



National Coalition
of STD Directors

April 30, 2020

Public Health Organizations Contact Workforce Emergency Supplemental Funding Request

As Congress continues to work on legislation related to the COVID-19 response, Association of State and Territorial Health Officials, Association of Public Health Laboratories, Council of State and Territorial Epidemiologists, National Association of County and City Health Officials, and National Coalition of STD Directors encourage Congress to ensure sufficient national capacity for a robust contact tracing workforce that builds on existing state, territorial, local, tribal, and federal health agency disease investigation programs to quickly identify and isolate COVID-19 cases. Congress must provide at least **\$7.6 billion** in its next emergency supplemental bill to expand the scale of disease investigation specialists (DIS) and contact tracing workforce in our state, territorial, local, tribal, and federal public health agencies.

A three-tiered approach to building the national contact investigation workforce is necessary in order to recruit the people public health agencies need to rapidly build capacity and complement extant expertise in every public health agency. Each state or local public health agency will develop contact tracing teams that make sense for their geography, expertise, target workforce, and community needs.

Further, we recommend that any new funding for contact tracing be provided through the existing system of state, territorial, local, and tribal health departments through CDC. This new federal funding must be flexible to meet local needs, while also recognizing the existing expertise of key public health workers and building the workforce for the long-term.

To support a formalized, three-tiered professional workforce, it is also important to strengthen existing mechanisms to facilitate volunteers who may wish to join the public health effort, provide technology and training, and solidify health departments' ability to recruit, hire, and retain staff with the help of a public health workforce loan repayment program.

COVID-19 Contact Tracing Workforce Emergency supplemental funding request overview

We have developed a three-tiered approach to address this issue:

1. Tier 1 at least 100,000 Contact Tracers: at least \$4.8 billion.
2. Tier 2 at least 10,000 Disease Intervention Specialist (DIS) Supervisors: at least \$1.3 billion.
3. Tier 3 at least 1,600 Epidemiologists: at least \$312 million.

We are also requesting additional funds as follows:

- Technology and training: at least \$700 million
- Medical Reserve Corps: at least \$100 million
- Public health workforce loan repayment: at least \$350 million

Total = At least \$7.6 billion

Detailed Funding Needs:

- 1. Contact Tracers (Tier 1):** At least \$4.8 billion in emergency supplemental funding to local, state, territorial, tribal, and federal public health agencies to support a workforce of at least 100,000 entry-level contact tracers.
- 2. Supervisors and Trainers (Tier 2):** At least \$1.3 billion to support 10,000 DIS and other public health managers as they train and supervise the new contact tracing workforce.
- 3. Advanced COVID-19 Response Professionals (Tier 3):** At least \$240 million to support 1,600 epidemiology/surveillance professionals at the state level (based on CSTE 2017 Epidemiology Capacity Assessment gap (https://cdn.ymaws.com/www.cste.org/resource/resmgr/eca/BCHA_ECA_WEB.pdf and https://cdn.ymaws.com/www.cste.org/resource/resmgr/eca/2017_ECA_Report_Web_final.pdf), clinical/medical specialists, and Epidemic Intelligence Service officers to perform advanced analysis of epidemiological and surveillance data and forecast trends.
- 4. Training and Technology:** At least \$700 million to meet the significant technology and training needs of the contact tracing workforce to ensure that new hires can be quickly trained and that contact tracers have access to the most effective tools to respond to COVID-19 in their individual jurisdictions.
- 5. Medical Reserve Corps (MRC):** At least \$100 million is needed to support a possible surge in volunteers. While a strong influx of public health workers must be hired to support this surge, volunteers may also be an important asset as we scale up testing and contact tracing capacity across the country. We note that many (but not all) regions are currently served by Medical Reserve Corps (MRC), which connect community members to health departments to help bolster preparedness and response activities. While the current size of MRC units is not sufficient to fill the great need for contact tracers, it is a mechanism that should be strengthened, resourced, and leveraged to facilitate volunteer support for public health activities. Unfortunately, funding for MRC units has been reduced over time. Health departments will require additional resources to successfully recruit, leverage, train, and manage volunteers to support contract tracing activities, as well as establish new units in unserved communities.
- 6. Public Health Workforce Loan Repayment:** At least \$350 million is needed for a public health workforce loan repayment program to help recruit and retain new talent to respond to COVID-19 and the many other needs of state, local, territorial, and tribal health departments. This funding could help nearly 10,000 recent graduates enter the governmental public health system.

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

Supports and Services: Once a case is identified, contact tracers must reach out to those who may have been exposed to the confirmed case to have them self-quarantine for 14 days. As local health departments saw early in the COVID-19 response, it is critical to have services and supports in place that make it easier for individuals to follow public health department directives. For example, people who are homeless or who live with especially vulnerable family members may not be able to self-quarantine at home. Individuals responsible for child or elder care may not be able to stay quarantined without

resources to fill those needs. Anyone who is asked to stay home for 14 days will also need help accessing essentials like food and medications. Therefore, clear, comprehensive wrap-around policies and services should be considered. We recommend Congress refer to a [letter](#) submitted to Congress from bipartisan health leaders for additional information and funding recommendations.

Public Health Infrastructure: Separate from contact tracing workforce needs, we urge Congress to provide annual mandatory funding for CDC, state, local, tribal, and territorial core public health infrastructure to pay for such essential activities. This funding could be scaled up over time. Essential activities include disease surveillance; epidemiology; laboratory capacity, all-hazards preparedness and response; policy development and support; communications; community partnership development; and organizational competencies. This funding should be in addition to the annual discretionary appropriations.

Beyond emergency supplemental funding, as Congress considers draft authorizing language or report language, we strongly encourage adhering to the guiding principles listed below.

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

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