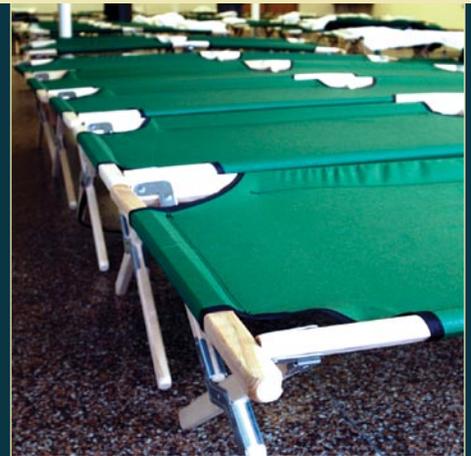




Federal Funding for Public Health Emergency Preparedness: Implications and Ongoing Issues for Local Health Departments



EXECUTIVE SUMMARY

This report describes the results of two surveys conducted by the National Association of County and City Health Officials that examine the local impact of changes in federal funding for public health preparedness. Since the terrorist attacks of 2001, local health departments (LHDs) have significantly increased their capacity to prepare for and respond to emergencies with the support of funding from the Centers for Disease Control and Prevention (CDC). Since 2001, the percentage of LHDs with a comprehensive emergency responsive plan has risen from twenty percent to over ninety percent. In recent years, federal funding to support all-hazards preparedness has declined dramatically, and there is concern about the negative impact of these cuts on LHDs' new preparedness programs.

Some of the key findings from this study include:

- Nineteen percent of LHDs feel that they are now "highly prepared" for an emergency; however, 77 percent of LHDs feel they have made improvements but more improvement is needed;
- The average amounts of CDC funding that LHDs received for all-hazards preparedness and the Cities Readiness Initiative declined by 20 percent and 29 percent respectively between FY05 and FY06;
- Due to cuts in their funding, 28 percent of LHDs reduced staff time on preparedness, 27 percent were forced to delay the completion of preparedness plans, and 17 percent delayed or canceled workforce training;
- Fifty-six percent of LHDs reported that CDC funding is not sufficient to meet their deliverables;
- LHDs' top three needs to meet preparedness deliverables are additional qualified staff, additional funding, and additional time to spend funds effectively; and
- The three occupations most difficult to hire are emergency preparedness planners, epidemiologists, and nurses.

In order for LHDs to continue to build and improve their preparedness and response capabilities, LHDs need qualified staff and support for continual training and exercising. Without reliable funding, most LHDs cannot create and maintain permanent, full-time positions for preparedness. This survey demonstrates that sustained federal funding and support for public health preparedness is needed to help LHDs continue the progress that they have made and to help them address the challenges of new and emerging threats.

The results from this study were derived from two Web-based surveys: the first directed to one representative of LHDs in each state (except Rhode Island), and the second directed to a sample of individual LHDs. The survey for state representatives yielded 41 completed questionnaires, an overall response rate of 76 percent. The survey for LHDs yielded 223 completed questionnaires, an overall response rate of 47 percent.

Introduction

Since 1997, Congress has provided funds for the Centers for Disease Control and Prevention (CDC) to “develop emergency-ready public health departments by upgrading, integrating and evaluating state and local public health jurisdictions’ preparedness for and response to terrorism, pandemic influenza, and other public health emergencies.”¹ These funds, which Congress dramatically increased after the events of September 11, 2001, have been distributed to states, territories, and four large cities through a cooperative agreement mechanism to increase their capacities to respond to large-scale emergencies, such as a bioterrorist attack. More recently, Congress and the Administration have paid attention to emerging infectious diseases with the potential to cause a pandemic, such as avian influenza or severe acute respiratory syndrome (SARS).

Although state health departments and local health departments (LHDs) have significantly improved their response capacities for small- to large-scale emergencies, federal funding to support all-hazards preparedness has declined steadily. The funds granted to the states, territories, and large cities were cut by \$20 million in Fiscal Year (FY) 2004 (August 31, 2004–August 30, 2005) and by an additional \$97 million in FY06 (August 31, 2006–August 30, 2007). Local health officials are concerned about the impact these repeated cuts will have on the sustainability of their relatively new preparedness programs.

The National Association of County and City Health Officials (NACCHO), representing the nation’s approximately 2,800 LHDs, developed two surveys to examine the local impact of changes in federal funding for public health preparedness. This report summarizes the findings from these surveys and discusses their implications for emergency preparedness.

Methods

This study was designed with two main components: a survey directed to one representative of LHDs in each state (except Rhode Island) and a survey directed to individual LHDs. Both surveys focused on three components of the CDC's state and local preparedness funds: (1) funds from the CDC's public health emergency preparedness cooperative agreement for all-hazards preparedness; (2) funding within the CDC's public health emergency preparedness cooperative agreement budgeted for the Cities Readiness Initiative (CRI); and (3) CDC's emergency supplemental funding for pandemic influenza planning.

NACCHO developed a Web-based survey using Zoomerang® for the LHD survey. The study population was the respondents to the 2005 National Profile of Local Health Departments questionnaire (n=2,300). All LHDs serving CRI cities were included in the survey sample. Stratified random sampling was used to select the rest of the survey sample. Strata were defined by jurisdiction population size, and LHDs serving large jurisdictions were over-sampled so that a sufficient number would be included. A unique Web link for the survey was sent via e-mail to 474 LHDs on Feb. 12, 2007. Reminder e-mails were sent to non-respondents. All non-respondents were later contacted via telephone. In addition, personalized e-mail messages were sent to LHDs in states where the response rate was particularly low. Data collection closed on March 23, 2007 with a total of 223 completed questionnaires, an overall response rate of 47 percent. Analysis of the LHD-level data included sample weighting to produce estimates for all LHDs and adjustments for non-response by population strata.

NACCHO also developed a Web-based survey using Zoomerang® for the survey directed to one state representative of LHDs in each state. This individual was either the executive director or president of a state association of local health officials or LHDs, or the top executive of an LHD who was expected to be knowledgeable about that state's emergency preparedness funding. A unique Web link for the survey was sent via e-mail to each state representative on Feb. 12, 2007. Reminder e-mails were sent to non-respondents. Non-respondents were later contacted via telephone to emphasize the importance of their participation, and the survey link was re-sent if needed. Data collection closed on March 23, 2007 with a total of 41 completed questionnaires, an overall response rate of 76 percent.

Successes of LHDs as a Result of CDC Public Health Preparedness Funds

LHDs receive federal funding for preparedness via their state health agencies. State health agencies are the direct recipients of the CDC cooperative agreement funds for public health emergency preparedness, with the exception of four large cities¹ that receive funds directly. States must consult with LHDs and receive their concurrence on the use of the funds.

This survey of LHDs found that approximately 77 percent of LHDs receive CDC cooperative agreement funding. With this support, LHDs have dramatically increased their emergency preparedness and response capabilities. Federally-funded LHDs were asked to respond about their accomplishments and whether they had completed them to a great or small extent. Table 1 illustrates the results:

Table 1: LHD Accomplishments

LHD Accomplishments	Total	To a great extent	To a small extent
Developed a mass prophylaxis or vaccination plan	99%	71%	28%
Developed an all-hazards preparedness plan	99%	51%	48%
Implemented the National Incident Management System (NIMS)	96%	56%	40%
Administered workforce training in emergency response	95%	35%	60%
Administered public education campaigns	95%	33%	62%
Implemented new or improved communication systems	93%	52%	41%
Completed an all-hazards public health emergency exercise	92%	30%	62%
Collaborated with non-profit and faith-based organizations on emergency response planning	86%	20%	66%
Enhanced their disease surveillance systems	82%	36%	46%
Hired new staff to work on preparedness planning	68%	44%	24%
Implemented or improved advanced syndromic surveillance systems	68%	24%	44%
Developed a medical surge capacity plan	66%	10%	56%
Improved the physical security of their facilities	49%	8%	41%
Implemented a Medical Reserve Corps (MRC) program	38%	11%	27%
Enhanced local public health laboratories	23%	7%	16%
Implemented a Citizen Emergency Response Team (CERT) program	21%	6%	15%
Locally stockpiled vaccines or antivirals	20%	6%	14%

¹ New York, Chicago, Los Angeles, and Washington, D.C.

Most LHDs have to a great extent developed mass prophylaxis or vaccination plans and all-hazard preparedness plans, implemented the National Incident Management System (NIMS), and implemented new or improved communication systems. These accomplishments are compatible with the performance expectations outlined in the CDC cooperative agreement guidance.² Many LHDs have also enhanced their disease surveillance systems, trained their personnel in emergency response, and administered public education campaigns.

This survey found that 19 percent of LHDs feel that they are now “highly prepared” for an emergency; however, 77 percent of LHDs feel they have made improvements but more improvement is needed. The differences between accomplishments achieved “to a great extent” and “to a small extent” illustrate where more improvements can be made; however, improvements will be challenging for LHDs impacted by cuts to their preparedness funding.

Impact of Federal Funding Cuts

Table 2 illustrates the average amounts of cooperative agreement funding for all-hazards preparedness that LHDs received based upon the size of the jurisdictions they serve. In FY05 (August 31, 2005–August 30, 2006), LHDs serving a population of 50,000 or less received an average of \$40,000 in CDC public health preparedness funding. LHDs serving between 50,000 and 499,999 people received an average of \$180,000. LHDs serving 500,000 people or more received an average of \$1.9 million.

The average amounts declined for all three categories of LHDs between FY05 and FY06. The largest health departments, serving a population of 500,000 or more, on average experienced a 26 percent decline in funding, compared to average declines of six percent for medium-sized health departments and 13 percent for small health departments.

Table 2: Average LHD Cooperative Agreement Amounts by Size of Population Served

	All LHDs	<50,000	50,000 – 499,999	500,000 +
All-hazards FY05	\$250,000	\$40,000	\$180,000	\$1,900,000
All-hazards FY06	\$200,000	\$35,000	\$170,000	\$1,400,000
Percent Change	-20%	-13%	-6%	-26%

Cuts in funding prohibit our progress—and the addition of new tasks makes our work more difficult—especially when [we are] getting other local and state public health funding cuts.

– LOCAL HEALTH OFFICIAL

HISTORY OF THE CDC COOPERATIVE AGREEMENT FUNDS FOR STATE AND LOCAL PREPAREDNESS

The CDC's cooperative agreement funds for state and local public health emergency preparedness began with modest sums in FY1997 and increased significantly after 9/11 and the 2001 anthrax attacks. Congress appropriated \$940 million to the Department of Health and Human Services in FY02, of which the CDC distributed \$918 million to states, territories, and four large cities for all-hazards preparedness activities.¹ Figure 1 illustrates that the amounts granted for each succeeding year have declined, beginning with a reduction to \$870 million in FY03, and a further reduction in FY04 to \$850 million.² In FY04, the Cities Readiness Initiative was implemented with funds from the all-hazards cooperative agreement. Funding increased slightly to \$863 million in FY05 to support the expansion of CRI.³ Unfortunately, this was followed by a precipitous decline in funding in FY06 to \$766 million, a cut of 11 percent.⁴ This trend will continue in FY07, with a reduction to \$722 million (excluding supplemental funding for pandemic influenza planning).⁵

Figure 1: CDC Cooperative Agreement Funds for State and Local Emergency Preparedness, FY02-FY07



- 1 Congressional Research Service. (2002). Bioterrorism: Legislation to Improve Public Health Preparedness and Response Capacity. Available from URL: <http://www.cas.umich.edu/funding/bioterrorhealthcrs.pdf>
- 2 Centers for Disease Control and Prevention. (2004). FY 2004 Funding Distribution Chart—Attachment M. Available from URL: <http://www.bt.cdc.gov/planning/continuationguidance/pdf/fy04-breakdown-attachm.pdf>
- 3 Centers for Disease Control and Prevention. (2005). Appendix 5: Funding Table. Available from URL: <http://www.bt.cdc.gov/planning/guidance05/pdf/appendix5.pdf>
- 4 Centers for Disease Control and Prevention. (2006). Program Announcement AA154–2006 (Budget Year 7). Available from URL: <http://www.bt.cdc.gov/planning/coopagreement/pdf/fy06announcement.pdf>
- 5 National Association of County and City Health Officials. (2007). CDC Public Health Emergency Preparedness Funding Table FY07. Available from URL: http://www.naccho.org/topics/emergency/documents/PHEPFY07fundingchart_000.xls

LHDs experienced an impact from cuts to the FY06 CDC preparedness funding. Sixty-two percent of federally-funded LHDs that responded to the survey received funding cuts, and many of these LHDs faced one or more negative outcomes:

- 28 percent reduced staff time on preparedness, five percent revoked preparedness staff openings, and one percent laid-off staff;
- 27 percent were forced to delay the completion of preparedness plans, 19 percent delayed the completion of exercises and drills, and three percent canceled scheduled exercises;
- 25 percent delayed acquisition of equipment and supplies, while 15 percent canceled their supply orders altogether; and
- 17 percent delayed or canceled workforce training.

Additional Federal Funding Streams

Two other sources of federal funding exist for state and local public health preparedness: CRI funding, which is a budget item embedded within the CDC cooperative agreement, and emergency supplemental funding for pandemic influenza planning that Congress provided in 2005 and 2006.

CITIES READINESS INITIATIVE FUNDING

CRI was implemented in FY04 and at that time was administered with \$27 million drawn from CDC's cooperative agreement funds for state and local preparedness. It was distributed to 21 cities to aid them in planning and exercising for emergency mass distribution of antibiotics in the aftermath of an anthrax attack.³ In FY05, this funding was expanded to \$40 million to include 15 additional cities and metropolitan areas.⁴ In FY06, CRI's funding was increased to \$54 million and now includes 72 designated cities.⁵

Eighteen percent of the LHDs who responded to the survey received funding for CRI, and these LHDs have made significant accomplishments. In FY05, LHDs serving a population of 50,000 or less received an average of \$20,000 in CRI funding; LHDs serving between 50,000 and 500,000 people received an average of \$110,000; and LHDs serving 500,000 people or more received an average of \$650,000. Of the LHDs that receive CRI funding:

- 89 percent have developed emergency mass dispensing plans;
- 75 percent have engaged in collaborative partnership building;
- 61 percent have conducted training; and
- 55 percent have conducted mass dispensing exercises.

Although the funds budgeted for CRI have almost doubled since FY04, the number of cities designated to receive a portion of these funds has more than tripled. Table 3 illustrates that for the smallest and largest LHDs, the

average amounts of CRI funds received declined between FY05 and FY06, while the average amount for medium-sized LHDs stayed approximately the same. Both the largest and smallest LHDs experienced an average decline of 25 percent in CRI funding.

Table 3: Average LHD CRI Amounts by Size of Population Served

	All LHDs	<50,000	50,000 – 499,999	500,000 +
CRI FY05	\$410,000	\$20,000	\$110,000	\$650,000
CRI FY06	\$290,000	\$15,000	\$110,000	\$490,000
Percent Change	-29%	-25%	0%	-25%

PANDEMIC INFLUENZA SUPPLEMENTAL FUNDING

The only additional source of CDC funding for public health preparedness has been emergency funding for state and local pandemic influenza planning. Congress appropriated \$350 million for this purpose in December 2005 and an additional \$250 million in June 2006. CDC is distributing these funds in phases. CDC distributed \$100 million to states and localities in March 2006,⁶ and an additional \$225 million in July 2006.⁷ In FY07 (August 31, 2007–August 30, 2008), CDC will distribute \$175 million.⁸ The use of the remaining funds has not yet been announced.

Eighty-four percent of the LHDs surveyed received a portion of the pandemic influenza supplemental funds and significant progress has already been made at the local level:

- 87 percent have completed or are developing a pandemic influenza plan;
- 84 percent have conducted public education activities;
- 68 percent have conducted workforce training;
- 67 percent have completed or are about to complete a pandemic influenza exercise;
- 47 percent have built or enhanced a local stockpile of medicines and/or medical supplies;
- 32 percent have improved surveillance systems; and
- four percent have purchased antiviral medication for a local stockpile.

Few LHDs have hired new staff to work specifically on pandemic influenza preparedness. Of those LHDs that received pandemic influenza preparedness funds, only 17 percent were able to hire new staff to assist in completing their deliverables. Eighty-two percent of federally-funded LHDs redirected staff from their normal activities to meet these deliverables. The survey found that large LHDs were more likely to have hired staff to work specifically on pandemic influenza planning than small LHDs.

It's difficult to hire people when [we] have one year of funding for the position, and it takes six months to get our funds approved and go through the hiring process.

–LOCAL HEALTH OFFICIAL

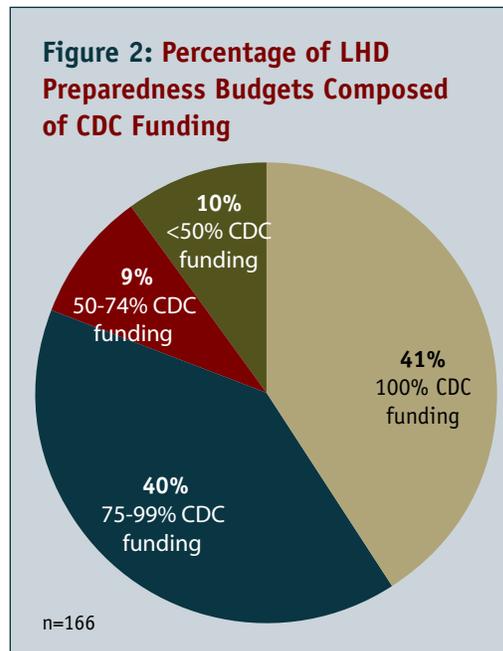
Other Support for LHD Preparedness Activities

For most LHDs, CDC funds are not the only source of support for preparedness activities. As depicted in Figure 2, forty-one percent of federally-funded LHDs reported that CDC funds constitute 100 percent of their budgets for public health preparedness activities and staffing. Of the remaining respondents, 40 percent reported that CDC funds constitute 75 to 99 percent of their preparedness budget; nine percent reported 50 to 74 percent; and 10 percent reported that CDC funds constituted 50 percent or less of their preparedness budget (n=166).

These figures understate the full amount of local support for public health preparedness. Many LHDs are contributing non-federal resources to preparedness. Approximately 46 percent of LHDs use funds budgeted by city or county governments for preparedness activities. Also, many LHDs contribute uncompensated staff time to preparedness activities. One health official from North Carolina wrote:

[The] staff time required to participate in National Incident Management System and other preparedness training has been extensive and expensive, but [it is] impossible to “charge” staff time costs to grants, due to strict budgeting and accounting formulas.

In addition to funding, many LHDs received one or more forms of in-kind support from their state health departments: 64 percent received technical assistance for planning; 56 percent received laboratory support; 55 percent received surveillance support; and 53 percent received support for exercise planning and administration.



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Challenges Faced by LHDs

Under the CDC cooperative agreement for public health emergency preparedness, state health departments have been required to report upon progress towards achieving 23 preparedness-related performance measures, which relate to both state health departments and LHDs. Many of these measures must be fulfilled through multiple exercises, after-action reports, and corrective action for issues exposed in exercises within the period of one fiscal year. Also, both state and LHDs have been required to become compliant with NIMS and exercise using this system. NIMS compliance requires rigorous staff training and the updating of all emergency response plans to be NIMS-compatible.

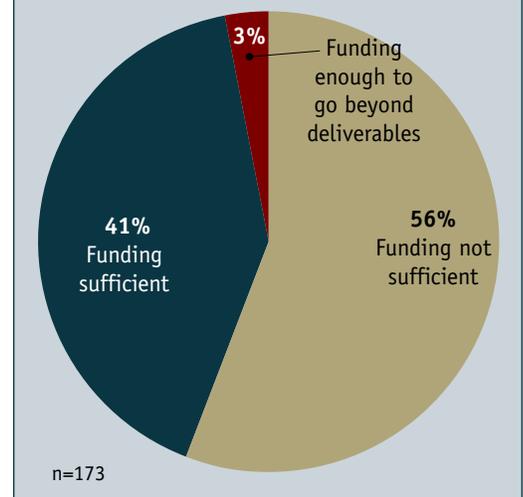
In addition to these annual deliverables, the CRI and pandemic influenza programs also require intensive activities. Metropolitan and local jurisdictions that receive CRI funding are required to plan and exercise mass dispensing systems for antibiotics.⁹ Jurisdictions that received pandemic influenza supplemental funds in 2006 were also expected to meet six unique deliverables, one of which was to develop, exercise, and improve operational plans for pandemic influenza at the state and local level.¹⁰

Figure 3 illustrates that, of the LHDs that receive funding for preparedness activities, 56 percent stated that funding is not sufficient to meet their deliverables. Forty-one percent reported that the funding was sufficient to meet all their deliverables and only 3 percent reported that funding was ample enough to conduct activities beyond their deliverables (n=173).

Beyond inadequate funding, LHDs face other obstacles in achieving deliverables. Sixty percent of LHDs reported they did not have enough time to meet deliverables, 50 percent reported that there are too many deliverables, 33 percent reported that they needed more technical assistance from their state health department, and 15 percent reported that they needed more technical assistance from the federal government.

LHDs were asked what three assets would most help them address performance measures and deliverables. As Table 4 illustrates, LHDs' responses in rank order

Figure 3: CDC Funding for LHDs—Sufficient to Meet Deliverables?



It has been difficult to manage so many deliverables that do not always fold into one another. [We] prefer less deliverables that would be more targeted to local preparedness needs. Also the short-term funding makes it difficult...to increase staff to work on all the deliverables.

were additional qualified staff, additional funding, and additional time to spend the funds effectively.

Table 4: Top Three LHD Needs to Meet Deliverables

Rank	LHDs' most common needs:
1	Additional qualified staff
2	Additional funding
3	Additional time to spend funds effectively

The need for additional qualified staff was a recurring theme throughout the results of the LHD survey. LHDs face a number of obstacles in hiring full-time staff to work on preparedness activities and deliverables. Nearly two-thirds of the LHDs that had attempted to hire new preparedness staff could not recruit qualified people. Table 5 shows the occupations most frequently reported as difficult to hire in rank order. They are emergency preparedness planners (for plan writing, exercising, etc.), nurses, and epidemiologists.

Table 5: Top Three Occupations Most Difficult to Hire

Rank	Occupations most difficult to hire:
1	Emergency preparedness planners
2	Nurses
3	Epidemiologists

The timing and the duration of the funding is also a barrier to hiring staff. The actual time available to spend funds is often less than one year due to delays in the distribution of funds to LHDs. One health official stated:

It's difficult to hire people when [we] have one year of funding for the position, and it takes six months to get our funds approved and go through the hiring process.

Another official offered:

A stable and secure funding source is needed to build a public health response infrastructure. Without it, potential employees will not train for or stay in grant-funded positions.

Some LHDs used consultants rather than staff members to complete deliverables. Nineteen percent of LHDs surveyed reported that they relied on external consultants to help them develop pandemic influenza plans and exercises.

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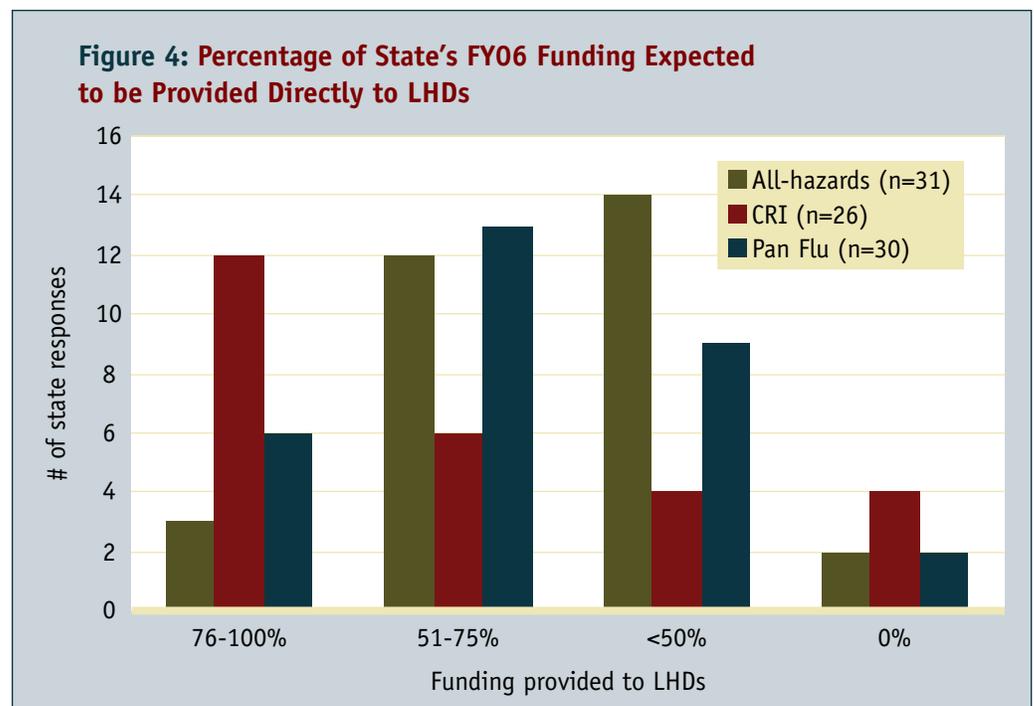
Distribution of CDC Funds: Response from State Representatives of LHDs

In the survey administered to state representatives of LHDs, respondents were asked to estimate the amounts of FY06 CDC preparedness funds the LHDs within their states would receive by the end of the cooperative agreement year (August 30, 2007). This inquiry was necessary because the actual sums that states have granted to LHDs in FY06 are not publicly available. Figure 4 depicts the results of the series of questions that were posed regarding the three streams of funding.

In response to the question concerning the CDC cooperative agreement funding, three state respondents expected that 76 to 100 percent of their state preparedness funds would be distributed to LHDs, 12 expected 51 to 75 percent to be distributed, 10 expected 25 to 50 percent to be distributed, four expected less than 25 percent to be distributed, and two responded that none of the funds would be distributed to LHDs (n=31).

When asked what percentage of their state's FY06 Cities Readiness Initiative funds they expected to be distributed directly to LHDs, 12 respondents expected 76 to 100 percent to be distributed, six expected 51 to 75 percent to be distributed, four expected less than 50 percent to be distributed, and four expected none of their state's funds to be distributed to LHDs (n=26).

Last, state representatives of LHDs were asked what percentage of their state's current and anticipated supplemental funds for pandemic influenza planning they expected to be provided directly to LHDs. Six expected 76 to 100 percent



of the funds to be distributed to LHDs; 13 expected 51 to 75 percent of the funds to be distributed; 9 expected less than 50 percent to be distributed; and 2 expected none of their state's funds to be distributed to LHDs (n=30).

State representatives of LHDs were asked how the total amount of CDC preparedness funding the LHDs in their states received was expected to change between FY05 and FY06. Eleven expected that the total funding to LHDs would increase, 12 expected total funding to remain about the same, and 12 expected funding to LHDs to decrease (n=35).

Respondents were also asked how they expected the percentage of their state's CDC preparedness funds that is given to LHDs would change between FY05 and FY06. Eight expected that the LHDs would receive a higher percentage, 17 expected that the percentage would remain about the same, and 10 expected the percentage to decrease (n=35).

The main difference between FY05 and FY06 CDC preparedness funds is that FY06 CDC funding included the \$350 million emergency supplemental funds for pandemic influenza planning. Even with this additional funding stream, approximately one third of state respondents expected the total funding distributed to LHDs to decrease. Also, despite a greater percentage of money budgeted within the FY06 CDC cooperative agreement funds for the Cities Readiness Initiative, a significant number of state respondents expected the percentage of the funds granted to LHDs to decrease.

Discussion

LHDs are more prepared for emergencies now than they have ever been. This progress is most evident as we compare the preparedness of LHDs today with their status in October 2001, immediately following the 9/11 terrorist attacks. Data collected by NACCHO at that time indicated that only twenty percent of LHDs had a comprehensive emergency response plan in place. Some of the common frustrations documented included lack of resources and poor communication from state and federal agencies.¹¹

Since 2001, LHDs' preparedness capacities have improved consistently and significantly. In April 2004, ninety-five percent of LHDs reported an increased level of preparedness in their health departments.¹² Today, over ninety percent of LHDs have accomplished mass vaccination and prophylaxis planning, all-hazards preparedness training, implementation of NIMS, and implementation of new or improved communication systems.

The most pressing issues facing LHDs today are continued training and capacity building and continued development of partnerships within communities.

I strongly believe LHDs need staff dedicating 100 percent of their time toward disaster planning. They need to concentrate on certain areas and coordinate all staff's work to make meaningful headway...and to [ensure] that we are continually updating and exercising [our plans]. Without dedicated staff the end result is fragmented.

These challenges require that a dedicated, trained staff be in place. As one health official said:

I strongly believe LHDs need staff dedicating 100 percent of their time toward disaster planning. They need to concentrate on certain areas and coordinate all staff's work to make meaningful headway...and to [ensure] that we are continually updating and exercising [our plans]. Without dedicated staff the end result is fragmented.

Without reliable and sustained funding, however, most LHDs are limited in their ability to create new or permanent, full-time positions for preparedness, thus making it difficult to recruit and retain qualified staff. Some LHDs use existing staff to address preparedness issues, causing other public health services to suffer. Others have relied on contractors, but this approach is suitable only for discrete tasks of limited duration.

Cuts in federal funding over the last year have resulted in a reduction in staff time dedicated to preparedness activities, delays in the completion of preparedness plans, and delays in acquisition of equipment, supplies, and stockpile items. Additional cuts would result in further cutbacks and delays in building on the successes achieved thus far. One local health official stated:

The continuation of public health preparedness dollars as multi-purpose funding is very important for [LHDs]. The infrastructure that we have built...is beginning to bear fruit. It would certainly hinder our efforts to reduce or eliminate these funds. Public health has been grossly under-funded for a very long time, and now that we have become a recognized face in the community we should maintain all of the tools that we have now...so we can best protect our communities from any public health event.

Another local health official remarked:

A significant improvement in [public health] preparedness has occurred at the local level after the early challenges...of the preparedness grant process. The gains will be quickly lost if sustained funding is not available. Partnerships at the local level take a great deal of time and effort to maintain and the local response capacity is dependent on these relationships.

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Federal funding for public health emergency preparedness does not just help LHDs build capacities to respond to large-scale emergencies. It also helps them improve their ability to respond effectively to “everyday” emergencies and events, as well as new and emerging threats. For example, the trained personnel and systems that are needed to detect a smallpox or pandemic influenza outbreak are the same needed to detect an E. coli outbreak or the increase in illness during a normal flu season. Also, through exercising plans to mass-dispense drugs and antivirals for a bioterrorist attack, LHDs test their communication systems and build collaborative relationships among the multiple agencies that participate, such as local police, fire, transportation, and schools, as well state and federal partners. These relationships are critical to all public health responses.

The public reasonably expects measurable outcomes and performance measures as a result of federal, as well as state and local, investments in preparedness. In response, NACCHO and its members, with the CDC’s support, developed Project Public Health Ready (PPHR), which recognizes LHDs that achieve specific benchmarks in public health preparedness. This program prepares staff of LHDs to respond to emergencies and protect the public’s health through a competency-based training and recognition program. The PPHR criteria, developed by a council of LHDs and state health agencies, are the only known national standards for local-level public health preparedness. These criteria are continually updated to incorporate the most recent federal initiatives. By assessing the accomplishments and gaps in preparedness at the local level, PPHR enables LHDs to use preparedness funding more effectively, measure and increase their progress, and remain accountable to their constituencies and funders.

Conclusion

These survey results illustrate areas where federal policy can more effectively address the challenges faced by LHDs in their efforts to improve local public health preparedness. LHDs have accomplished a great deal, notwithstanding some practical barriers to their success. They now need flexible and sustained federal funding and the ability to hire and train more public health professionals in order to reap the benefits of the new preparedness programs they have built. A strong commitment must be made at the federal, state, and local levels to maintain and improve local public health preparedness capacities and to make this effort a national priority.

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Endnotes

- 1 Centers for Disease Control and Prevention. (2006). *Program Announcement AA154—2006 (Budget Year 7)*. Available from URL: <http://www.bt.cdc.gov/planning/coopagreement/pdf/fy06announcement.pdf>
- 2 Ibid.
- 3 Centers for Disease Control and Prevention. (2004). *Cities Readiness Initiative Funding Chart—Attachment L*. Available from URL: <http://www.bt.cdc.gov/planning/continuationguidance/pdf/fy04-breakdown-attachm.pdf>
- 4 Centers for Disease Control and Prevention (2004). *Appendix 5—Funding Table*. Available from URL: <http://www.bt.cdc.gov/planning/guidance05/pdf/appendix5.pdf>
- 5 Centers for Disease Control and Prevention. (2004). *Program Announcement AA154—2006 (Budget Year 7)* Available from URL: <http://www.bt.cdc.gov/planning/coopagreement/pdf/fy06announcement.pdf>
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