Dear Members of Congress:

The Association of State and Territorial Health Officials (ASTHO) is the national nonprofit representing state and territorial public health agencies. ASTHO’s members—the chief public health officials of these agencies—are dedicated to formulating and influencing sound public health policy and assuring excellence in public health practice.

The COVID-19 pandemic has underscored the importance of our state and territorial governmental public health infrastructure. ASTHO’s members are committed to a thorough and robust pandemic response. This book compiles COVID-19 specific issue briefs covering top issues in the pandemic response that include:

- Vaccine Distribution
- Workforce
- Health Equity
- Data Technology
- Testing and PPE
- Contact Tracing
- Needs of the United States Affiliated Pacific Islands

We appreciate your time in reviewing these issue briefs and applaud Congress for their critical attention and work to provide governmental public health agencies with the necessary resources, tools, and flexibilities to respond to the pandemic.

If you have any questions or require additional information, please do not hesitate to contact a member of ASTHO’s government affairs team: Carolyn Mullen (cmullen@astho.org) or Jeffrey Ekoma (jekoma@astho.org).

Sincerely,

Michael Fraser, PhD, MS, CAE, FCPP
Chief Executive Officer
Association of State and Territorial Health Officials
Background
The COVID-19 national vaccination campaign is a historic undertaking aimed at providing safe and effective vaccines to prevent COVID-19 infections in all residents of the United States. Every jurisdiction submitted a comprehensive plan for a phased rollout of the vaccine. Tens of thousands of private providers were enrolled and trained on vaccine administration and storage. A national tracking system was built to connect state immunization information systems. More than 57 million doses have been administered in the first eight weeks of the vaccine campaign. States and jurisdictions continue to improve vaccine distribution efficiency, standing up large-scale vaccination clinics while distributing to private providers and pharmacies. Furthermore, they are engaging with communities to build trust and confidence in vaccines as they look to improve equity in vaccine distribution. We remain encouraged by announcements of increased vaccine allocations and look forward to expanding vaccine availability to additional priority populations in more community-based settings.

ASTHO is grateful for the emergency supplemental appropriations passed in December 2020 to support state and territorial implementation of jurisdictional plans to allocate, distribute, and administer unprecedented amounts of vaccine. Funds have been used to update existing data systems and implement new ones, enroll providers to administer vaccines, develop public information and education campaigns, and coordinate vaccine distribution with partners across the public health and healthcare sectors (e.g., pharmacies, hospitals, physician offices, local health departments) – all while continuing to manage the daily impact of COVID-19. Previously approved appropriations are a critical down payment to support the initial stages of distribution. On Jan. 27, 2021, ASTHO and the Association of Immunization Managers (AIM) communicated to Congress support for President Biden’s proposal for an additional $20 billion for vaccine distribution activities, with at least $6 billion specifically allocated to state, local, territorial, and tribal health departments in the next COVID-19 supplemental funding package. Funds are needed to continue essential work supporting additional vaccine administration sites, improve communication, support outreach and education, upgrade existing data reporting systems, and hire additional staff. Because there are many uncertainties about the future course of the pandemic, including potential virus variations and the possible need for booster shots, we advocate that ongoing, predictable, and sustained funding for public health vaccine distribution infrastructure is equally imperative as the current urgent need.

Issues and Considerations
- Congress approved $4.5 billion in federal funding to state and local agencies for COVID-19 vaccine distribution and administration. Three billion of this funding was allocated to states in January of 2021, a month into the vaccine distribution effort.
- Coordination and communication between federal, state, and local health agencies have been challenging. Lack of transparency and a national vision impeded the collaborative development and execution of consistent vaccine implementation plans across states, territories, and large
cities. Questions remain concerning sustained funding, IT system implementation, interoperability of interstate data exchange, and predictability of vaccine supply and distribution.

- The federal government has engaged private sector pharmacy providers, including chain pharmacies, to administer vaccines with minimal state or local governmental public health pre-decisional involvement. There has been limited coordinated effort to harmonize plans between public and private sectors, and a clear understanding of the role of the private sector in the vaccine effort is still lacking.
- There is a lack of coordinated communication to promote confidence in the safety and efficacy of COVID-19 vaccines. Vaccine refusal and hesitancy and public mistrust of vaccines are compounded by a climate that is critical of state efforts to prevent and control COVID-19.

Solutions and Ideas for Improvement

- Form a governmental public health advisory group including members of ASTHO, AIM, and other state and local officials to inform federal leadership on issues from the state or local perspective and to ensure coordinated implementation of a national vaccination program.
- Support $20 billion in additional emergency supplemental funding dedicated to a national vaccination program, with **at least $6 billion specifically allocated to state, local, territorial, and tribal health departments**.
- Develop a federally coordinated, locally customizable communications strategy following CDC’s Vaccinate with Confidence framework. Utilize a robust scientific evidence base and communications strategies devoid of political interference to promote confidence in vaccination among the American people. Highlight increasing data on vaccine safety and extraordinarily low incidence of serious adverse events.
- Develop a communications and community partnership strategy to address vaccine hesitancy among communities of color and to assure equitable administration and uptake of the COVID-19 vaccine across the United States, including rural, frontier, and highly urbanized areas.
- Explore incentives for timely compliance with required reporting on race and ethnicity.
- Identify options to increase vaccine production to improve the predictability of vaccine supply.

Further Resources

- [What You Need to Know About the COVID-19 Vaccine](#)
- [Leading Health Organizations Unite to Implement National COVID-19 Vaccination Plan](#)
- [Nation’s Health Officials Call for Greater Collaboration and Communication with Federal Government](#)
- [COVID-19 Vaccination Program Planning: A Checklist for State and Territorial Health Officials](#)
- [Summary and Analysis: ASTHO Survey of State Health Agency Staff on H1N1 Response Policy and Legal Issues](#)
- [ASTHO and the Association of Immunization Managers Immunization Campaign Policy Principles](#)
- [ASTHO Commentary on Equitable Vaccine Allocation](#)

Contact

For more information, contact Jeffrey Ekoma at jekoma@astho.org.
Issue Brief
Clinical Workforce Capacity and Surges
February 2021

Background
At the local, state, and territorial levels, public health, emergency management, and healthcare partners collaborate to monitor the capacity of the clinical workforce within a jurisdiction’s healthcare system. Because most of the clinical workforce is privately employed and subject to decisions by hospital and healthcare leaders, health agencies have a limited role in addressing private sector surge capacity. Nonetheless, agencies work with leaders to request needed resources through Emergency Medical Assistance Compacts that address regional shortfalls, especially following natural disasters and other emergencies. Because COVID-19 is now straining healthcare sector resources nationwide, these agreements may be difficult to support and new models for triage and surge may be needed.

Issues and Considerations
• A long-term approach to growing and retaining the clinical workforce is needed, with a specific focus on diversity to address issues of patient trust and confidence in the healthcare system.¹
• The lack of personal protective equipment (PPE) continues to be an area of concern, with reuse of masks and inadequate protective equipment top of mind in many jurisdictions.²
• The consistent availability of COVID-19 vaccine and vaccination prioritization of clinical and patient-facing non-clinical healthcare workforce continues to be of concern.
• Staffing requests placed through the Emergency Management Assistance Compact system have often been unfulfilled due to the national scale and workforce demands of the COVID-19 pandemic.
• State and territorial governments often have difficulty visualizing and planning to mitigate workforce shortages across the healthcare spectrum. The system is privately operated and there are few incentives to support real-time exchange of clinical workforce data within local and state settings. States often rely on professional associations, including state and territorial hospital associations, for current information on capacity and needs.
• The COVID-19 response will continue to impact the mental health of the clinical workforce, especially if difficult triage decisions continue to become commonplace in the United States. The public health and medical enterprise must establish and promote staff use of mental health programs to reduce stress, burnout, and despair among the clinical workforce.
• In settings where infection rates are high, severe cases are likely to exceed workforce and institutional capacity to meet demand in multiple states, especially in rural and frontier areas with limited capacity. Crisis Standards of Care must be implemented to meet the most urgent needs for care first.

Solutions and Ideas for Improvement
• Develop and enhance existing data management and visualization tools to help state and local government officials visualize data and predict future workforce needs.
• Encourage states to retain or expand regulatory flexibility for licensing and credentialing of health professionals, including students, retired providers, international clinicians, and community-based paraprofessionals such as care navigators and community health workers. Ensure consistent availability of COVID-19 vaccine and priority vaccination of clinical and patient-facing non-clinical healthcare workforce.

• Assess the benefits of using military or national guard personnel to assist in surge staffing beyond their current deployment.

• Increase domestic manufacturing capacity of PPE and other medical supplies through full use of the Defense Production Act. Most PPE has been sourced individually by health systems through existing commercial distribution systems, which has led to a detrimental environment with states competing against each other for products.

• Create innovative solutions to meet staffing demands, such as staffing collaboratives between competing systems and with national associations that serve various clinical specialties and professions.iii

• Review and consider expanding incentives to increase and maintain the clinical workforce, with a special focus on clinical and non-clinical specialties (patient-facing or population focused) that are valuable in the COVID-19 response.

• Conduct an in-progress review of the HHS/ASPR Hospital Preparedness Program and adjust strategies used by federal partners to support the clinical system during emergencies.

Communities facing an imminent threat to their medical care capacity will need federal policies and resources that provide emergency support and compensation to businesses and workers. While our reliance on the clinical workforce is vital, the best way to prevent hospital capacity surges is to prevent COVID-19 through common sense measures. Healthcare leaders should stress this point even as they are addressing acute needs for clinicians and attempting to address ICU shortfalls nationwide.

Contact
For more information, contact Jeffrey Ekoma at jekoma@astho.org.

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Background
As with other communicable and chronic diseases, COVID-19 has disproportionately impacted communities of color, people living with disabilities, and those living in rural and frontier areas. Our nation’s history of racial discrimination has led to disparities in overall health status, with Black Americans experiencing lower life expectancies than White Americans in every state. Immediate policy changes that support investments in social and environmental health factors and address these disparities head-on are needed to reduce COVID-19 illness and death in all populations, especially in communities of color, settings where individuals with disabilities live, and rural and frontier communities.

Issues and Considerations
- A disproportionate number of people of color work in industries deemed essential (e.g., public transportation, hospital environmental sanitation/custodial, grocery store, meat-packing, seasonal agricultural work). These jobs are at the highest risk of COVID-19 infection due to the duration of potential COVID-19 exposures and, in some instances, employers failing to adequately protect their workforce. These are also jobs that cannot be performed during “stay-at-home” or “shelter-in-place” orders.
- Public health messages about mitigation, containment, risk reduction, and vaccine safety were created without significant input from communities of color, resulting in decreased trust in the health system, decreased compliance with mitigation strategies, and increased vaccine hesitancy among minority populations.
- Failure of state and local plans to specifically address the needs of individuals with disabilities has put these populations at greater risk for COVID-19 infection.
- Housing, economic, and food insecurity disproportionately experienced by Black, Brown, American Indian, Native Alaskan, and other non-White groups have put these populations at greater risk of serious COVID-19 illness and exacerbated non-COVID-19 related health issues.
- Low wage and part-time workers without health insurance and paid leave will feel pressure to continue to report to work, avoid isolation, and not comply with contact tracing systems for fear of the economic consequences of not attending work, including termination.
- The lack of race and ethnicity data collection early in the pandemic led to a slow federal and state response to outbreaks within many communities of color.
- Overreliance on national pharmacy chains and direct healthcare services could create unequal access to vaccine and testing sites. National pharmacy chains and direct healthcare services are limited in poorer urban neighborhoods and rural areas across the United States, especially in frontier states such as Alaska, areas of the mountain west, and the southwest.

Solutions and Ideas for Improvement
- Invest in a community-informed, culturally sensitive, and linguistically appropriate national messaging campaign to build trust in the public health system and reduce vaccine hesitancy.
• Mandate disaggregated race and ethnicity data reporting for cases, testing, hospitalizations, and deaths. Incentivize the collection of these data with federal funding.
• Invest in actions that can moderate the economic and social impact of COVID-19 containment or mitigation efforts that may result in loss of housing or employment. Examples include extending the moratorium on evictions, income supplements to offset job losses, and paid sick leave during ordered quarantine and isolation periods.
• Provide testing and vaccination services in locations and at times that are convenient for people who may not have flexibility in their schedules.

Further Resources
• Rebuilding a More Equitable Housing System Post-COVID
• Promoting Health Equity through State Orders for COVID-19 Testing
• Health Equity During COVID-19: Top Strategies for an Equity-Focused Recovery Strategy
• Getting Creative to Keep Americans Fed During COVID-19


Contact
For more information, contact Jeffrey Ekoma at jekoma@astho.org.
Issue Brief
COVID-19 Immunization Data Reporting and Technology
February 2021

Background
The U.S. public health information technology infrastructure is a complex network of local, state, and national databases, data systems, and legal authorities used to support disease surveillance, case investigation, disease reporting and analysis, vaccination event tracking and reporting, and many other activities. While this infrastructure is comprehensive, it is challenged by a lack of interconnectivity among programs, partners, and—most importantly—the healthcare sector. State and territorial health agency information systems are comprised of both outdated legacy systems and newer technologies, which are often deployed by available resources in a particular program area versus a comprehensive IT plan. For example, during the pandemic, we continue to see state and territorial health agencies receiving faxes from clinical partners and facilities because IT systems do not connect with these vital partners.

A series of “fixes” have been made to improve real-time data reporting of COVID-19 laboratory testing, but these are short-term solutions to long-standing problems. Individual state statutes and policies shape differences in how data are collected and what is reported federally. There is an urgent need to improve the existing infrastructure and bring 21st century technology to the work of governmental public health during the COVID-19 response and beyond. CDC’s Data Modernization Initiative (DMI) has five key pillars and is working across public health data systems at the federal, state, and local levels to create a data superhighway that will be able to move data seamlessly from healthcare to public health. In addition to the work being done by DMI, specific resources must be invested to ensure that we are collecting accurate and timely data about COVID-19 vaccinations and improving our immunization information systems.

Immunization Information Systems: Issues and Considerations
- State immunization information systems (or immunization registries) routinely collect data on vaccine doses distributed and administered on child, adolescent, teen, and adult immunization schedules. While states routinely collect personally identifiable patient data for these vaccine events, aggregate data is only typically reported to CDC. For COVID-19 vaccine administration reporting and tracking, CDC and Operation Warp Speed have requested personally identifiable information for each American receiving the vaccine, including name, address, date of birth, and ethnicity, without clearly and adequately articulating the purpose of such data. Further, many states have laws prohibiting or limiting data sharing with other entities, including the federal government.
- The current COVID-19 data and technology strategy relies on several new systems to track vaccine distribution and administration, including CDC’s Vaccine Administration Management System (VAMS), the Immunization Gateway, Immunization Data Lake, Tiberius, and Privacy-Preserving Record Linkage (PPRL). Introducing new systems or methods without adequate testing for functionality, security, and privacy introduces significant risk, especially for a vaccine event of this magnitude.
- The unprecedented nature and scale of the COVID-19 pandemic has exposed strains and weaknesses in the country’s public health data infrastructure. For the last decade, the public
health community has shifted to modernize its systems to create a core enterprise-level infrastructure that breaks down silos, sets standards for interoperability, and cultivates an environment of innovation. While the CARES Act made a down payment towards public health data modernization, this shift will require unprecedented investment over the next decade, as well as leadership at all levels of government.

**Immunization Information Systems: Solutions and Ideas for Improvement**

- Support the submission of either deduplicated and deidentified or aggregate COVID-19 vaccine administration data from state immunization information systems to CDC. If the collection of personally identifiable data is necessary, provide a clear purpose for such data and a comprehensive list of any federal agencies to receive it.
- Support systems or products to track vaccine distribution and administration, including VAMS, the Immunization Gateway, Immunization Data Lake, Tiberius, and PPRL.
- Support immediate, continued investment in public health data system modernization. This next-generation approach will include building a world-class data workforce and data systems that are ready for the next public health emergency. Significant investments must be made to build real-time, automated, electronic, enterprise public health data systems.

**Further Resources**

- [Letter to CDC Director on Critical COVID-19 Vaccine Infrastructure and Rollout](#)
- [Public Health Organizations Request $450 Million for CDC's Data Modernization Initiative](#)
- [ASTHO Joins Data Elemental to Health Letter Thanking Congressional Leadership for the CARES Act and Requesting $450 Million for CDC's Data Modernization Initiative](#)
- [ASTHO Joins Data Elemental to Health Letter Requesting $100 Million in FY2021 Appropriations for Public Health Data/IT Systems Modernization Within CDC](#)
- [ASTHO Joins Letter Requesting Funding for Data Modernization to Grow CDC Data Infrastructure and Respond to COVID-19](#)
- [Driving Public Health in the Fast Lane: The Urgent Need for a 21st Century Data Superhighway Report by the Council for State and Territorial Epidemiologists](#)

**Contact**

For more information, contact Jeffrey Ekoma at [jekoma@astho.org](mailto:jekoma@astho.org).
Issue Brief

COVID-19 Testing and Personal Protective Equipment Supply
February 2021

Background
Testing is an important component of infection control in the COVID-19 pandemic. Real-Time Reverse Transcriptase (RT)-PCR tests have been the standard for testing but have been in short supply in the United States. Antigen tests have increased our capacity to screen and test for COVID-19, particularly in situations where testing can be done regularly and repeatedly. Antigen tests are relatively inexpensive and results are rapidly available. Despite these advantages, use of antigen tests in the field has been challenging because they have sensitivity limits and will fail to identify a proportion of people with COVID-19 (i.e., false-negatives). In addition, logistical issues of long-term supply, cost, and reimbursement policies must be addressed.

Issues and Considerations
- Antigen tests have been authorized by FDA for diagnostic use, but access to timely RT-PCR testing is needed to confirm negative tests when pretest probability of infection is high.
- In communities where transmission rates are low and mitigation efforts are effective, RT-PCR testing may be a more reliable and manageable approach to screening.
- Antigen tests are most useful as screening tests if screening is performed on a regular and frequent basis every few days.
- Widespread screening using antigen tests has been challenging due to limited availability of a trained workforce to administer tests and low public tolerance for frequent and repeated testing in settings like schools.
- More widespread testing is contingent on an adequate supply of PPE.

Solutions and Ideas for Improvement
- Antigen tests are an important adjunct to expand national testing capacity, but the federal government must take more aggressive steps to ensure there is an adequate supply of the more accurate RT-PCR tests for confirmation and for primary use in low prevalence settings. Focus should be on testing platforms with the largest market share.
- The federal government must take aggressive steps to ensure there is an adequate supply of testing supplies and PPE through use of the Defense Production Act. A thorough review of existing investments aimed at strengthening the supply chain for all testing supplies (e.g., reagents, consumables, collection/transport devices, PPE) and equipment should be performed, and revised or expanded where necessary.
- The federal government should take steps to assure the quality of expanded point of care testing, including providing or supporting hands-on training for individuals performing tests.
- Create federal rapid response teams that can be deployed to hot spots to provide hands-on training to local groups as well as help with organization of pop-up testing sites.
• The federal government must develop clear communications messages, campaigns, and regulations to reinforce that community screening is a complementary, secondary strategy to mitigation strategies such as vaccination, face coverings, and social distancing.
• The federal government must provide clear guidance to local, state, and territorial health departments on inventory management of laboratory supplies. Specifically, it should improve coordination of laboratory supply deployment, including improved transparency on how allocations are determined.
• CDC should sponsor short- and long-term comprehensive evaluations of the feasibility and success of different testing strategies in the field and in disparate populations and make this information quickly available to all local, state, and territorial health departments.
• FDA should publicly share information about post-market evaluation of all devices authorized under the Emergency Use Authorization process.

Further Resources
• Considerations for Use of Point-of-Care Antigen Testing by State and Territorial Health Agencies
• Considerations for Implementation of SARS-CoV-2 Rapid Antigen Testing

Contact
For more information, contact Jeffrey Ekoma at jekoma@astho.org.
Case Investigation and Contact Tracing
February 2021

Background
Case investigation and contact tracing (CI/CT) have been cornerstones of infectious disease control in the United States for decades, and health agencies have extensive experience implementing these strategies to prevent the spread of both endemic and emerging infectious diseases. While these public health interventions are not new, the COVID-19 pandemic has required health agencies to carry out CI/CT at an unprecedented scale and speed. As health agencies work to rapidly expand and operationalize their COVID-19 CI/CT programs, surges of infection, testing delays, shortages of testing supplies and personal protective equipment, and challenges with public acceptance of disease investigation have strained program capacity and posed implementation challenges.

Issues and Considerations
- During periods of widespread COVID-19 community transmission, high caseloads may overwhelm local, state, and territorial CI/CT capacity. Testing delays and shortages can also negatively impact CI/CT effectiveness. Surge capacity and support for sustained expansion of the local, state, and territorial disease investigation workforce is essential to conduct effective CI/CT.
- Lack of public awareness and trust have resulted in low participation in CI/CT efforts in many communities (e.g., low response rates to contact tracer calls, unwillingness to provide information on contacts). A best practice to address this issue is to hire community-based disease investigation specialists (DIS) who know their communities and will have sustained contact over time. DIS are an existing public health workforce who have, for 70 years, performed CI/CT services for other infectious diseases such as sexually transmitted diseases and tuberculosis.
- A dramatically expanded public health workforce is required to address COVID-19 CI/CT needs, representing a significant investment for health agencies in the recruitment, training, and retention of new personnel, in addition to accompanying equipment and infrastructure. Unfortunately, governmental procurement systems can create significant bottlenecks in efforts to quickly hire or procure staff and supplies.
- An individual’s ability to work from home or take paid work leave, a lack of access to child or adult care alternatives, and other factors may make it difficult for individuals to adhere to public health recommendations for isolation or quarantine.

Solutions and Ideas for Improvement
- CI/CT should be implemented as part of a larger national disease investigation and response strategy that includes sustainable testing and community mitigation approaches, while being responsive to local circumstances, and scalable based on transmission patterns within communities (prioritization schemes).
- A federally coordinated, state and territorially implemented, and locally customizable communications strategy should be developed to build awareness and trust in CI/CT efforts.
and the entire public health response. One example is Massachusetts’ Answer the Call campaign. However, resources are not easily tailored to the specific needs of communities.

- Sustained investment in the disease investigation workforce expansion—including training and technology supports—is needed. Workforce development should build on existing health agency infrastructure and prioritize recruitment from communities most impacted by COVID-19.
- Federal policies and resources for local, state, and territorial health agencies are helpful in providing social supports and incentives to promote adherence with isolation and quarantine guidance. Workforce shortages in essential areas have meant individuals infected with COVID-19 have had to go to work, raising the risk of infections at essential businesses and facilities.

**Further Resources**

- [A National Plan to Enable Comprehensive COVID-19 Case Finding and Contact Tracing in the US](#)
- [A Coordinated, National Approach to Scaling Public Health Capacity for Contact Tracing and Disease Investigation](#)
- [COVID-19 Case Investigation and Contact Tracing: Considerations for Using Digital Technologies](#)
- [Making Contact: A Training for COVID-19 Contact Tracers](#)
- [State and Territorial Contact Tracing Legislation](#)

**Contact**

For more information, contact Jeffrey Ekoma at jekoma@astho.org.
Issue Brief

Specialized COVID-19 Needs of the United States Affiliated Pacific Islands

February 2021

Background

ASTHO urges that special consideration be given to meet the unique COVID-19 testing, PPE, laboratory infrastructure, and vaccine distribution needs of the United States’ Affiliated Pacific Islands (USAPI). The USAPI are comprised of three territories (American Samoa, Commonwealth of the Northern Mariana Islands, and Guam), and three freely associated states (Federated States of Micronesia, the Republic of Palau, and the Republic of the Marshall Islands). These jurisdictions experience lower standards of living than the U.S. mainland, have limited public health, healthcare, and laboratory infrastructure, are located at vast distances from the mainland, and are often comprised of populations dispersed across remote island archipelagos.

Among U.S. jurisdictions, the islands have the highest chronic disease and obesity rates and suffer frequent severe weather events and infectious disease outbreaks, such as Chikungunya and Dengue. Given their status, USAPI residents may travel without visa restrictions between islands and to states, and frequently do so for work, education, and healthcare given limited options on-island. However, the FAS have closed their borders for nearly a year in order to remain COVID-19-free.

Issues and Considerations

- Relatively small populations dispersed on remote island archipelagos a great distance from the mainland pose logistical challenges for developing laboratory infrastructure, testing capabilities, PPE procurement and distribution, and vaccine distribution.
- The total USAPI population is just under 400,000, with about 60,000 (15%) residing on extremely remote, isolated islands with virtually no infrastructure.
- Healthcare and public health workforce shortages, along with limited infrastructure for vaccine transportation, storage, and administration, create significant challenges for the COVID-19 response. No chain drugstores are able to provide vaccine services in the USAPI.
- There is no central plan for vaccine distribution in the region. Relatively small shipments are made separately to each jurisdiction (and to islands within jurisdictions) at great expense. In January 2021, monthly jurisdictional allotments ranged from just 3,200 in Palau to a high of 15,000 in Guam. Kosrae’s allotment (a state within the Federated States of Micronesia) was just 600. Thus far, reported vaccination rates are relatively high in the USAPI.
- Limited information technology capabilities create tracking and reporting challenges.

Solutions and Ideas for Improvement

- Regional collaboration among agencies and jurisdictions creates the opportunity for greater efficiencies and must continue to be pursued. This is especially critical for HHS and DoD.
• Efforts to build a regional public health laboratory hub in Guam have begun but should be accelerated by additional investment and leadership attention so COVID-19 testing can be quickly expanded.
• CDC and the Pacific Islands Health Officers Association should continue to coordinate bulk procurement of PPE and testing supplies, and coordinate weekly with jurisdictions, partners, and governmental agencies on repatriation of citizens and pre-travel quarantine facilities in Honolulu.
• Monthly vaccine allotments should be accelerated and increased dramatically given significant at-risk populations, inefficiencies with the current vaccine distribution system, the high cost to local economies of remaining closed, and relatively high vaccination rates.

Further Resources
• Letter to House and Senate Committees on Armed Services Leadership in Support of Sec. 2852 of H.R. 6395
• Congressional letter to CDC on Vaccine Planning and Distribution
• PIHOA Communique on Vaccine Planning and Distribution

Map of the USAPI


Contact
For more information, contact Jeffrey Ekoma at jekoma@astho.org.
January 29, 2021

The Honorable Charles Schumer  
Majority Leader  
U.S. Senate  
Washington, D.C., 20510

The Honorable Mitch McConnell  
Minority Leader  
U.S. Senate  
Washington, D.C., 20510

The Honorable Nancy Pelosi  
Speaker  
U.S. House of Representatives  
Washington, D.C., 20515

The Honorable Kevin McCarthy  
Minority Leader  
U.S. House of Representatives  
Washington, D.C., 20515

Dear Majority Leader Schumer, Speaker Pelosi, and Minority Leaders McConnell and McCarthy:

On behalf of the Association of State and Territorial Health Officials and the Association of Immunization Managers, we are writing in support of President Biden’s American Rescue Plan proposal to Congress for $20 billion in emergency supplemental funding, dedicated to a national vaccination program. We specifically request that of that $20 billion, at least $6 billion be specifically allocated to state, local, territorial, and tribal health departments in the next COVID-19 supplemental funding package. Furthermore, due to the rapidly changing course of the pandemic, including the possibility that variant mutations may require individuals to receive an additional booster shot and documented levels of vaccine hesitancy, we anticipate that COVID-19 vaccination distribution will require a sustained multi-year effort. Therefore, we request funds be available for expenditure through the end of the fiscal year 2025. This will actively promote efforts to ensure that vaccines are equitably distributed and allow for the enhancement of systems that support follow-up with individuals who have missed their routine vaccinations and improved vaccine delivery infrastructure, including immunization information systems.

We are grateful that Congress appropriated an additional $8.75 billion to the Centers for Disease Control and Prevention (CDC) for COVID-19 response in the COVID Relief and Response Act (Division M of Public Law 116-260, enacted Dec. 27, 2020), of which $4.5 billion was dedicated to states, localities, territories, tribes, and tribal organizations, urban Indian health organizations, and health service providers to tribes, largely to support vaccination efforts. Of this appropriation, CDC has already made available $3 billion to states and territories, going well beyond the statutory requirement that $1 billion be made available within 21 days of enactment. We applaud CDC for moving rapidly to respond to our needs.

While this funding has been vital to supporting ongoing COVID-19 vaccination campaigns, it represented a critical down payment for public health departments. Given the current level of complexity of the vaccination campaign, our members believe there are additional cost burdens to address emerging issues to successfully execute a national vaccination campaign of this magnitude. We believe our funding request of $6 billion represents our best professional estimate at this time for a multi-year effort that will allow our nation to bolster the entire federal, state, local, tribal, and territorial public health immunization infrastructure that has been woefully underfunded for decades. This need has
been well-documented through annual reports to Congress at the request of the Committees on Appropriations, from CDC directors of both Democratic and Republican administrations, that the 317 Immunization Program at CDC has been underfunded by hundreds of millions of dollars for vaccine infrastructure and purchase, and that a focus on adult vaccination is desperately needed. Now is the time to fortify this essential component of our nation’s public health infrastructure. While we support surge capacity that can be provided by emergency support services such as FEMA for the current COVID-19 vaccine efforts, we must take this opportunity to invest in core public health functions and needs that have been identified for many years. Now is the time to build the data information systems, surveillance and testing capacity, and vaccine infrastructure to confront the next infectious disease threat.

Our request for $6 billion for vaccine distribution, administration, and infrastructure specifically would support the following activities:

- Standing up large scale vaccination sites in communities across the country.
- Delivering locally tailored communication campaigns to better inform the public on where and when they can receive a vaccine.
- Public outreach and education to ensure that vaccines are equitably distributed to address health disparities and reach communities with higher levels of vaccine hesitancy.
- Improving existing immunization infrastructure systems to ensure interoperability with federal government systems, such as those at the Department of Veteran Affairs and the Department of Defense.
- Increasing staffing at governmental public health jurisdictions for activities not related to standing up large scale vaccination sites.

We stand ready as partners in the effort to vaccinate the nation, and our request addresses non-federal activities. We fully support additional resources for CDC and other agencies as the new Biden administration further defines the budgetary needs of those federal agencies.

We are grateful that Congress has appropriated emergency COVID-19 supplemental funding directly to CDC, which has translated into the rapid distribution of funds to state and territorial public health jurisdictions. We urge Congress to continue to allocate resources using existing approaches, budget mechanisms, and formulas in future funding packages, as this assists jurisdictions in allocating resources to critical partners and systems in an efficient manner. It is also critical that efforts to provide additional resources consider the urgent need to build and strengthen our public health infrastructure, which remains vital to effectively respond to emerging and future public health crises.

Eleven months ago, we wrote you to request funding to respond to this pandemic as a down payment when there was one COVID-19 confirmed case, but we could predict then that a serious infectious disease outbreak was on our shores and needed to be controlled. Since then, we have written you with additional funding requests asking for supplemental funding knowing that we cannot predict the pathway of this raging pandemic. The request we make today is also predictive based on estimates that we receive from our members that are the frontlines of the response. While supplemental funding has just been appropriated to states in the last appropriations bill, we can already predict that additional funding is needed.
Thank you for your attention to this critical step in our collective response to the pandemic. We look forward to our continued collaboration with Congress to support state and territorial governmental public health jurisdictions. For additional information, please contact Jeffrey Ekoma, ASTHO’s director of government affairs, at jekoma@astho.org.

Sincerely,

Michael Fraser, PhD, MS, CAE, FCPP
Chief Executive Officer
Association of State and Territorial Health Officials

Claire Hannan, MPH
Executive Director
Association of Immunization Managers