

## **NACCHO Position Statement**

### **Building COVID-19 Contact Tracing Capacity in Health Departments to Support Reopening American Society Safely**

**April 16, 2020**

#### **Introduction**

As the COVID-19 outbreak continues to evolve and require increased response from our nation's public health community, the National Association of County and City Health Officials (NACCHO), on behalf of the nearly 3,000 local health departments across the country, encourages large-scale investments to help ensure that communities can safely dial back strict social distancing orders as we enter the next phase of the outbreak. To do so, we will need to strengthen our nation's capacity to test rapidly for COVID-19 infection in a multitude of settings, better understand the extent to which individuals have been infected in the past via serological testing, and quickly harness data for intensive contact tracing. This will be instrumental to ensuring that local, state, tribal, and territorial health departments can identify potential cases early and implement infection prevention and control measures. To do this, we will need a massive expansion of professionals and trained volunteers equipped with the appropriate skills, training, and technology, distributed equitably across the country to help identify, notify, and support those who may have been exposed, and help them self-quarantine to stop the spread.

Contact tracing, notification, and quarantine are some of the oldest public health tools, developed in a time when few, if any, treatments were available for the many infectious diseases that affected communities. Today, they are especially relevant as we currently lack a vaccine or effective treatments for COVID-19. Mitigation efforts for this response require tracers to connect with known patients to identify and alert their contacts of possible exposure. These contacts must then quarantine to ensure the safety of their families and communities, monitor their symptoms, and provide periodic updates back to the health department on their health status. To ensure compliance with quarantine orders, contact tracers need to be able to gain the trust of the contact during this time of great stress and may need to employ case management skills to link the individual who is being asked to quarantine to additional services and supports—like groceries, safe housing, behavioral health services, or child care—to help reduce barriers to effect quarantining. Staff of local health departments across the country have honed these skills to prevent and control other diseases like HIV, sexually transmitted infections (STIs), and tuberculosis (TB). However, the governmental public health system already struggles to properly fund and staff these programs, let alone scale the efforts necessary for preventing and controlling the spread of COVID-19.

As our nation begins to develop plans to revitalize the economy and reopen businesses, schools, and other institutions without the burden of social distancing measures, testing and contact tracing are vital components, but that we must get it right. Therefore, NACCHO recommends the following key points when addressing the contact tracing gaps within local health departments and the public health system as a whole.

## **Workforce**

For the COVID-19 response, a strong, scalable network is needed to test, isolate, contact trace, and conduct follow up. Contact tracing pulls from an extensive list of skillsets, including, but not limited to, disease investigation specialists, public health nurses, community health workers, public health social workers, and epidemiologists. Therefore, it is critical that any plan allow for flexibility of staff roles that can be hired to take on contact tracing duties during this surge. It is also important to recognize the need for critical support roles including health educators, community health workers, public health nurses, and communicable disease staff to educate individuals and communities on COVID-19; ensure accurate, rapid testing for anyone that needs a test; and provide support to workplaces, schools, stores, and other sites that may require appropriate guidance and services to disinfect and implement best practices if a case is detected.

## **Volunteers**

While a strong influx of public health workers must be hired to support this surge, volunteers may also be an important asset as we scale up testing and contact tracing capacity across the country. We note that many (but not all) regions are currently served by Medical Reserve Corps (MRC), which connect community members to health departments to help bolster preparedness and response activities. While the current size of MRC units is not sufficient to fill the great need for contact tracers, it is a mechanism that should be strengthened, resourced, and leveraged to facilitate volunteer support for public health activities. Unfortunately, funding for MRC units have been reduced over time. Health departments will require additional resources to successfully recruit, leverage, train, and manage volunteers to support contract tracing activities, as well as stand up new units in unserved communities.

## **Training**

As noted, public health departments have used contract tracers for decades to address HIV, STIs, and TB as well as other infectious disease outbreaks. Health departments understand the skills and abilities required for contact tracers to build trust with individuals, gather accurate information, and ensure the provision of testing, medical care, and other services. As part of maintaining a standing workforce of contact tracers, health departments have trainings in place to ensure that individuals working as contact tracers, regardless of their profession, have the skills they need to be successful in the field. Local health departments and their staff are uniquely positioned to train and manage any newly-added surge professional or volunteer workforce because they already do this work in their communities

and are a trusted partner, allowing them to design and target the style of outreach to best reach their residents (including non-English speaking, communities distrustful of government, and other special populations.) However, standing-up the significant number of volunteer contact tracers required to address COVID-19 will require funding and support to expand health department training capacity. It will also require support from partner organizations at the local, regional, state, and national level to expand training capacity.

### ***Capacity***

There are many estimates on the number of contact tracers needed to keep the virus at bay as we reopen communities. Given global experience with contact tracing, as well as staffing needs at local, state, tribal, and territorial health departments across the many disciplines needed for contact tracing, we estimate a surge capacity of at least 100,000 individuals will be needed.<sup>1</sup> This number is a baseline and will need to be revisited as we learn more about the virus and develop improved cases count estimates.

Moreover, it is important to remember that this is a surge to address one aspect of the coronavirus response. However, it will not be enough to scale up lab capacity, point of care testing, acquisition of personal protective equipment or to plug the existing holes in our governmental public health workforce and infrastructure that have left communities less safe over time (discussed below). Any estimate on how many individuals will be needed to surge contact tracing capacity will be affected by, and must be scaled based on, future case counts over time (e.g., 100 cases to trace in one day versus 10 cases to trace each day for 10 days) as well as the technology that can be leveraged to speed the process (e.g., an app that can more quickly access contact information for tracing purposes). In addition, the experience of the contact tracer may increase their capacity to clear cases quickly, while the circumstances of the individual (e.g., those who are homeless, undocumented, in a justice or detention facility; group home situation, etc.) may elongate the timeframe to complete a case investigation.

### ***Distribution***

While the overall number of the contact tracer surge workforce is critical, so too is how they are distributed across the country. COVID-19 is affecting every community across the country—large urban centers, the suburbs, as well as rural and frontier areas. Local health departments have varying base staffing levels, but all will need surge capacity staff to

---

<sup>1</sup> We estimate that in non-emergency situations, we need 15 professionals per 100,000 population, including epidemiologists, disease investigation specialists, public health nurses, community health workers, and others typically involved in contact tracing activities. Given the magnitude of COVID-19, the need to quickly complete contact tracing (within hours versus days for other communicable diseases), and the demand for these services across all areas of the country at once, we estimate that twice as many professionals will be needed. 30 professionals per 100,000 population equates to a nationwide force of 98,460 workers. While the estimate is based on a strict per capita basis, it is critical that these individuals be distributed across health departments in a more equitable fashion, with a base+ per capita formula so that health departments that serve smaller populations still have access to the surge capacity they need to do this important work.

complete this work. Therefore, we strongly recommend a formula for distribution of the surge workforce that takes into account a baseline number of contact tracers as well as a per capita calculation to ensure that smaller communities are not inadvertently missed in this national effort to scale up contact tracing.

## Supports and Services

Once a case is identified, contact tracers must reach out to those who may have been exposed to the confirmed case to have them self-quarantine for 14 days. Local health departments saw very early in the COVID-19 response that it is critical to have the services and supports in place that make it easier for individuals to follow public health department directives. For example, people who are homeless or who live with especially vulnerable family members may not be able to self-quarantine at home. Individuals responsible for child or elder care may not be able to stay quarantined without resources to fill those roles. Anyone who is being asked to stay home for 14 days will also need help accessing essentials like food and medications. Therefore, clear, comprehensive wrap-around policies and services must be enacted, including:

- Safe housing for quarantine or isolation
- Paid time off
- Childcare
- Behavioral health services to address stress on the individual and family
- Access to essentials such as food, medications, laundry, etc.
- Transportation and/or access to routine medical care or emergency care
- Materials, such as a reliable thermometer, masks and gloves, and internet access

## Resource Needs

Federal resources are needed to quickly ramp up surge capacity for contact tracing, including:

- **At least \$3.7 billion in emergency supplemental funding to local, state, territorial, tribal, and federal public health agencies to support a force of at least 100,000 contact tracers.** This includes \$100 million to scale up and support the MRC program to help facilitate volunteer support for this critical function (an average award of about \$100,000 per MRC unit), as well as \$3.6 billion to support the surge of contact tracers, which is based on the average salary of a community health worker taken to scale and equates to \$36,000 per tracer over the course of a year. It is important to note that this number is likely an underestimate as there will also be needs for higher-level supervisors and skilled professionals to supervise the work, guide strategy, and undertake the most challenging cases. The federal funding must provide maximum flexibility to enable public health agencies to recruit and retain staff. While this is a large number, the tradeoff for being able to reopen our communities and commerce is much greater.

How funding is distributed in order to ramp up the surge of contact tracers is also critically important. Any infusion of funds, staff, and volunteers must take into account that, depending on the state, contact tracing responsibilities may sit at the local health department and/or state health department level. Therefore, proposals and legislation should be written to allow flexibility for funding eligibility. Moreover, a bolus of one-time money is difficult to spend and ramp up quickly, even in the best of circumstances. Therefore, we will need to remove federal, state, and jurisdictional-level barriers to hiring. It is also important that public tracking of funds is adopted to follow resources as they flow from the federal government down to the local level to help model effective practices for funding and hiring and ensure that all communities benefit from this investment.

While these funds are critical for the current and necessary contact tracing surge, to truly protect communities we must do more to support the sustained operation of local health departments across the country who have been on the front lines of this response. We will not be successful if we continue to ignore the underlying deficits in health departments that have plagued the response since it began.

Local health departments have lost nearly 25% of their workforce since 2008, equating to more than 50,000 jobs lost. This means fewer staff to pull from to respond to challenges like COVID-19, but also fewer employees in key roles for this response, like public information officers who are needed to effectively inform and educate the public about how to stop the spread and disease investigation specialists to carry out existing contact tracing responsibilities. Over the same time period, local health department budgets are at best flat on average, with the average small health department operating with 11% fewer resources and the average large health department operating with 30% fewer resources, not accounting for inflation.

Today, local health departments are already facing the budgetary impacts of reduced local and state tax revenues due to the economic impacts of the COVID-19 response, with health department staff being furloughed as funding evaporates. We must act now to ensure that public health departments will be there for their communities in the months and years to come to get us through the response and better prepare us for the next crisis. Therefore, NACCHO also requests that Congress support:

- **\$200 million to enact and implement a loan repayment program for public health professionals** who agree to serve two years in a local, state, or tribal health department. In the coming years, nearly half of the local and state health department workforce might leave in as the workforce ages and far too many health departments struggle with recruiting and retaining new talent to fill critical roles. In an effort to recruit and retain a new generation of public health workers, NACCHO, along with over 60 other stakeholder organizations, support the enactment and implementation of a loan repayment program for public health professionals who agree to serve two years in a local, state, or tribal health department. Such a program, modeled off the success of the National Health Service Corps in bringing

health care providers to communities in need, will help health departments across the country recruit appropriate staff who can tackle 21st Century challenges and increase health departments' capacity, now and in the future. We estimate that a program funded at \$200 million per year could support over 6,000 new hires in local and state health departments across the country. This is a critical mechanism to retain individuals who will gain important experience and expertise as part of the contact tracing surge stay in the health department workforce so that they can use this experience to help us better able to respond to the next crisis.

- **\$4.5 billion in additional annual mandatory funding for local, state, tribal, and territorial core public health infrastructure**, in addition to existing annual discretionary appropriations. The contact tracing surge can only be as successful as the public health infrastructure that supports it. Unfortunately, our nation's public health system is uneven across the country with far too many unable to financially support key activities and services. The economic downturn related to COVID-19 will only exacerbate these issues. These dollars would be used to support the scale up and delivery of essential activities like disease surveillance, epidemiology, laboratory capacity, all-hazards preparedness and response; policy development and support; communications; community partnership development; and organizational competencies. The importance of strong, predictable federal investment in the public health system is even more vital now as the economic impacts of the pandemic are felt nationwide. Local and state governmental budgets, and therefore public health budgets, are likely to be devastated in the wake of COVID-19, possibly for years to come. This will leave our nation even more vulnerable to emerging health risks. By building the core public health infrastructure of localities, states, tribal governments, and territories the nation will be better prepared for the next threat.

The response to COVID-19 has and will continue to be labor, resource, and time intensive. However, investments made now will help bring this phase of the response to a close. It is critical that we do all we can to stop the spread of COVID-19, learn the lessons from this response, and strengthen the governmental public health system now so that we are better able to respond to the next threat that comes our way, saving money and lives.

For additional information, please contact Adriane Casalotti, NACCHO's Chief of Government and Public Affairs, at [acasalotti@naccho.org](mailto:acasalotti@naccho.org).