Truth in Testimony Disclosure Form

In accordance with Rule XI, clause 2(g)(5)* of the *Rules of the House of Representatives*, witnesses are asked to disclose the following information. Please complete this form electronically by filling in the provided blanks.

Committee: Appropriations

Subcommittee: Departments of Labor, Health and Human Services, Education, and Related Agencies

Hearing Date: 02/24/2021

Hearing Title :

Ready or Not: US Public Health Infrastructure

Witness Name: Jennifer C. Kertanis

Position/Title: Director of Health, Farmington Valley Health District

Witness Type: ◎ Governmental ○ Non-governmental

Are you representing yourself or an organization? ◎ Self ○ Organization

If you are representing an organization, please list what entity or entities you are representing:

National Association of County and City Health Officials

FOR WITNESSES APPEARING IN A NON-GOVERNMENTAL CAPACITY

Please complete the following fields. If necessary, attach additional sheet(s) to provide more information.

Are you a fiduciary—including, but not limited to, a director, officer, advisor, or resident agent—of any organization or entity that has an interest in the subject matter of the hearing? If so, please list the name of the organization(s) or entities.

National Association of County and City Health Officials

Please list any federal grants or contracts (including subgrants or subcontracts) related to the hearing's subject matter that you, the organization(s) you represent, or entities for which you serve as a fiduciary have received in the past thirty-six months from the date of the hearing. Include the source and amount of each grant or contract.

Farmington Valley Health District:
Preventive Block Grant-$26,000/year
Public Health Preparedness Grant-$75,000/year
NACCHO:
Please see attached.

Please list any contracts, grants, or payments originating with a foreign government and related to the hearing's subject that you, the organization(s) you represent, or entities for which you serve as a fiduciary have received in the past thirty-six months from the date of the hearing. Include the amount and country of origin of each contract or payment.

Please complete the following fields. If necessary, attach additional sheet(s) to provide more information.

☑ I have attached a written statement of proposed testimony.

☑ I have attached my curriculum vitae or biography.

***** Rule XI, clause 2(g)(5), of the U.S. House of Representatives provides:

(5)(A) Each committee shall, to the greatest extent practicable, require witnesses who appear before it to submit in advance written statements of proposed testimony and to limit their initial presentations to the committee to brief summaries thereof.

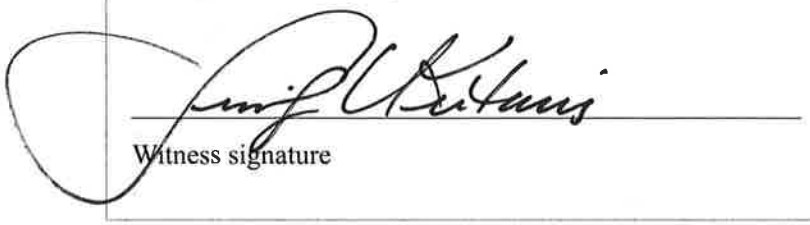
(B) In the case of a witness appearing in a non-governmental capacity, a written statement of proposed testimony shall include— (i) a curriculum vitae; (ii) a disclosure of any Federal grants or contracts, or contracts, grants, or payments originating with a foreign government, received during the past 36 months by the witness or by an entity represented by the witness and related to the subject matter of the hearing; and (iii) a disclosure of whether the witness is a fiduciary (including, but not limited to, a director, officer, advisor, or resident agent) of any organization or entity that has an interest in the subject matter of the hearing.

(C) The disclosure referred to in subdivision (B)(iii) shall include— (i) the amount and source of each Federal grant (or subgrant thereof) or contract (or subcontract thereof) related to the subject matter of the hearing; and (ii) the amount and country of origin of any payment or contract related to the subject matter of the hearing originating with a foreign government.

(D) Such statements, with appropriate redactions to protect the privacy or security of the witness, shall be made publicly available in electronic form 24 hours before the witness appears to the extent practicable, but not later than one day after the witness appears.

False Statements Certification

Knowingly providing material false information to this committee/subcommittee, or knowingly concealing material information from this committee/subcommittee, is a crime (18 U.S.C. § 1001). This form will be made part of the hearing record.



Witness signature

2/22/21

Date

Building Capacity of the Public Health System to Improve Population Health through Local Health Departments	115K
Building Health Department Capacity to Apply Quality STD Clinical Services and Recommendations	155K
CSTLTS Priority	1.2 million
Strong Systems, Stronger Communities (SSSC)	275K
Building Health Department Capacity to Apply Quality STD Clinical Services and Recommendations	155K
Strong Systems, Stronger Communities (SSSC)	275K
Advancing Health in All Policies among Local Health Departments through capacity building and technical assistance	75K
Exploring Funding Streams, Processes, and Financial Requirements	100K
Improving Public Health Messaging Reach and Public Affairs Capacity through Empowering Communicators and Public Information Officers	150K
Big City Health Coalition (BCHC) Deputy to CDC Deputy Project	150K
Equipping Local Health Departments to Address Vaccine Hesitancy	500K
Hiring Local Public Health Attorneys: Return on Investment Analysis	200K
Supporting Statewide Training Priorities for Performance Improvement and Capacity Building	200K
Operationalizing multisector partnerships	200K
Technical Assistance for small LHDs	250K
Local Capacity for COVID-19 Workforce Needs	3.5 M
Supporting Rurals and Tribes	300K
USVI Vital Records	375K
USVI Disaster Risk Reduction	270K

Written Testimony
House Labor, Health and Human Services, Education Appropriations Subcommittee
Ready or Not: U.S. Public Health Infrastructure
February 24, 2021

Statement of Jennifer Kertanis, MPH
Director, Farmington Valley Health District
President, National Association of County and City Health Officials

Good morning Chair DeLauro, Congressman Cole, and members of the Subcommittee. My name is Jennifer Kertanis. I am the Director of Health at the Farmington Valley Health District, serving a population of approximately 110,000 people in ten towns west of Hartford, Connecticut. I have served in this position since 2012. I am also the President of the National Association of County and City Health Officials (NACCHO), the association that represents our nation's nearly 3,000 local health departments. Thank you for the opportunity to speak to you today about the critical importance of our nation's local public health infrastructure, including our workforce.

Local health departments have been on the front lines of the COVID-19 response since the beginning. In my own health department, and as President of NACCHO, I have witnessed my colleagues' incredible efforts over the past year to keep their communities safe and the work that they are doing on all fronts of the pandemic response, including efforts to ensure an equitable and efficient roll out of the COVID-19 vaccines. However, I have also seen the challenges that so many of us face to do this work in a way that does not come at a cost of other public health priorities. Disinvestment over time means that staff were already stretched thin well before COVID-19, and every day we continue to face challenges fully staffing the many

aspects of the pandemic response, let alone the other pressing public health matters that continue to affect our communities.

Local Health Departments Promote Healthy Communities

Local health departments are responsible for safeguarding the public, as well as responding to routine health threats and emergencies. At the local level, we know our communities block-by-block, including the assets and barriers to care, the industries and living situations that pose particular challenges, as well as the community-level partners and organizations that must be included to be successful. We live in our community and serve our neighbors, fielding the many concerns or questions that families, local decision makers, and health care providers have—whether they are asked through a call to the health department or in the parking lot of a grocery store. We understand the concerns of the community and have a pulse on emerging issues. While my health department might be considered mid-sized, local health departments as a whole range in size and geographic location, governance, and resources. But no matter these differences, we all have the shared goal of protecting and promoting the public's health.

Healthy people contribute to a healthy workforce, better educational outcomes, and healthier communities overall. Public health differs from health care in that its primary focus is preventing disease before treatment is required. For decades, public health departments have worked to address the rise in chronic diseases that can bankrupt our health care system and impact the security of this nation. Community based policies and programs to encourage healthy eating and physical activity are a critical part of the work local health departments do to facilitate healthy choices and protect the public's health.

These efforts—though not on the front pages of the newspaper—are critically important to creating a healthier and more resilient community and nation. We see this in the pandemic, as individuals with underlying conditions have worse and more painful outcomes from COVID-19. But we also see this impact in other areas of society. For example, the Centers for Disease Control and Prevention (CDC) has found that nearly three-quarters of young people are not eligible to join the military if they so choose because of an epidemic of obesity.[1]

Similarly, preventable, chronic conditions can impact economic productivity and the overall fiscal health of the individual and their community, while preventable health care costs weigh heavily on our nation's balance sheet. The benefits of a strong public health system have wide ranging impacts. Investment both during and long after the pandemic is key to unlocking these for all Americans.

The Role of Local Health Departments in Responding to the Pandemic

Even before a single case of the virus was detected within the United States, we at local health departments began to mobilize and engage our community and health care partners. Local health departments provide testing and contact tracing services, monitor the health of those who may have been exposed to COVID, and support them to self-isolate. We use data derived from case investigations to locate not only who is developing COVID-19, but also to identify trends and hot spots that inform local policies and actions related to the primary transmission routes in their communities. We are planning and ramping up as a key player in the largest mass vaccination campaign our nation has ever embarked on and working with community partners to disseminate credible information, calm fears, dispel myths, and develop and implement plans to protect the highest at-risk groups including Black Americans, Latinx

people, and the elderly of all races. We have also worked closely with the entirety of the federal-state-local governmental public health partnership, working to bring the local perspective to our national plans.

It is important to note that this takes an incredible amount of staff time building relationships and trust with their communities over time. Our people are our greatest asset, and there is always more work to be done.

Pre-COVID Public Health Workforce Deficits

Day in and day out, pandemic or not, public health is a discipline that relies on people. However, as a nation, this system in many ways came into the pandemic starting at a deficit. A lack of sufficient, predictable funding has led to challenges in supporting these roles, recruiting top talent, and retaining this expertise.

The work of governmental public health—and local public health in particular—has long been under resourced. Prior to COVID-19, local health departments had already seen decreases in available funding and staff amid increasing threats to the public's health. The Great Recession of 2008 hit all sectors of local government hard, but whereas other sectors were able to bounce back, funding for local public health did not recover. NACCHO's research shows that over time, average local health department expenditures per capita decreased 30%, from $80 in 2008, to $56 in 2019.[2] This is particularly pronounced when looking at the data by size of health department. Over the same time period, we have been facing increasingly complex public health challenges, while population increases and an aging population put a further strain on scarce dollars. In many ways we have had to triage, with many health departments

having to make difficult choices as a myriad of threats like Zika, Ebola, measles, youth e-cigarette use, chronic disease, and opioid abuse and overdose competed for scarce resources.

Without the needed investments, cracks emerge in our system and we only see them later. For example, average life expectancy in the United States has dropped in recent years, from 78.9 years in 2014, to 78.6 in 2017.[3] And in 2018-2019 this nation nearly lost our measles elimination status as under vaccination and hesitancy allowed for sustained outbreaks for nearly a year. We have had many successes in public health, but to keep them that way they must be maintained, even then they are out of the spotlight.

Local public health budget cuts show themselves most clearly in workforce reductions that have made the current pandemic response even more challenging. After the 2008 recession, local health departments lost 20% of their jobs (37,000) nationwide, and although they had finally started to rebuild in the past few years, adding 3% of that lost workforce back (6,000 jobs) between 2016 and 2019, the increases have not kept up with population, need, or demand.[4] Over the same period, the nation's population increased by 8%.[5] As a result, local health departments have actually lost 21% of their workforce capacity since 2008, with the number of full-time equivalent employees dropping from 5.2 per 10,000 people in 2008 to 4.1 per 10,000 people in 2019.[6] In 2019, just prior to the most deadly public health emergency in a century, nearly a quarter of local health departments reported job loses.[7]

The types of jobs lost also matter. We have seen a huge reduction in public health nurses on staff—the key utility player in the COVID-19 response — with a loss more than one third since 2008. Similarly, key roles that work across programs were also lost. For example, public information officers were difficult to train with decreased budgets, but their importance

as lead communicators to help get information to the public in a clear and consistent way is a critical component of a public health response built on the actions of individuals to properly social distance and use masks.

The types of workforce available to local health departments vary widely due to the size of the health department and its budget. Almost all local health departments employ registered nurses and office and administrative support staff. Local health departments serving populations greater than 500,000 are much more likely than small agencies to employ epidemiologists or statisticians, information systems specialists, public information professionals, and public health physicians.[8] The lack of professionals who are trained to assess data and information coming in from health care and other sectors has been particularly critical in the COVID-19 response. Less than 10% of the smallest health departments employ epidemiologists/statisticians or public information officers, which affects the ability of these agencies to adequately track the spread of disease and communicate timely, science-based information to the public.

When COVID-19 emerged, local health departments again had to make difficult choices about which lifesaving efforts to stop doing or dial back in order to respond to the pandemic. Staff were pulled from all other sectors of the health department to respond, but that left those programs unable to continue at needed levels. HIV prevention, substance abuse interventions, and food safety inspections were just a few of the services that health departments curtailed in the spring and summer of 2020 to shift focus to the pandemic, with impacts that continue today.[9] Many health departments also had to put programs on hold that address the causes of ill health like racial inequity, uneven access to affordable housing, and food insecurity. A lack of

public health workforce capacity has real world implications that expand the human cost of the pandemic beyond the astronomical number of lives lost to the virus. We will be picking up the pieces of these other priorities long after the pandemic—and the supplemental funding appropriated for it—ends. It is critical that we commit to strong, long-term investments in our public health infrastructure to have the workforce and resources to do it.

Recruitment and Retention of Public Health Professionals

The public health workforce crisis needs our attention now—not just to get through the pandemic, but also to pick up the pieces of the many other public health issues that have not gotten their needed attention. To do so, we must focus on the three key factors to building a strong health department workforce: retaining trained staff, recruiting top talent, and expanding the workforce with predictable, sustainable funding. We must act to create a comprehensive approach to increasing available jobs to grow the public health workforce, recruiting key professionals, and retaining them for the long term.

That is why over the past year, NACCHO has organized and led over 100 stakeholder organizations in a call to create a federal loan repayment program for public health professionals who complete a term of service in a local, state, or tribal health department that would help to fill these workforce gaps. This is particularly relevant now, as new staff and volunteers are being brought into the field for the COVID-19 response on a temporary basis and others are leaving due to extreme burn out. A public health loan repayment program, modelled after the successful National Health Service Corps, would provide an added incentive to retain staff long term and help ensure that their experience is harnessed and available to address current as well as future public health emergencies. Bipartisan legislation was introduced in the

last Congress and included in the Heroes Act to stand up this program, and we urge Congress to move forward to fund this initiative as quickly as possible so that the program can be initiated in time to help the pandemic response.

Beyond this, more must be done to support the local health department workforce over the course of their careers. Pay is very low, hours are long, and long-term retention can be a challenge. However, that expertise is critical to preserve in the governmental health system. We are seeing this play out in our health departments every day. For example, my colleague, a local health director in a metro area, has lost many of her public health nurses to a contract nursing firm which was hired to help supplement the work of her local health department. Her nurses heard how much the contract nurses were paid for doing the exact same work, made the rational choice to work for the contract firm instead, and were back doing the same work in their community, but lost to the overall capacity in the health department. The pandemic has shown the importance of the governmental public health system to the very functioning of our daily lives and we must value it accordingly.

Long Term Investment in Public Health Infrastructure

The importance of strong, predictable federal investment in the public health system is even more vital now as the economic and social impacts of the pandemic are felt nationwide, and as local and state budgets contend with lost tax revenue. Since the 2008 recession, local health department spending per capita has been flat at best: while small local health departments have seen median per capita spending remain essentially flat in the last decade, after accounting for inflation, medium and large local health departments report 14% and 22% declines in median per capita spending, respectively. And last year, 175 million Americans were

living in communities that experienced stagnant or reduced local health department funding in 2019, impacting over half of the U.S. population.[10] Over the summer we saw some local health departments furlough staff in the middle of the pandemic due to budget challenges related to the economic impact of COVID-19 on local and state budgets, and similar constraints could arise as the pandemic continues. Predictable, sustainable funding is critical for us to be able to create and maintain the workforce needed to do this work now and into the future.

The reality is that we need to do more to ensure that every American is protected and supported by a strong public health system, as the resources, staffing, and capacity of local health departments greatly vary across the country. It is critical that we have sustained investments in the basic infrastructure of the governmental public health system at all levels, federal, state *and* local. By building the core public health infrastructure of localities, states, tribal governments and territories, as well as the CDC, the nation will be better prepared for emerging threats in ways that will more meaningfully address the health inequities magnified by such threats.

A baseline of public health investment and services is essential so that all Americans can be confident that the public health system is strong no matter where they live. Investing in our governmental public health infrastructure now is also important to our overall future preparedness to effectively and efficiently address pandemic response and other threats to our nation's health.

Thank you again for the opportunity to address the subcommittee today and I look forward to your questions.

[1] Centers for Disease Control and Prevention, Chronic Diseases and Military Readiness. Retrieved February 18, 2021 from https://www.cdc.gov/chronicdisease/resources/publications/factsheets/military-readiness.htm#:~:text=Nearly%201%20in%204%20young,get%20injured%20during%20basic%20training

[2] NACCHO. 2019 Profile of Local Health Departments. Retrieved September 29, 2020 from https://www.naccho.org/resources/lhd-research/national-profile-of-local-health-departments.

[3] Centers for Disease Control and Prevention, National Center for Health Statistics. Life Expectancy. Retrieved February 18, 2021 from https://www.cdc.gov/nchs/fastats/life-expectancy.htm.

[4] NACCHO. 2019 Profile of Local Health Departments. Retrieved September 29, 2020 from https://www.naccho.org/resources/lhd-research/national-profile-of-local-health-departments.

[5] Population Reference Bureau, The U.S. Population Is Growing at the Slowest Rate Since the 1930s, https://www.prb.org/the-u-s-population-is-growing-at-the-slowest-rate-since-the-1930s/

[6] NACCHO. 2019 Profile of Local Health Departments. Retrieved September 29, 2020 from https://www.naccho.org/resources/lhd-research/national-profile-of-local-health-departments.

[7] Ibid.

[8] Ibid.

[9] NACCHO. Reports from the Field: Impact of COVID-19 on Local Health Departments. Retrieved February 21, 2021 from https://twitter.com/i/events/1291810184558452736.

[10] NACCHO's 2019 Profile Study: Changes in Local Health Department Workforce and Finance Capacity Since 2008. Retrieved October 30, 2020 from https://www.naccho.org/uploads/downloadable-resources/2019-Profile-Workforce-and-Finance-Capacity_final-May-2020.pdf

Jennifer Kertanis is the Director of Health for the Farmington Valley Health District serving a population of approximately 110,000 in ten towns, west of Hartford, Connecticut. Ms. Kertanis has over 28 years of public health experience serving in multiple capacities in non-profit, state and local public health agencies. She was appointed Director of the Farmington Valley Health District in September of 2012.

Prior to joining the Health District, Ms. Kertanis served for ten years as the Executive Director of the Connecticut Association of Directors of Health (CADH), a SACCHO affiliate of NACCHO. During her tenure at CADH, she co-established the CT practice-based research network and was a contributing architect of the Health Equity Index, a tool that measures the relationship between social conditions and health outcomes. Prior to her position at CADH, Jennifer worked for eleven years with the CT Department of Public Health in the environmental epidemiology unit working with communities to assess the health implications of hazardous waste sites. During this time, she wrote several peer reviewed health assessments and advanced a number of health outcome studies. Jennifer also established the department's first asthma surveillance program.

Ms. Kertanis serves on the CADH Board of Directors and serves as the Advocacy Chair. Jennifer is an active member of the National Association of County and City Health Officials (NACCHO) and has served on a number of Committees and Workgroups. She has also been an active member of a number of statewide committees including the CT Department of Public Health Emergency Management Committee, Capitol Region Emergency Preparedness-ESF8, CT Cancer Partnership Prevention Committee and the CT Practice-Based Research Leadership Team.

Ms. Kertanis received her undergraduate education at Southern CT State University where she was recognized as "Outstanding Public Health Major" and her Masters in Public Health from the University of Connecticut. She received the Distinguished Alumni Award in 2015. She has served as an Adjunct Instructor at the Southern Connecticut State University. Ms. Kertanis is also a 2013 graduate of NACCHO's Survive and Thrive leadership program for new health officials.