CSTE National Office
Council of State and Territorial Epidemiologists

February 4, 2022

The Honorable Patty Murray
Chair
Committee on Health, Education, Labor, and Pensions
United States Senate
428 Dirksen House Office Building
Washington, DC 20510

The Honorable Richard Burr
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate
217 Russell Senate Office Building
Washington, DC 20510

Dear Chair Murray and Ranking Member Burr,

Thank you for your leadership in addressing the current COVID-19 pandemic and for providing the opportunity to comment on the PREVENT Pandemics Act discussion draft. As we have learned over the past two years, pandemic response impacts all areas of government. State, Territorial, local and Tribal (STLT) public health agencies across the country have been on the front lines of the response. We know we have work to do to better prepare public health in our country to respond successfully to the next pandemic and we appreciate that you are thinking ahead about preparations that must be in place before the need arises. On behalf of the Council of State and Territorial Epidemiologists (CSTE) I am pleased to offer the following comments on the discussion draft.

CSTE is an organization of member states and territories representing public health epidemiologists. CSTE represents epidemiologists on the front lines of the current pandemic response. All states and territories are active voting members of CSTE, and our individual membership is 2,500 applied public health epidemiologists. CSTE works to advance public health policy and epidemiologic capacity and to establish more effective relationships among state and other health agencies. It also provides technical advice and assistance to partner organizations and to federal public health agencies such as the Centers for Disease Control and Prevention (CDC). CSTE members have surveillance and epidemiology expertise in a broad range of areas including occupational health, infectious diseases, environmental health, chronic diseases, injury, maternal and child health, and more. CSTE supports effective public health surveillance and sound epidemiologic practice through training, capacity development, and peer consultation.

Title I: Strengthening Federal and State Preparedness

- Section 101: CSTE strongly recommends that the members of the task force include persons with previous experience working at public health agencies in STLT governments. Below we outline several specific recommendations to strengthen this section:
    - Page 7, line 24: strike the word “may” and replace it with “shall.”

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- Page 13, line 10 through page 15 line 15: maintain bracketed language providing the Task Force with subpoena power to ensure that the group has access to all critical information to inform their recommendations.

- Section 102: CSTE does not support requiring Senate confirmation for the Director of the CDC. As was the case at the start of the 2009 H1N1 influenza pandemic and during a critical time of the ongoing COVID-19 pandemic with the start of the vaccine rollout, a new presidential Administration must have immediate and unquestioned authority to place a CDC Director without the additional time required to organize Senate confirmation. We believe Congress has sufficient oversight over the CDC through committee hearings and other activities.

- Section 104: Too often during the COVID-19 response, STLT health departments learn about major Federal policy changes at the same time as the public. Unfortunately, this served to further feelings of mistrust of public health agencies as it left STLT public health agencies scrambling (*or rushing)* to adjust their policies and messaging. Often there were unintended consequences of operationalizing these changes at the STLT level which could have been avoided or addressed ahead of time if STLT public health leadership had the opportunity to provide input and raise the potential implications on operationalizing the proposed changes. This is not an effective way for public health officials to build trust within their communities, and CSTE feels strongly this must be addressed to foster a more cohesive pre-decisional input and communication strategy across the federated public health infrastructure during a national public health emergency. Along these lines, CSTE recommends the following revisions to this section:

  - Page 42 line 1: insert a new "(C) strategies to improve early and consistent ongoing communication and input from state, local, and Tribal health departments prior to release of any new guidance or policies to the public;" and make current (C) (D)
  - Page 42 line 25: insert "risk" before "communications,"

- Section 111: CSTE recommends the following revision:

  - Page 45 line 10: insert "homeless shelters, correctional facilities,"

- Section 114: The Government Accountability Office (GAO) study to assess the containment and mitigation of infectious diseases should not solely be a review of states and territories, but also the federal government's actions pertaining to isolation and quarantine recommendations or requirements. This study should include an evaluation of the effectiveness of actions taken at the beginning of the COVID-19 pandemic as well as the response to new variants of concerns to prevent and/or minimize the introduction of COVID-19 from returning international travelers, including the repatriation of U.S. citizens, as well as travelers on international flights and maritime requirements that impacted the many Americans traveling on cruise ships. These findings would help inform whether similar measures should be considered in the response to future outbreaks of infectious diseases of public health importance occurring overseas.

Title II: Improving Public Health Preparedness and Response Capacity

- Section 201: CSTE supports efforts to address social determinants of health and improve health outcomes.

- Section 211: To be adequately prepared before the next pandemic, it is critical that public health data modernization efforts be adequately funded by the federal government. The current annual funding for CDC's Data Modernization Initiative (DMI) is only $50 million. Unless annual funding is increased and combined with significant additional federal investments, this funding will not come close to truly transforming our public health data systems for the modern era. A lack of sustained, adequate funding is the single biggest threat to the successful implementation of DMI. CSTE, along with 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. The true cost of bringing our public health data systems into the 21st century is an estimated $7.84 billion over five years. As a start, Congress should appropriate at least $250 million for DMI in fiscal years 2022 and 2023 and commit to making a larger long-term investment as soon as possible.

  Public health data system improvement must be completed in a way that enables the systems to meet surveillance goals at the STLT level where immediate action and response to infectious and other disease threats occur. Failure to deliver real-time information to STLTs will cripple a national response and compromise our national health security. Identifiable real-time data is needed at the STLT level to fully respond, but identifiable data is not needed and should not be collected at the federal level. As a foundational guiding principle, federal data systems should not duplicate STLT data collection efforts and data must be delivered and available first to STLT, prior to being shared with federal agencies.

  The language, as currently drafted, is unclear as to whether data reporting will bypass STLT health departments at the time of collection or even be available to STLT health departments.

- CSTE recommends the following revisions:

  - Page 70 line 12, insert "establish a jointly structured process to"
  - Page 71 lines 12-17, adjust the language to read "(VII) strategies to improve linkages between laboratory test results and electronic health records to support rapid and accurate reporting of laboratory test results and associated relevant data, including strategies to improve accurate and reliable patient identification and matching."
  - Page 73 line 9, replace "integrate infectious disease detection" with "integrate detection of diseases and conditions of public health importance" (*Since not all public health emergencies are due to infectious diseases*)
  - Page 73 line 14, insert "territorial,"
  - Page 74 line 9, insert STLT, so that is now reads "…duplicate efforts of **state, local, and Tribal health departments** or other agencies…"

- Section 212: To improve disease surveillance CSTE recommends adding language requiring clinical and academic laboratories to report the results of any genomic sequencing carried out during a pandemic to STLT health departments in the manner such health departments request. Information reported to STLT health departments, unlike that reported to CDC, should include personal identifiers that support the linking of genomic sequencing results to other records in case or laboratory surveillance databases at health departments. This linkage is critical for fully investigating individuals with variants of concern and detecting and following up on clusters. Additional recommended revisions include:

- Page 75 line 17, insert “state, local, and Tribal” between “appropriate entities” and “public health authorities”
- Page 76 line 12, insert “and state, local, and Tribal health departments” after “appropriate”
- Page 77 line 6, insert “and analyze” following “perform”
- Page 77 line 25, insert “and electronically sharing these data with state, local, and Tribal health departments” after pathogens
- Page 78 line 15, insert “electronically sharing and” between “for” and “integrating”
- Page 78 line 25, insert “and public health practitioners” following “experts”

- Section 213: CSTE has concerns about the intent and impact of this section on STLT health departments’ existing authority as stewards of identifiable public health data. Public health data from health care and laboratory systems **must** be reported directly to STLT health departments and flow from there to CDC. Raw and personally identifiable public health data often requires case investigation, implementation of immediate disease control activities, and/or data management (e.g., removing duplicate reports, erroneous reports) to ensure that the data reported publicly is accurate. STLT health departments are also responsible for the protection and security of personal identifiable data, which is necessary for response, but should not be reported to or used by the federal government unless authorized by a STLT health department to ensure the trust of both the public and the health care community.

  Complete public health data is essential in understanding the impact of an outbreak on particular communities, including minority populations, and in monitoring the spread of a disease geographically. A number of data elements are necessary to ensure the completeness of public health data. This legislation should define “demographic data’ as including, but not limited to, name, address, phone number, date of birth, race, ethnicity, sex assigned at birth, and gender identification. Additionally, we recommend the insertion of language to address the need for patient identification and matching, a need highlighted by the COVID-19 pandemic. The U.S. currently lacks a nationwide strategy to address patient identification and matching (such as a national patient identifier or a limited minimum set of data elements reported for each person to ensure effective matching), which has exacerbated the challenges within and between the clinical and public health systems during the current pandemic (e.g., ability to accurately integrate data between surveillance data and death registries, hospitalization systems and immunization registries to monitor key factors such as disease severity and vaccine breakthrough infections).

  As stated above, data must flow from health care providers to STLT health departments before it goes to the federal government. The language as drafted is ambiguous as to whether it gives the CDC new authority to preempt STLTs in being the responsible recipient of public health data from clinical care. Additional clarification is needed to ensure data are delivered and accessible first to STLT where immediate action and response occurs and that any standards or development work will have adequate frameworks and processes for STLT involvement.

  Additionally, the language is not clear regarding how STLT health departments will be able to formally have input into the process of defining how data will be collected and shared. Further, the language suggests that there are not existing public health standards. In fact, standards do exist, yet there have been limited incentives to leverage or support the use of these standards,

particularly in reporting to STLT health departments where the data is MOST needed. For example, current EHR certification does not reference any standards for electronic case reporting. EHRs and health care organizations can use anything or nothing, even though there are existing, mature, consensus-based standards for eCR.

CSTE recommends the following revisions:

- Page 79 line 24-25, retain "shall, as appropriate," rather than "not later than 2 years"
- Page 80 lines 8-9, revise to read "(i) the accurate and complete exchange of electronic health information to state, local, and Tribal health departments for—"
- Page 80 lines 17-20. revise to read "(ii) automated electronic reporting to relevant State, local, and Tribal public health data systems with a deidentified subset of those data provided to the Centers for Disease Control and Prevention not sooner than such data have been delivered to state, local, and Tribal health departments."
- Page 81 line 20, insert "in collaboration with State, local, , and Tribal health departments and the Centers for Disease Control and Prevention" before "shall conduct a study"
- Page 82 lines 12-14, adjust the language to read "(C) identify challenges related to collection and complete and timely reporting of demographic and other data elements, including data relating to patient identification and matching, with respect to laboratory test results;"
- Page 85 line 21, insert "local, and Tribal" before "health departments"
- Page 86 lines 14-16, revise to read: "The Secretary, in consultation with the Council of State and Territorial Epidemiologists and representatives of State, local, and Tribal public health officials, may carry out activities…"
- Page 86 line 16-18, CSTE is concerned about what is meant by "availability" (i.e., to whom the data is being made available). *Is the intention of this section for the data to be available to the CDC or to the public? Additionally, we are concerned about the use of the term "appropriate" in this instance as it is not clear what would be meant by appropriate data, this would be very different for STLT health departments vs. the CDC or the general public, for example.* ***CSTE recommends that the intent of this section be clarified in the legislative language.***
- Page 86 line 17-18, change "communicable diseases" to "conditions of public health concern
- Page 87 lines 1-2, delete "State, local and Tribal health departments."
- Page 87 line 2, insert "(4) Vital statistics departments or coroners and medical examiners"
- Page 87 line 9, following "communicable diseases" insert following "ensuring identifiable data from any of those sources shall not be disclosed to the Centers for Disease Control and Prevention or the Assistant Secretary for Preparedness and Response unless authorized by a State, local, or Tribal health department."
- Page 87 lines 16: *We understand this to be an additional protection against the rerelease of data under FOIA but would like to see this confirmed.*
- Page 89 line 4, add "laboratories, immunization providers,"
- Page 90 line 4, insert "patients and" before "providers"

- Section 214: CSTE recommends the following revision:

- Page 90 lines 20-21, replace “infectious diseases” with “conditions of public health concern”

- Section 221: CSTE supports efforts within this provision to improve recruitment and retention of the frontline public health workforce. Additionally, we recommend GAO assess and make recommendations regarding the resiliency of the public health workforce, including the impact of the COVID-19 pandemic on the mental health of public health employees. CSTE recently released it’s 2021 Epidemiological Capacity Assessment, which identified major gaps in the applied epidemiological workforce. Despite the staffing surge for COVID-19, at the state and territorial levels alone 2,196 additional epidemiologists are needed to deliver basic public health services across all program areas.

  Loan repayment for public health careers is a critical recruitment tool for understaffed STLT health departments and CSTE supports this provision. Public health fellowships, important positions in STLT health departments, often last two years and should be made eligible for loan repayment. Additionally, fellowships supported by known national public health associations (e.g., APHL, CSTE) should be eligible.

Again, thank you for the opportunity to provide comments on this discussion draft. CSTE shares the committee’s goal of ensuring that our nation is prepared to respond to any future pandemic that may threaten our society. As this issue is of critical importance to our public health community, we respectfully request a meeting with your staff to discuss our recommended revisions to the draft legislation. Please contact Erin Morton at emorton@dc-crd.com with any questions or to schedule a meeting.

Sincerely,

Janet Hamilton, MPH
Executive Director
Council of State and Territorial Epidemiologists