with STLT public health authorities—and for nationally notifiable conditions, high-quality data can be rapidly shared with CDC. Early DMI investments in eCR are making a difference: more than 29,200 facilities in all 50 states are actively sending electronic initial case reports to public health using eCR. Ongoing funding is needed to ensure that initial progress made to date is not interrupted, or worse, reverted back to manual paper processes due to lack of sustained funding.

2. **National Notifiable Disease Surveillance System (NNDSS)** is the system that allows STLT health departments to quickly transmit data to CDC during an outbreak response and routinely provide a timely, steady source of data on diseases that are nationally notifiable. Resources are needed to make improvements in NNDSS and expedite data submission from STLT public health authorities to CDC.

3. **Syndromic Surveillance** provides near real-time data on hospital emergency department visits for continuous monitoring of community health incidents such as the impact of natural disasters, including hurricanes, respiratory diseases, and opioid overdoses. It provides public health professionals with the ability to monitor the pulse of the community and identify health threats as they emerge.

4. **Electronic laboratory reporting (ELR)**, which is in place across the country, formed the basis of the nation's situational awareness during the COVID-19 pandemic. ELR enables STLT public health authorities and the federal government to have timely information on laboratory results. ELR often provides the first piece of information about a case or even an outbreak, triggering investigations and immediate action at STLT health departments. Without ELR, public health authorities would not be able to implement life-saving prevention and control measures expediently. Beyond ELR, laboratory information systems need to be modernized to include electronic ordering of lab tests to help ensure critical information is captured at the time of test order to supply public health with the information needed to launch a rapid response.

5. **Vital records** are foundational public health data. Improvements are needed to our electronic vital records systems to ensure real-time transmission of birth and death data for longitudinal statistical and monitoring purposes and to track mortality during public health emergencies. Systems must be interoperable so physicians, coroners, medical examiners, and funeral directors can easily report deaths through their existing electronic records systems—eliminating delays and reducing errors.

At a 10,000 foot level, the key principles of DMI to transform the nation's public health data systems are **interoperability**–ensuring all five of these core data pillar systems can receive, communicate, and share data effectively with one another; **an enterprise-wide approach** that remains disease agnostic; **data standards** to ensure data can be shared across systems, between jurisdictions, and with the federal government; **security** to protect privacy; a **workforce** that is trained in appropriate data science technology; and **partnership with the public and private sectors** to build, maintain, and refine the public health data superhighway and establish leading-edge public health data systems and processes.

DMI will help to break down silos and ensure that all systems are secure and interoperable, thus allowing STLT public health authorities to more efficiently use data for public health action and to communicate data to CDC. Underfunding DMI limits what CDC can allocate to jurisdictions and will hinder our ability to make improvements and incorporate evolving technology. DMI is not just an emergency response mechanism; it is necessary for tracking daily public health threats including respiratory viruses like influenza and RSV, opioid overdoses, foodborne illnesses, and natural disasters. STLT health departments are the front line of our nation's public health system and all disease detection and response efforts rely largely on federal funds, with states contributing an average of only 12%. Likewise, few federal dollars have gotten to local health departments across the country to increase their data capacity.

Federal Data Authority

BCHC also supports the Improving *Data Accessibility Through Advancements in Public Health Act* or *Improving DATA in Public Health Act* (H.R. 3791) 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.

Electronic health record (EHR) data and CDC's data modernization

Efficient use of EHR data is critical to DMI efforts. For example, as discussed above, eCR is currently transforming the process in which data for potential cases of disease are detected and rapidly submitted to public health. The automated eCR process mitigates the risk of duplicative data entry, transmission errors, or failures to report at all. Healthcare providers collect only the information that are already collected for patient care in the clinical encounter (no additional public health specific information needs to be collected) and no additional clinical care time is necessary to report the information housed in the EHR to public health. With more accurate disease data, eCR systems can promote more timely notifiable disease reporting and optimize public health surveillance functionality throughout the system,

supporting rapid public health responses and implementation of control measures at the STLT level and more rapid case data sharing with CDC.

Case reporting is a key component of public health and occurs when reporting entities such as hospitals and health care providers submit information about patients with reportable conditions to public health authorities pursuant to jurisdictional laws. An initial case report to public health departments includes health data from the time of suspected disease onset and often before the disease is confirmed. Unlike traditional case reporting, the use of eCR supports automated identification and transmission of case reports from electronic health records and then routes them through decision support tools to the correct public health jurisdiction. Data reported via initial eCR are made available first to STLT public health departments, where the data are processed, integrated with other information collected by the STLT disease investigators through investigation or electronic sources, confirmed, deduplicated and then deidentified before the case information is sent to CDC. Most of these activities can be automated but additional funding is needed to support STLTs' capacity to be able to implement eCR with all providers in the jurisdiction and to ensure rapid delivery of the correct information to the national level.

CDC's Center for Forecasting and Outbreak Analytics

Created with American Rescue Plan funding in early 2022, the Center for Forecasting Epidemics and Outbreak Analytics (CFA) works to deliver decision support to government entities, state and local leaders, and the public through infectious disease forecasting and outbreak analytics. CFA recently awarded funds to 13 primary awardees to establish the first national network for outbreak analytics and disease modeling. Many of these awardees are leading a consortium of collaborators to design, prototype, test, and scale up advances in data modeling tools and technology that can be used to support public health decision makers at all levels of government. This network of networks extends the geographic reach and technical diversity of performers focused on innovating, integrating, and implementing modeling and forecasting tools to improve outbreak response. The network's goal is to improve speed, accuracy, and use of data and analytics during health emergencies, which is an important step towards ensuring Americans have the information they need to keep themselves and their families safe during outbreaks. BCHC believes the advanced analytics for disease forecasting and modeling will be an important resource for our members. Sustained funding is required to maintain the center's functionality over time.

Public Use of Data

It is important to make accurate data available to the public. However, as discussed above it is imperative that any data shared publicly—including on a public dashboard or other website—be fully deidentified, and not able to be reidentified, accurate and representative. This is one reason why the implementation of eCR is so critical as current manual processes are slow, can be duplicative, require time consuming deduplication, are often missing the most basic information that is already collected in the EHR, and worse yet, reports by providers may never be made. There should be a clear, defined process for the re-release of data, including close coordination with STLT to ensure individuals are not identifiable or able to be reidentified. Modernized, scientifically sound and robust methods to suppress selected data are necessary to protect personally identifiable data. When CDC publishes public health data at the national level, we recommend that STLT health departments are given the opportunity to review and preview the data prior to its release to the public. CDC could invest in an "STLT view-only" pre-published prototype site that would allow STLT health departments to review the data to address potential gaps, anomalies, prepare for a coordinated response, as well as monitor data sharing of ongoing outbreaks.

Utility of Data Collection

The public's health depends on having data to preserve and protect it. A public health crisis shows this need more than anything else. Data collection is a vital process for understanding and identifying a potential health crisis from its inception through de-escalation or even resolution. By gathering and analyzing data related to health, public health professionals can discover patterns, trends, and disparities that affect the well-being of all communities including those most marginalized or key settings with those most vulnerable (schools or nursing homes). Data can also help to determine who is at risk of developing or transmitting a disease, and who needs the most urgent intervention. For example, during the mpox virus outbreak in 2022, data on travel history, sexual orientation, and clinical symptoms were collected to identify the populations most vulnerable to the infection and its complications. Data collection during the mpox response also informed the development and evaluation of prevention and control strategies, such as vaccines, treatments, and public health policies. Therefore, core demographic data collection as well as disease specific data are essential for protecting and improving the health of the public in the face of emerging or re-emerging threats. The public health system is the biggest protector of our nations water supply and ensuring food safety. Every day, STLT health departments conduct foodborne disease investigations and use the information to locate the potential source and eliminate contaminated sources from the food supply such as *Cronobacter* contaminated infant formula. Data elements like age, race, ethnicity, pregnancy, disability status, treatments, and co-morbidities across both acute and chronic conditions are critical to ensure a public health response is directed to the individuals and areas most in need of intervention as well as identifying communities or individuals at higher risk of severe outcomes (e.g., pregnant women) or most likely to have unmet health needs or vulnerabilities.

Improving Upon What Works Well

State, Tribal, Local, and Territorial (STLT) Relationships

The tripartite governmental public health system – federal, state, and local – is essential to ensuring the health and safety of communities. These relationships can be better supported through transparent communication and consultation, sharing of data at all levels, and robust, predictable funding. Effective public health response depends on action at the federal, state, tribal, local, and territorial levels of government. Explicit authority to direct funding to governmental agencies at all levels of government is needed. Updated authority would improve the timeliness of awards intended specifically for state and local government jurisdictions. Any such authority should also include an analysis of efficiency and efficacy of dollars getting local through grants to states.

Further, 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. CDC has made a concerted effort to expand funding opportunities to large city and county health departments through Overdose Data to Action 2.0 and the National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities grant. CDC should continue to seek opportunities for direct funding to the local level.

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.

As most local health departments receive funding through their state, 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, as well as ramp up programs. Further, local leaders, not just states, should be able to request resources and staffing from federal agencies and partners when needed.

Epidemiology and Laboratory Capacity Cooperative Agreement (ELC) Program

The Epidemiology and Laboratory Capacity Cooperative Agreement (ELC) Program strengthens the epidemiologic and laboratory capacity in 50 states, several large local (city/county) health departments, and eight territories. This funding provides critical support to disease detectives (epidemiologists) and laboratory scientists who are instrumental in discovering and responding to various public health threats, including food and vector-borne outbreaks and antibiotic resistance. While most of the funding comes from CDC's National Center for Emerging and Zoonotic Infectious Diseases, it is a core program that allows state and local health departments to strengthen and maintain their epidemiology and laboratory capacity to respond to public health needs.

Funding across CDC's National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) programs is essential to combat new and emerging threats. Disease specific funding bolsters the ELC program by directly supporting capacity within the specific program areas (e.g., vector-borne disease, foodborne disease, influenza, and healthcare-acquired infections); however, this funding is tied to a specific disease category and cannot easily be reassigned when a new threat emerges. Increased funding across NCEZID programs will allow for an increase in funding available to STLT health departments through the ELC mechanism and it must be coupled with an increase in the foundational ELC program line—which has not been increased from $40 million since 2011. Increased funding is needed to enhance core epidemiological response, which supports flexible epidemiologists who can respond to and support outbreaks for multiple disease threats.

The ELC program is critical to state and local health departments' ability to combat infectious diseases. Funding from the ELC program is a critical resource to help states respond in the early stages of a pandemic. It is the principal funding source for emerging infectious disease prevention and control, which strengthens detection and response for infectious diseases, early detection of newly emerging disease threats, and identification and response to outbreaks. The ELC uniquely supports a core epidemiology, informatics, and laboratory workforce that can work across disease/condition disciplines, which is critical to ensure optimal capacity, coordination, and outbreak needs.

As recent years have demonstrated via concurrent outbreaks of COVID-19, pediatric hepatitis, mpox, Ebola Sudan virus, Marburg, surge in pediatric hospitalizations due to the respiratory syncytial virus

(RSV), and other threats, the United States remains at high risk for new and emerging diseases. The ELC program is unique to CDC as it is the only source of support for core epidemiology and laboratory workforce and infrastructure, specifically intended to respond to outbreaks across the spectrum of infectious diseases and is not tied to categorical disease areas.

ELC dollars should be directly sent to big city health jurisdictions so they can support local epi and lab capacity. While federal funds supported more than 90% of state epidemiologists (both in annual appropriations and COVID supplementals) in 2021, they only accounted for about 60% of the staff costs for local epis. This is higher than in years past due to COVID supplementals. Further, where funds are not directly sent to local jurisdictions, states should be made to track and report through CDC how they are sub-allocating funding to the local level, including amount, date funds are made available, and how allocation decisions are made.

CDC 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 recognized the need to take steps to change the culture and processes of the agency to make it a more responsive, innovative 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 within 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.

Mechanisms to Modernize

Workforce

As is well documented, 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.[1] Over the same period, the nation's population increased by 8 percent.[2] 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.[3] The CDC would benefit from a modern approach to expanding its staffing capabilities.

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, 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.[4]

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.

While not a substitute for permanent staff directly 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

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[1] 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

[2] 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

[3] 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

[4] 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

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.

Further, the "boom and bust" cycle on which health departments are funded is not conducive to sustaining a high level of preparedness or health screening and 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. That is not possible, however, when we continue to set the workforce up to hit a funding cliff when the current one-time $3 billion investment is spent down.

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.

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.

Thank you for the opportunity to comment on the RFI. Please do not hesitate to contact me at juliano@bigcitieshealth.org for additional information.

Sincerely,

Chrissie Juliano, MPP
Executive Director