ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

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March 29, 2023

The Honorable Bernard Sanders
Chair
Health, Education, Labor, and Pensions Committee
United States Senate
Washington, D.C. 20510

The Honorable Bill Cassidy, M.D.
Ranking Member
Health, Education, Labor, and Pensions Committee
United States Senate
Washington, D.C. 20510

The Honorable Robert Casey
Member
Health, Education, Labor, and Pensions Committee
United States Senate
Washington, DC 20510

The Honorable Mitt Romney
Member
Health, Education, Labor, and Pensions Committee
United States Senate
Washington, DC 20510

Dear Chair Sanders, Ranking Member Cassidy, Senator Casey, and Senator Romney:

The Association of State and Territorial Health Officials (ASTHO) is pleased to provide comments in response to the Senate Health, Education, Labor, and Pensions request for information in their deliberations to reauthorize the Pandemic and All-Hazards Preparedness Act (PAHPA). As the national nonprofit organization representing state and territorial public health officials, ASTHO recognizes the need for strong federal support for state and territorial public health preparedness to maintain and advance public health emergency response capacity.

A collaborative national preparedness effort requires a clear understanding of roles, responsibilities, and resource support across federal, state, local, territorial, and tribal (SLTT) health agencies. SLTT health agencies are critical to our nation's ability to prepare for, respond to, and recover from public health emergencies and threats. Principally, they ensure their jurisdictions' health through their inherent—and often legal—authority to protect and promote the populations' health, safety, and general welfare. SLTT public health departments have repeatedly demonstrated their robust ability to protect the health and safety of their populations from the effects of natural and people-made disasters. Yet these capacities can degrade rapidly without the support of federal grants, policies, and community and business practices that foster coordinated planning and response activities.

Below are ASTHO's comments on the specific questions included in the Request for Information. It is important to note the numbering of our responses connects directly back to the numbering in the Request for Information.

Program Effectiveness - What specific changes could Congress make to improve the efficiency and effectiveness of current HHS programs and activities?

Public Health Emergency Coordination and Policy

1. **The responsibilities and authorities of the Secretary of Health and Human Services (HHS) prior to or during a public health emergency (PHE)**

Maximum Federal Funding Flexibility (new language)

Congress should increase the accountability and responsivity of HHS such that when the Secretary of HHS declares a public health emergency, CDC, HRSA, and other agencies automatically enable maximum flexibility of existing federal grant funds for SLTT departments within 48 hours of a declaration. Moreover, it is critically important that federal agencies continue to develop workflows and enhance staff support to reduce the administrative burden on SLTT departments during a public health emergency.

Temporary Reassignment of Federally Funded Staff (existing program)

ASTHO is grateful that Congress continues to authorize SLTT health agencies to temporarily reassign federally funded employees during a public health emergency, and ASTHO supports its reauthorization. During the COVID-19 emergency, ASTHO and its members saw improvement in the process of temporarily reassigning federally funded SLTT public health agency staff. In most SLTT health agencies, this mechanism enabled increased continuity of operations that were vital for a response. However, a patchwork of systems and inconsistent policies still need to be addressed across the government. Administering flexibilities program by program requires a great deal of time and can create inconsistencies across programs administered by the same federal agency.

- ASTHO requests that Congress require HHS to work with its agencies to establish a "one-stop shop" for SLTT health agencies to submit emergency reassignment requests. Should the federal employee's temporary reassignment need renewal, SLTT health agencies should not need to repeat the entire process each time the public health agency renews an employee nor for every discrete federal program.
- ASTHO requests that Congress amend the language to allow for the lead public health official(s) of the jurisdiction, the primary awardee of the federal grants involved, to be allowed to submit the request on behalf of the jurisdiction rather than requiring every program administrator to do so with every technical monitor at the federal level.

This tool, available during a public health emergency declared by an HHS secretary as defined by 42 U.S. Code § 247d (a), allows SLTT health agencies to move resources where needed while hiring additional staff and, if authorized, reducing administrative burden.

Ample and Sustained Flexible Funding for All-Hazards Preparedness and Response

The past three years have demonstrated the need for Congress to support robust, fully funded public health infrastructure with sustainable annual resources, with the ultimate goal of minimizing the dependency on supplemental emergency funding. The ongoing funding and support to modernize our public health system is a move in the right direction, but the system still has a way to go. The nation needs a continuous, robust commitment to any post-pandemic effort, similar to how the government supports domestic security through defense spending. Our federal and SLTT public health data and surveillance systems must be modernized to rapidly detect and respond to public health threats domestically and globally. Foundational improvements to the nation's public health data infrastructure and continued investments in public health data modernization are necessary, while also continuing to support SLTT core public health activities, including disease surveillance and epidemiology, laboratory services, assessment, policy development and support, preparedness and response, community partnerships, communications, equity, accountability, and performance management.

The federal government must consider that the impact of all public health emergencies will not affect every population, state, territory, or region in precisely the same way. SLTT health agencies should prepare and plan for public health by understanding communities' unique geography and demographics while recognizing the interconnected nature of our natural, built, and social systems. Vulnerable populations—including children; older adults; persons with disabilities, chronic disease, and existing mental illness; and those impacted by poverty, racism, violence, and other forms of social isolation—are likely disproportionally impacted by public health emergencies. It is also important to consider geographic vulnerability, including coastal areas and island nations. With the support of relevant federal agencies, state and territorial health agencies can continue to assess their distinct vulnerabilities—both locally and regionally—and prepare for, respond to, and recover from public health emergencies.

ASTHO supports the need for four separate but equally essential funding streams:

- Increasing baseline public health infrastructure funding via annual appropriations that supports the modernization of core public health data systems and the core functions of public health, such as daily assessment, surveillance, monitoring, testing, vaccinations, and more.
- Establishing a mandatory public health infrastructure fund outside of the annual appropriations process to provide public health jurisdictions with predictable and sustained funding.
- Adequate and appropriate all-hazards preparedness funding via CDC Public Health Emergency Preparedness Program (PHEP) and Administration for Strategic Preparedness and Response (ASPR) Hospital Preparedness Program (HPP) that strengthens the country's readiness and capabilities, such as emergency operations coordination, emergency public information sharing, mass care, medical surge, and medical countermeasure dispensing and administration.
- Rapid and flexible response funding that allows for the necessary expansion of core public health and response capabilities and activities during an emergency.

This format would demonstrate federal commitment to ensuring that the nation's core public health infrastructure and capabilities are sustained and ready for expansion during an emergency.

4. The National Advisory Committees on Children and Disasters, Seniors and Disasters, and Individuals with Disabilities and Disasters

ASTHO supports these important national advisory committees as they provide an arena to discuss relevant issues and recommendations necessary to ensure the inclusion and care of special and unique populations. For example, people with disabilities are consistently disproportionally impacted by disasters. Research shows that people with disabilities are more than twice as likely to be injured or die in a disaster. To achieve disability inclusion in emergency planning, people living with disabilities must be included in and integrated into all facets of emergency planning. The disability community is subject matter experts in inclusion and key partners in planning and must be seen as equals. The continued existence of these advisory committees provides an opportunity for a continued national dialogue on the needs of special populations. As special populations are fully integrated into planning and response efforts, doing so leads to increases in community and national resilience.

Medical Countermeasures Development and Deployment

1. **The Strategic National Stockpile (SNS)**

Improving Functionality and Transparency of Strategic National Stockpile
ASTHO supports increased transparency in the SNS's inputs, processes, and activities to public health officials to improve the system's integration and use. With adequate annual funding, SLTT health agencies can continue coordinating and distributing SNS assets that support public health and healthcare needs during known and unknown chemical, biological, radiological, or nuclear threats and emerging infectious diseases.

ASTHO supports:

- Continued funding to SLTT health agencies (through CDC and ASPR) to support their logistical, warehouse, and tracking systems to ensure they can readily receive and distribute critical medical countermeasures and materials during emergencies to public health, healthcare, and first responder partners and communities.
- A thoughtful review of the SNS to examine how the nation determines stockpile inventory through distribution by establishing a national advisory committee on countermeasures.
- The advisory committee or other appropriate body should comprise a diverse group of individuals representing SLTT public health practitioners, private industry, academia, and more.

Grants for Stockpile Pilot Programs
As Congress establishes the pilot program for state stockpiles as authorized in Section 2409 of the Omnibus Appropriations Act, 2023, ASTHO encourages Congress to add the following:

- A rigorous analysis of the utility of state-run stockpiles in disaster-prone areas versus a national reaching model. Moreover, it is essential to note the financial burden of maintaining state stockpiles. Therefore, HHS should facilitate collaboration and coordination between federal entities and SLTT health agencies. Special consideration should be given to: (1) how any state stockpiling program would be sustained since there is no permanent funding for such a program and (2) how such a program would connect and function with the more significant federal SNS functions.
- This program’s authorization should also be aligned with the other provisions included in this bill for five years.
- Congress may consider adding a regional stockpile pilot program that could aid in the identification of best practices and strategies to improve the efficiency and sustainability of countermeasure distribution. Should Congress add a regional pilot program, the GAO should evaluate the impact similar to the state pilot program.

4. **The Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) and related strategy, implementation plan, and budget plan**

HHS must strengthen the Public Health Emergency Medical Countermeasure Enterprise (PHEMCE) and evaluate its functioning as part of any effort to enhance public health emergency response coordination. ASTHO requests the following to improve the capacity and outputs of the PHEMCE:

- ASTHO appreciates that Congress included language in the previous reauthorization that requires ASPR to solicit and consider input from SLTT public health departments or officials, as appropriate. To strengthen this provision, we recommend deleting the provision “as appropriate.”

- The requirement for inclusion and representation of SLTT public health officials on the PHEMCE ensures the inclusion of SLTT public health officials' considerations of the SNS products and distribution plans from the beginning. This will improve the efficiency of countermeasure distribution by ensuring end-to-end logistical factors. The need for a "boots on the ground" perspective regarding medical countermeasures during the COVID-19 response was apparent, and Congress should codify this representation in the PHEMCE. We, therefore, recommend the following addition: In 42 U.S. Code § 300hh–10a, include section (b), the following: (11) state, local, territorial, and tribal health officials.

6. The Public Readiness and Emergency Preparedness (PREP) Act

The PREP Act declaration (and subsequent amendments) issued by the HHS Secretary to provide liability immunity for activities related to medical countermeasures against COVID-19 addressed novel areas of pandemic response that could use clarification before the next emergency. For example, the COVID-19 PREP Act declaration effectively expanded the scope of practice of pharmacists and pharmacy technicians in certain jurisdictions and provided liability protection for administering routine childhood vaccines and the flu vaccine, activities that were beyond the direct response to COVID-19. ASTHO recommends that Congress follow up with states about the impact of this use of the PREP Act so a better understanding of needed changes and clarifications to the PREP Act can be made.

Support for Jurisdictional Preparedness and Response Capacity

1. The Public Health Emergency Preparedness (PHEP) Cooperative Agreements

Maintain Current Funding Channels
HPP and PHEP cooperative agreements must continue to fund existing awardees, including all states, territories/freely associated states, and four directly funded localities. State and territorial health agencies ensure coordination and efficiency across the jurisdictions, reduce redundancy and lower inefficiency, and are essential as the locus of operation that supports community-level preparedness. HPP and PHEP are critical to the foundational capabilities of healthcare and public health preparedness, respectively. They are complementary yet distinct programs vital to ensuring the growth of the nation's public health infrastructure.

Reauthorizing PHEP
The current authorization level of $685 million does not meet the needs of the SLTT public health systems. Sufficient federal resources are necessary to sustain readiness capability. SLTT health agencies must retain a well-trained staff, exercise emergency operations plans, support partnerships, navigate grant administration, and modernize systems for interoperability among agencies from the local to the federal level. Sufficient baseline federal all-hazards preparedness funding is crucial to maintaining SLTT public health readiness and bolstering our nation's ability to respond to all threats as they arise. As the country works to rebuild its public health infrastructure after decades of underfunding, increased efforts and ongoing resources are needed to support coordination between simultaneous efforts to modernize and strengthen jurisdictional and national readiness and capabilities. ASTHO underscores that PHEP is not funding for a response, but preparedness activities should not preclude Congress or HHS from acting swiftly in the face of a public health threat to adequately resource the boots on the ground. The most recent appropriation was $735 million, and public health systems remain strained. The highest appropriation for PHEP

was in FY03 at $919 million. ASTHO strongly supports reauthorizing the PHEP program at a funding level of no less than $1 billion.

Increasing Impact and Efficiency of State and Local Funding
Congress should consider the following strategies to reduce administrative burdens on SLTT health agencies for non-emergency federal funds:

- Require, where appropriate, alignment and interoperability between CDC and ASPR reporting systems.
- Establish multi-year funding awards with 24-month budget periods and the ability to redirect funds during the budget period.
- Eliminate the maintenance of effort while continuing the 10% match requirement for awardees, reducing the administrative burden and maintaining investment from the public and private sectors.
- Notwithstanding existing provisions, formally allow SLTT public health staff funded through any federal categorical cooperative agreements and grants to allocate up to 5% of their time to participate in pre-incident preparedness-oriented training and exercises and be assigned to response activities to promote an agency-wide culture of preparedness. Doing so would enable SLTT health agencies to more easily and quickly redirect, on a temporary and limited basis, existing skilled staff to serve as a force multiplier when needed. This is critical especially during smaller-scale events when an SLTT public health agency is in the early response phase and additional personnel are necessary, but an emergency is not declared.

Preparedness Funding in the Community
SLTT public health leaders work to provide education, tools, ongoing training, policies, and programs to equip their jurisdictions with critical capabilities to prevent and mitigate threats to the public's health, and respond to and recover from potential disasters. The CDC PHEP and ASPR HPP programs are vital to ensuring that the public health system is ready to address emergencies at all times. SLTT health agencies must be resourced at stable, equitable, and sufficient levels to ensure that every community across the nation can respond to and recover from disasters. The SLTT public health workforce depends heavily on reliable, ongoing funding to support a network of efficient and effective experts who have built relationships and trust with each other and their respective communities through shared responses, training, and exercises.

Inflation stretched these programs even further, negatively impacting the procurement of resources and increasing workforce demands. There are mutual benefits to collaboration between SLTT health agencies and healthcare systems. Routinely, SLTT health agencies serve as the lead for the healthcare piece of national emergency preparedness and response plans by working with healthcare systems on population-focused strategies. The public—as well as HHS—hold SLTT health agencies and healthcare systems to increasingly ambitious standards for data reporting in several areas, including patient surges, specific types of bed availability, staffing, medical materiel, and supplies. They are also held accountable for delivering life-saving resources to people.

2. The Hospital Preparedness Program (HPP) Cooperative Agreements

Maintain Current Funding Channels
HPP and PHEP cooperative agreements must continue to fund existing awardees, including all states, territories/freely associated states, and four directly funded localities. State and territorial health agencies ensure coordination and efficiency across the jurisdictions, reduce redundancy and

lower inefficiency, and are essential as the locus of operation that supports community-level preparedness. HPP and PHEP are critical to the foundational capabilities of healthcare and public health preparedness, respectively. They are complementary yet distinct programs vital to ensuring the growth of the nation's public health infrastructure.

Reauthorizing HPP
The current authorization level for HPP is $385 million. Its highest appropriation was $515 million in FY03 and FY04. Appropriations for the program have eroded to $474 million, a vastly insufficient level given the task of preparing healthcare systems for patient surges, continuity of operations, and recovery. Public health and healthcare preparedness efforts through the HPP need increased support to build and maintain interoperable systems that reduce duplication of efforts, increase resource visibility, and meet the federal and local leadership expectations of the communities they serve. Inadequately funding this program impairs public health and healthcare systems' ability to provide competent care and services at the most trying of times. ASTHO strongly supports reauthorizing the HPP at a funding level of no less than $500 million.

3. Other ASPR activities financed through the general HPP budget, such as the Regional Disaster Health Response System (RDHRS) demonstration projects

Regional systems being developed should be *complementary* to individual state planning to help build capabilities and capacity across recipients and regions while not removing existing funding and capacity for recipients. These demonstration projects should be evaluated to determine how successful their efforts were. Lessons learned and evaluation results should be shared with states to allow for program expansion or alteration as needed.

8. The Epidemiology and Laboratory Capacity (ELC) Cooperative Agreement Program and related activities, including mosquito abatement

Maximize Coordination to Advance a Response-ready Public Health Data Infrastructure
The ELC Program has provided states, territories, and select cities with critical investments to jumpstart the CDC's Data Modernization Initiative, which aims to transform public health data and surveillance systems and improve the timeliness, completeness, and quality of data available to respond to emerging threats and public health emergencies. As jurisdictions advance data modernization priorities through the ELC Program, coordination across federal programs is necessary to ensure alignment across data modernization priorities and funding streams.

To support a response-ready public health infrastructure through data modernization, ASTHO recommends the following:

- Coordination between the ELC Program, managed through CDC's National Center for Emerging and Zoonotic Infectious Diseases, and (a) CDC's new Office of Public Health Data, Surveillance and Technology, (b) the National Center for State, Tribal, Local, and Territorial Public Health Infrastructure and Workforce, and (c) the Center for Forecasting and Outbreak Analytics—each of which is responsible for a key part of coordination or management of funding that supports data modernization priorities.

- Maximize flexibilities as ELC recipients complete required grant activities and plan for additional data modernization efforts through the new Public Health Infrastructure Grant Program.

10. Vaccine tracking and distribution

During the build-up to the release of the COVID-19 vaccine in 2020-2021, there was little clarity on a CDC and HHS plan to raise public confidence in COVID-19 vaccine safety. We believe this communications strategy is imperative and must be tailored state-by-state to address our nation's diversity, as well as local concerns that may not apply nationwide.

For a future pandemic response, ASTHO recommends the following:

- The President should execute a robust communications strategy across the entire federal government, and "flow down" throughout all levels, including state, local, and tribal governments. A robust scientific evidence base should be utilized devoid of political interference. This communications strategy ensures a unified approach to combatting whichever disease without sending confusing mixed messages.
- Communications about an infectious disease outbreak and vaccination program should leverage the expertise of local leadership, celebrities, and businesses to target hard-to reach-populations. The information should be shared in a culturally competent way for multiple audiences.

Furthermore, public health officials had vaccine distribution plans ready to implement as soon as FDA authorized a safe and effective vaccine. It is a herculean effort to stand up a nationwide program of this magnitude. Governmental investments in state and local health agencies were needed immediately to accelerate planning, update systems, enroll providers, and staff vaccination clinics. A vaccine is not effective until it is delivered to a patient. The Trump Administration's emphasis on production was critically important, but the pivot to supporting state efforts to administer vaccine on a broad scale in every community lagged far behind.

For future pandemic response, H-Core/ASPR should convene a meeting with ASTHO, the National Association of County and City Health Officials, and the Association of Immunization Managers to debrief on challenges and insights to ensure the successful implementation of a national vaccination program.

Adult Immunization Program

The success of any pandemic vaccination program will be determined in large part by the strength of state and local vaccination programs during the Interpandemic Period. The recent pandemic vividly illustrated several gaps in our nation's public health system, including the lack of an adequately funded adult immunization program. ASTHO strongly supports increased, stable, and sustainable federal funding to support the public health infrastructure necessary for a successful vaccine delivery system, meet the increasing cost of vaccines, ensure continued vaccine research and development at the federal level, and provide sustainable safety-net coverage for children and adults without adequate health insurance coverage.

We urge Congress to consider including authorization of an uninsured adult immunization program that would sustain infrastructure improvements made with emergency supplemental funding and

provide states with predictable, adequate, and sustainable funding to promote the uptake of both routine vaccines and improve preparedness to address outbreaks. Building on the successful bi-partisan Vaccines for Children Program, this would support jurisdictions in purchasing and administering vaccines for the estimated 30 million uninsured adults who lack any coverage for recommended adult vaccines against diseases such as influenza, pneumococcal disease, hepatitis, and COVID-19. It should include provisions supporting the core pillars of vaccine purchase, provider payment, program operations, and safety monitoring. Including such authorization in PAHPA would be a significant step toward filling existing gaps in vaccine coverage among U.S. adults and providing sustained support for better preparedness.

Gaps in Current Activities & Capabilities

1. **What gaps do you see in the PAHPA framework, or how it has been implemented to date? (These gaps could be related to any of the programs noted above or other aspects of the public health and medical preparedness and response ecosystem that are otherwise currently unaddressed.)**

Reducing Airborne Threats and Strengthening the Power Supply

The federal government should support meaningful heating, ventilation, and air conditioning (HVAC) upgrades in buildings such as schools and early care, long-term care, other residential facilities, and education centers to reduce disease and toxin spread. Indoor air quality improvements within the built environment may also decrease airborne disease and toxins and the economic and social impacts they create. Improving HVAC systems can be costly, and indoor air quality factors vary significantly between buildings due to age, system design, and maintenance status. HHS should do the following to support improvements to indoor air quality:

- Support and incentivize the implementation of science-backed solutions to improve air filtration at scale and implement solutions within the built environment, especially in places where vulnerable populations congregate. In parallel, the federal government should support and incentivize strengthening how electricity gets to facilities for day-to-day use. Additionally, protecting vulnerable populations requires ample backup power supplies and an efficient way to connect to the building, like a transfer switch (enabling a smooth electricity switch quickly to a backup source). These improvements can be expensive, but the people who live, work, play, and learn in these locations should not be compromised due to the cost of updating the power supply that supports ventilation.
- As ventilation upgrades are required to reduce airborne threats, our reliance on electricity will also increase. Our national power supply must be resilient and address the need for indoor temperature controls to protect vulnerable populations. Specifically, millions rely on the resilience of our electrical grids for their well-being and medical conditions. Every day there are individuals in hospitals, dialysis centers, long-term care facilities, and even more who maintain their independence at home and who must rely on electricity.

2. **Additionally, aside from currently authorized programs and activities, what gaps exist in HHS' capabilities, and what types of activities or authorities are necessary for HHS to fulfill the intent of PAHPA and related laws?**

Health Literacy and Impact of Mis- Mal- and Dis-Information

ASTHO strongly supports the need to increase health literacy in the nation. Health literacy is how people and organizations find, interpret, use, or provide health-related information. As we saw during the COVID-19 emergency, the heightened probability of mis- mal- and dis-information is

often the cause of or perpetuated by low health literacy. A successful response to a public health emergency is most effective when the people trust and are guided by science. If the foundation of health literacy is not intact, the public may not accept or even undermine life-saving interventions and mitigations and put themselves and others at risk. While the effects of this are harmful individually, when aggregated into a community or national perspective, low health literacy is a significant component of excess strain on the healthcare system and the public health system and a risk to national security. ASTHO encourages dedicated federal funding and provisions to support SLTT health agencies and community organizations in their efforts to increase health literacy by:

- Authorizing HHS to fund a program that supports trusted community partners and organizations to develop accurate health messages that are culturally competent, inclusive, accessible, and support public health preparedness activities.
- Supporting collaboration between HHS and SLTT health agencies, law enforcement, and homeland security experts to increase the public health workforce's awareness and knowledge of the characteristics and ideologies of dissenters and ways to prevent the spread of this dangerous misinformation, as well as enhance available mitigation strategies to avoid the exploitation of online platforms from threatening public health officials and activities.

Partnerships - What specific steps could Congress take to improve partnerships with states and localities, community-based organizations, and private sector and non-government stakeholders, such as hospitals and health care providers, on preparedness and response activities? For example:

1. **How can these entities be better supported in appropriately engaging with the federal government to understand available resources, capabilities, and expectations prior to, during, and following a public health emergency?**

   The lack of pre-decisional consultation during the COVID-19 response significantly impacted the efforts of ASTHO members to protect the health and safety of the American public. Since the beginning of the pandemic, state and territorial health officials urged federal leaders to improve lines of communication through standing consultation and information sharing. ASTHO recommends the following:

   - The White House should appoint a high-level liaison from its task force who can work with ASTHO to rapidly query state and territorial health officials on policy considerations and share situational awareness updates daily or as needed.
   - ASTHO could convene a regional advisory group comprised of one state health official or designee for every HHS region of the country, and an extra two designees to represent U.S. territories in the Atlantic and Pacific. These 12 health officials could be convened weekly for brief consultations on the COVID-19 response in their regions, "pulse checks" on current response activities, and discussions on future response strategies.

2. **How can foundational programs, such as the Public Health Emergency Preparedness cooperative agreements and the Hospital Preparedness Program, be improved to ensure state, local, and health system readiness to mount effective responses?**

   There must be a requirement, where appropriate, to ensure proper alignment and interoperability between CDC and ASPR reporting programs. In addition, we recommend the establishment of multi-

year funding awards with 24-month budget periods and the ability to redirect funds during a budget period.

Thank you for the opportunity to contribute to this important work. We look forward to continuing the conversation in the future. Please contact Jeffrey Ekoma, ASTHO's senior director of government affairs at jekoma@astho.org for additional information.

Sincerely,

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