FY21
Governmental Public Health Appropriations Book

Association of State and Territorial Health Officials
Dear Members of Congress:

The Association of State and Territorial Health Officials (ASTHO) is the national nonprofit representing state and territorial public health agencies. ASTHO’s members—the chief public health officials of these agencies—are dedicated to formulating and influencing sound public health policy and assuring excellence in public health practice. ASTHO and its members are supported in this work by a network of 20 affiliate organizations representing a wide array of public health issues, with the shared mission of promoting and protecting the public’s health and preventing illness and injury.

Outbreaks like the 2019-nCoV are critical reminders of the significance of public health readiness and the need for continued strengthening of public health agencies’ core response capabilities. Federal resources continue to account for nearly half of all state and territorial health department funding. ASTHO and its affiliates strongly urge Congress to prioritize funding for all public health programs in FY21 so that this important work can continue.

This book compiles top federal funding priorities and recommendations for nonprofit public health associations in FY21. It is designed to ensure that Congress appropriates the necessary resources for CDC and HRSA and includes appropriations forms from the following organizations:

Association of State and Territorial Health Officials
Association of State and Territorial Dental Directors
Association of Immunization Managers
Association of Maternal and Child Health Programs
Association of Public Health Laboratories
Council of State and Territorial Epidemiologists
National Alliance of State and Territorial AIDS Directors
National Association of Chronic Disease Directors
National Association for Public Health Statistics and Information Systems
National Association of Vector-Borne Disease Control Officials
National Coalition of STD Directors
Safe States Alliance

Thank you for considering these funding requests. We stand ready to work with Congress to address the many public health challenges and opportunities impacting our nation’s health.

If you have any questions or require additional information, please do not hesitate to contact a member of ASTHO’s government affairs team: Carolyn McCoy (cmccoy@astho.org) or Jeffrey Ekoma (jekoma@astho.org)

Sincerely,

Michael Fraser, PhD, MS, CAE, FCPP
Chief Executive Officer, ASTHO
Table of Contents

ASTHO Public Health Preparedness and Response (HPP) ................................................................. 3
ASTHO Core Public Health Funding .................................................................................................. 5
ASTHO Public Health Preparedness and Response ................................................................. 7
ASTHO Core Public Health Infrastructure and Disparities .................................................. 11
Public Health Data/IT Systems Modernization .............................................................................. 13
Immunization Funding .......................................................................................................................... 15
Maternal and Child Health ................................................................................................................... 17
Oral Health ........................................................................................................................................ 19
Epidemiology and Laboratory Capacity and Advanced Molecular Detection ..................... 21
Chronic Disease ................................................................................................................................. 23
Electronic Vital Records Systems ...................................................................................................... 25
HIV and Hepatitis Programs .............................................................................................................. 27
Sexually Transmitted Disease ............................................................................................................. 33
Injury and Violence Prevention .......................................................................................................... 35
Organization name: Association of State and Territorial Health Officials (ASTHO)

Topic area: Public Health Preparedness and Response

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention (CDC)

Program, office, or center: Public Health Emergency Preparedness (PHEP)

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20 Enacted</th>
<th>FY21 President's Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Emergency Preparedness Cooperative Agreement</td>
<td>675,000</td>
<td>N/A</td>
<td>824,000</td>
</tr>
</tbody>
</table>

Funding recommendation: Appropriate $824 million, a $149 million—or 22%—increase over FY20 enacted levels for the Public Health Emergency Preparedness Cooperative Agreement.

Bill or report language: Recent events, such as the response to the 2019 Novel Coronavirus, show how investing in this program has bolstered the United States’ public health preparedness and response capabilities. At the same time, programs cannot maintain active response postures to a growing number of natural disasters, infectious diseases, and person-made incidents—while also improving systems—with level funding. It’s necessary to increase support to meet the ever-changing, complex public health environment.

Justification: Since its establishment in 2002, the PHEP program has invested in states and territories to create and maintain foundational capabilities. It is critical to provide stable and sufficient health emergency preparedness funding to maintain a standing set of core capabilities so that jurisdictions are ready when needed. The program funding, at $918 million in 2002, is currently 36% lower in 2020, at $675 million, but public health threats are not experiencing similar declines. Cuts in program funding will force health departments to cut critical staff and programmatic investments that are challenging to rebuild over time and especially during a response to a public health emergency. As we know, the people are our net.

Role of the state health agency: State and territorial health agencies are critical to our nation’s ability to...
prepare for, respond to, and recover from public health emergencies and threats. Principally, they ensure the public health of their jurisdictions through their inherent and often legal authority to protect and promote the health, safety, and general welfare of their populations. Over the last 19 years, virtually all state and territorial health agencies have developed the infrastructure needed for a 24/7 readiness posture in partnership with responsible individuals, communities, other government and non-governmental organizations, and the private sector as a result of the PHEP funding.

How funds are allocated or used: This 2019-2024 funding opportunity provides fiscal resources to 62 total state, local, and territorial public health agencies to advance their ability to demonstrate response readiness. It requires states to make available nonfederal contributions in the amount of 10% ($1 for each $10 of federal funds provided in the cooperative agreement) of the award. PHEP recipients must also increase or maintain their levels of effectiveness across six key public health preparedness domains and focus efforts on strengthening preparedness and response capabilities to prevent or reduce morbidity and mortality. As additional public health threats continue to emerge, state, local, tribal, and territorial public health systems must remain effectively prepared and ready to respond to the public health consequences of incidents or events whose scale, rapid onset, or unpredictability stresses the public health system. Subject to the availability of funding, CDC may introduce future projects through PHEP that support advanced development of key public health preparedness capabilities in high population cities during the 2019-2024 performance period. This future project may help high population cities identify gaps and strengthen chemical and radiological preparedness.

Public health impacts: Since Sept. 11, 2001, PHEP has collaborated with state, local, and territorial health departments to prepare and plan for emergencies, resulting in measurable improvement. The PHEP cooperative agreement funds programs that work to strengthen state, local, tribal and territorial public health preparedness and response capability through a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action. An effective public health response will prevent or reduce morbidity and mortality from threats and emergencies whose scale, rapid onset, or unpredictability stresses the public health system and ensure the earliest possible recovery and return of the system to pre-incident levels or improved functioning.

Supporting organizations: Trust for America’s Health and the National Association of County and City Health Officials also support this request.

For more information: ASTHO’s Preparedness web page, http://www.astho.org/Programs/Preparedness/

Contact information:
Carolyn McCoy, ASTHO senior director of federal government affairs
cmccoy@astho.org
(571) 522-2307

Jeffrey Ekoma, ASTHO director of federal government affairs
jekoma@astho.org
(443) 754-0393

See updates to this paper at: https://www.astho.org/Advocacy-Materials/

Date: Jan. 27, 2020
Organization name: Association of State and Territorial Health Officials (ASTHO)
Topic area: Core Public Health Funding

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies
Agency Centers for Disease Control and Prevention
Program, office, or center: Cross-Cutting Activities and Program Support

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20 Enacted</th>
<th>FY21 President's Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Health and Health Services Block Grant</td>
<td>160,000</td>
<td>N/A</td>
<td>170,000</td>
</tr>
</tbody>
</table>

Funding recommendation: Appropriate $170 million, a $10 million—or 6.25%—increase over FY20 enacted levels for the Preventive Health and Health Services Block Grant (Prevent Block Grant).

Bill or report language: The Prevent Block Grant is a critical source of funding for states and territories. It provides the flexibility necessary to address emerging health issues at the state and local levels, while tailoring those activities to best address the diverse health needs of a community.

Justification: For more than 30 years, the Prevent Block Grant has served as an essential source of funding for state and territorial health agencies. In 1999 funding peaked at $194.9 million, and since then it has dropped by 17.9%, not including adjustments for inflation. Programs funding by the Prevent Block Grant cannot be adequately supported or expanded through other funding mechanisms. States and territories use these flexible dollars to offset funding gaps in programs that address the leading causes of death and disability. These funds also enable states and territories to respond to unanticipated or emerging public health threats.

Role of the state health agency: State and territorial health agencies are best equipped to monitor and evaluate the needs of the community. Grantees use this funding to address the leading causes of illness, disability, injury, and death in their jurisdictions.

How funds are allocated or used: Administered by CDC’s Center for State, Tribal, Local, and Territorial Support, the Prevent Block Grant funds 61 grantees: all 50 states, the District of Columbia, two American Indian tribes, eight U.S. territories, and three freely associated states. Grantees set their own goals and program objectives and implement strategies to address national health priorities. For FY18, grantees received a total of $147,332,088 in Prevent Block Funding. Of this funding, $129,309,666 is discretionary health topic area funding, which is allocated by grantees.

Fast Facts or Highlights:
- The Prevent Block Grant provides all 50 states, Washington, D.C., two American Indian tribes, and eight U.S. territories with funding to address their unique public health needs.
- The grant is a non-categorical source of funding to address any of the more than 1,200 national health objectives available in the nation’s Healthy People 2020 health improvement plan.
- All funding for the Prevent Block Grant is provided through the Prevention and Public Health Fund.
based on their priority public health needs. In addition, $7,000,000 is legislatively mandated for sexual violence/rape prevention activities. The remaining $11,022,422 is used for grantee administrative costs.

Public health impacts: The Prevent Block Grant funds support critical investments that strengthen the ability of state, territorial, and tribal health agencies to respond to public health threats. The top allocation of fund supports critical public health needs, including:

- Public health infrastructure (e.g., vital statistics and disease registries).
- Injury and violence prevention.
- Prevention of chronic diseases such as diabetes, heart disease, and stroke.
- Immunization and infectious diseases.
- Oral health.
- Emergency medical services.
- Environmental health activities.

The success of the Prevent Block Grant is achieved by using evidence-based methods and interventions; reducing risk factors such as smoking; establishing policy, social, and environmental changes; leveraging other funds, and continuing to monitor and re-evaluate funded programs.

Supporting organizations: National Association of Country and City Health Officials also supports this request.

For more information: See ASTHO’s website or CDC’s Preventive Health and Health Services Block Grant web page. http://www.astho.org/ and https://www.cdc.gov/phhsblockgrant/index.htm

Contact information:
Carolyn McCoy, ASTHO senior director of federal government affairs
cmccoy@astho.org
(571) 522-2307

Jeffrey Ekoma, ASTHO director of federal government affairs
jekoma@astho.org
(443) 754-0393

See updates to this paper: http://www.astho.org/Advocacy-Materials/

Date: Jan. 27, 2020
**Organization name:** Association of State and Territorial Health Officials (ASTHO)

**Topic Area** Public Health Preparedness and Response

**Name of appropriations bill:** Labor, Health and Human Services, Education, and Related Agencies

**Agency:** Assistant Secretary for Preparedness and Response (ASPR)

**Program, office, or center:** Hospital Preparedness Program (HPP)

<table>
<thead>
<tr>
<th>(Dollars in thousands)</th>
<th>FY20 Enacted</th>
<th>FY21 President's Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Preparedness Program (HPP)</td>
<td>275,555</td>
<td>TBA</td>
<td>474,000</td>
</tr>
</tbody>
</table>

**Funding recommendation:** Appropriate $474 million, which is a $198.5 million—or 72%—increase over the FY20 enacted level for the Hospital Preparedness Program (HPP).

**Bill or report language:** This funding supports cooperative agreements with state, local, and territorial health departments to improve surge capacity and enhance community healthcare coalitions. HPP must continue to fund existing awardees—all states, territories, freely associated states, and four directly funded large cities—as this program is key to the foundational capabilities of healthcare preparedness.

**Justification:** As the only source of federal funding that supports regional healthcare system preparedness, HPP promotes a sustained national focus to improve patient outcomes, minimize the need for supplemental state and federal resources during emergencies, and enable rapid recovery. Current responses to novel viruses reflect the critical need for these programs to maintain active exercising and response readiness. Increased community preparedness and response reduces financial burden in the long term by improving immediate response capability at the community level, lowering sometimes more costly outputs by federal governments, after emergencies have escalated. The HPP program received an increase of $11 million in FY20, however this funding is to support expiring funds for the national network of Ebola treatment centers and hospitals, not the core HPP program.

**Role of the state health agency:** State and territorial health agencies are critical to our nation's ability to prepare for, respond to, and recover from public health emergencies and threats. HPP funding focuses on developing regional healthcare coalitions guided by the state and territorial awardees and the four funded local jurisdictions. Awardees disburse funds to incentivize diverse and often competitive healthcare organizations to work together to prepare for and respond to medical surge events.

**Fast Facts or Highlights:**

- HPP prepares the nation’s healthcare system to save lives during emergencies and disasters.
- Approximately 85% of hospitals nationwide participate in healthcare coalitions through HPP.
- There are 476 healthcare coalitions across the nation.
How funds are allocated or used: The current five-year project period is from 2017-2022. The state, territory is required to make nonfederal contributions in the amount of 10% ($1 for each $10 of federal funds provided in the cooperative agreement) of the award. Funds for preparedness activities go to 62 state, local, and territorial public health systems from the ASPR Division of Grants Management. Awardees include state health departments, select large U.S. cities, and eight U.S. territories and freely associated states.

Public health impacts: HPP has contributed to healthcare system progress throughout the years and supported responses to a wide variety of events, including the Ebola virus, active shooters, chemical explosions, and hurricanes. According to an ASPR survey, 96% of awardees feel that HPP support has improved their ability to decrease morbidity and mortality during disasters.

Supporting organizations: Trust for America’s Health and the National Association of County and City Health Officials also support this request.

For more information: See ASTHO’s preparedness web page (http://www.astho.org/Programs/Preparedness/) or the U.S. Department of Health and Human Services’ HPP web page (https://www.phe.gov/Preparedness/planning/hpp/Pages/default.aspx).

Contact information:
Carolyn McCoy, ASTHO senior director of federal government affairs
cmccoy@astho.org
(571) 522-2307

Jeffrey Ekoma, ASTHO director of federal government affairs
jekoma@astho.org
(443) 754-0393

See updates to this paper at https://www.astho.org/Advocacy-Materials/

Date Jan. 27, 2020
Organization name: Association of State and Territorial Health Officials (ASTHO)
Topic area: Public Health Preparedness and Response

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies
Agency: Assistant Secretary for Preparedness and Response (ASPR)
Program, office, or center: Hospital Preparedness Program (HPP)/Ebola Treatment Network and National Ebola Treatment and Education Centers

<table>
<thead>
<tr>
<th>(Dollars in thousands)</th>
<th>FY20 Enacted</th>
<th>FY21 President’s Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Treatment Network for Ebola and Other Special Pathogens and National Ebola Training and Education Center (NETEC)</td>
<td>11,000*</td>
<td>TBA</td>
<td>45,600</td>
</tr>
</tbody>
</table>

*This funding is limited to the NETEC and the 10 designated regional treatment facilities.

Funding recommendation: States’ immediate and comprehensive responses to the 2019 novel Coronavirus (2019-nCoV), show that investments in public health preparedness programs have improved healthcare and public health systems’ ability to protect countless Americans. It is essential that Congress appropriate $40.6 million for the Regional Treatment Network for Ebola and Other Special Pathogens (RTNESP) and $5 million for the National Ebola Training and Education Center (NETEC) to continue this work.

Bill or report language: By appropriating these funds, Congress recognizes the importance of sustaining an investment to ensure that the nation’s healthcare and public health system is adequately prepared to respond to Ebola and other special, high consequence pathogens.

Fast Facts or Highlights:
- This network is focused on screening, transfer, and treatment for many highly pathogenic diseases, not just Ebola.
- This program works collaboratively with the ASPR Hospital Preparedness Program and the CDC to prepare and support a broad system of healthcare facilities to better respond to these diseases.

Justification: In FY15, Congress provided $239.5 million via an emergency supplemental bill for HHS to establish and maintain RTNESP and NETEC as multiyear initiatives until May 2020. In FY20, Congress appropriated $11 million within the Hospital Preparedness Program to sustain critical parts of the entire set of network and NETEC, but without ongoing, increased funding, institutional capability and expertise will wane, leaving our nation vulnerable to dangerous pathogens. The 2018 National Biodefense Strategy stated that it was in the United States’ vital interest to manage the risk of biological incidents that can cost thousands of American lives, cause significant anxiety, and greatly impact travel and trade.

Role of the state health agency: HHS built on existing infrastructure led by state and territorial health departments to establish the entire set of networks, and state health officials also collaborated with the private healthcare system to designate and prepare healthcare facilities across their states and regions.
to serve in the four-tiered system, in which each tier has a specified role and level of readiness.

**How funds are allocated or used:** This funding would support the National Ebola Training and Education Centers; the 10 regional treatment centers; the state-designated treatment facilities; and public health operations, including planning, coordination, training/exercising, and support for the assessment, and frontline hospital and support for the training, simulation, and quarantine facility.

**Public health impacts:** Prior to the Ebola outbreak in 2014-2015, the United States didn’t have an organized plan to detect and respond to highly infectious diseases and special pathogens. According to recent information provided by ASPR, 82% of RTNESP members now consider themselves highly prepared for an Ebola event, as compared to 2% in July 2014, with the greatest improvements noted in the areas of transportation, coordination, and responder safety and training. NETEC’s FY18 annual report notes that the center has funded 57 facility readiness consultation visits; trainings attended by representatives from 46 states, Washington, D.C., and five U.S. territories; and participation from more than 8,200 healthcare professionals in related educational activities. Furthermore, the recent 2019-nCoV outbreak has clearly demonstrated how every hospital must have the basic and requisite capacity and capabilities to recognize, identify, and safely care for and treatment individuals who present with both “everyday” and novel, highly infectious and potentially life-threatening illnesses.

**Background information:** Since Congress’ initial investment in 2015, RTNESP and NETEC have allowed our healthcare system to make significant progress toward preparing for future public health incidents and emergencies dealing with high consequence infectious agents. RTNESP is composed of 10 designated select regional and 59 jurisdictional treatment centers that are staffed and equipped with the capabilities, training, and resources to provide the necessary level of complex definitive care and treatment. RTNESP also provides for more than 170 assessment hospitals that can safely receive and isolate a person under investigation and care for these individuals until a diagnosis can be determined, and the program resources many more frontline healthcare facilities around the country that can rapidly identify and triage potentially exposed or infected patients and coordinate patient transfer for higher-level care. Similarly, NETEC, funded by ASPR and CDC, was established and serves as a consortium of three healthcare institutions: Emory University, the University of Nebraska Medical Center, and New York City’s Bellevue Hospital, which successfully treated patients with Ebola. NETEC draws upon these institutions’ unique expertise and accomplishments to assess and assist in achieving healthcare facility operational readiness; educate, train, and exercise healthcare providers; lend real-time technical assistance upon request; and provide a research infrastructure to address the critical areas of network engagement, infrastructure readiness, and training readiness.

**Supporting organizations:** Trust for America’s Health (TFAH)

**For more information:** See ASTHO’s preparedness web page (http://www.astho.org/preparedness).

**Contact information:**
Carolyn McCoy, ASTHO senior director of federal government affairs, cmccoy@astho.org, (571) 522-2307

Jeffrey Ekoma, ASTHO director of federal government affairs, jekoma@astho.org, (443) 754-0393

**See updates to this paper:** http://www.astho.org/Advocacy-Materials/

**Date** Jan. 27, 2020
**Organization name:** Association of State and Territorial Health Officials (ASTHO)  
**Topic area:** Core Public Health Infrastructure and Disparities  

**Name of appropriations bill:** Labor, Health and Human Services, Education, and Related Agencies  
**Agency:** Health Resources and Services Administration  
**Program, office, or center:** National Academies of Sciences, Engineering, and Medicine (NASEM)

<table>
<thead>
<tr>
<th>(Dollars in thousands)</th>
<th>Program</th>
<th>FY20 Enacted</th>
<th>FY21 President's Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Academies</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>2,000</td>
</tr>
<tr>
<td>of Sciences, Engineering, and Medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Funding recommendation:** Appropriate $2 million for a new study through the National Academies of Sciences, Engineering, and Medicine.

**Bill or report language:** This funding will support a study that will inform Congress’ work to improve healthcare delivery systems and public health and assess the strengths and challenges unique to the U.S. territories and freely associated states.

**Justification:** In 1998, the National Academies published the report “Pacific Partnerships for Health: Charting a New Course,” which examined the United States’ involvement in the healthcare delivery systems of just the Pacific Basin jurisdictions. This proposed study would expand such work to also include the Atlantic territories and the public health system, as well. One major outcome from this study would be recommendations to Congress on legislative and budgetary needs to improve the health of these jurisdictions. In addition, this work would study the territories’ and freely associated states’ current health and public health systems in order to improve the existing system of care for these residents in their home communities rather than requiring them to engage in costly travel and care outside their home jurisdictions. Current data on these systems is over 20 years old and does not lend itself to modern technological advances and solutions.

**How funds are allocated or used:** The Health Resources and Services Administration should enter into

---

**Fast Facts or Highlights:**

- The freely associated States are three independent nations that encompass 104 inhabited islands spread over an ocean space larger than the continental U.S.
- The five U.S. territories are American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands. The freely associated states are Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.
an agreement with NASEM to review the population health of the U.S. territories and freely associated states. Specifically, NASEM should:

1) Based upon available data, report on the health status of the residents of the U.S. territories and freely associated states.
2) Identify the availability and quality of health data for planning, developing, and implementing programs to address health priorities, including surveillance systems such as the National Electronic Disease Surveillance System.
3) Examine the availability and quality of on-island health and public health system resources, including services, providers, and veterans’ access to care.
4) Examine the interface with mainland health and public health services and programs and the ability of freely associated states to access medical care in the U.S. states and territories.
5) Determine the ability of current health system financing to support the healthcare needs of the U.S. territories, including federal programs such as Medicaid, the Children’s Health Insurance Program, Medicare, lab capacity, the Vaccines for Children Program, and other programs supported by the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other relevant federal agencies.
6) Make recommendations to Congress and other federal agencies for solutions to identified deficiencies that would positively impact the health of citizens living in U.S. territories, freely associated states, and states.

Public health impacts: This study aims to understand the opportunities to improve the health of the populations in these communities given the great health disparities that exist among these populations.

Background information: According to the Kaiser Family Foundation, the U.S. territories differ from the states on key demographic, economic, and health status indicators. The territories include American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands, and the freely associated states include the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. Many of the entities face longstanding fiscal challenges, and recent natural disasters and other external factors have exacerbated these challenges. A NASEM study would provide the foundation and evidence needed for Congress, the Trump administration, and others to improve the health of these populations.

For more information: See ASTHO’s website, www.astho.org.

Contact information:
Carolyn McCoy, ASTHO senior director of federal government affairs
cmccoy@astho.org
(571)-522-2307

Jeffrey Ekoma, ASTHO director of federal government affairs
jekoma@astho.org
(443) 754-0393

See updates to this paper at https://www.astho.org/Advocacy-Materials

Date Jan. 27, 2020
Organization Name: Association of Public Health Laboratories, Council of State and Territorial Epidemiologists, National Association for Public Health Statistics and Information Systems.

Topic Area: Public Health Data/IT Systems Modernization

Name of Appropriations Bill: Labor, Health and Human Services, Education and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, Office or Center: Public Health Scientific Services

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20 Enacted</th>
<th>FY21 President’s Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Data/IT Systems Modernization</td>
<td>50,000</td>
<td>TBA</td>
<td>100,000</td>
</tr>
</tbody>
</table>

Funding recommendation: Appropriate $100 million, which represents a $50 million increase over FY20.

Bill or report language: Public Health Data/IT Systems Modernization – The nation’s public health data systems are antiquated, rely on obsolete surveillance methods, and are in dire need of security upgrades. Lack of interoperability, reporting consistency, and data standards leads to errors in quality, timeliness, and communication. In addition, public health professionals are faced with rapid advances in data science and evolving cybersecurity threats, and many do not yet have the necessary 21st century skills to understand and securely integrate health data. The Committee provides $100 million in FY 2021 to the Centers for Disease Control and Prevention (CDC) to continue to modernize IT systems and recruit and retain skilled data scientists both at CDC, and state, local, and territorial health departments.

Justification: The nation’s public health data systems are antiquated, rely on obsolete surveillance methods, and are in dire need of security upgrades. Lack of interoperability, reporting consistency, and data standards lead to errors in quality, timeliness, and communication. Sluggish, manual processes—paper records, spreadsheets, faxes and phone calls—still in widespread use, have consequences, most notably, delayed detection and response to public health threats of all types: chronic, emerging, and urgent.

In addition, public health professionals are faced with rapid advances in data science and evolving cybersecurity threats. Degree programs and early- and mid-career workforce development overhauls are needed for epidemiologists, vital registrars, and laboratorians, and other public health professionals to perform 21st century skills.

- The development of 21st century data systems and the public health workforce needed to operate and maintain them have been woefully underfunded.
- A $1 billion investment over the next decade at CDC and health departments would transform public health surveillance into a state of the art, secure, rapid response system—that is urgently needed to prepare public health departments to respond to increasing threats.
**Role of the state health agency:** Critical public health data originate in the community. Public health departments are responsible for the collection, reporting, analysis, and security of these data provided by health care providers via health records, vital records, and laboratory samples. These data are shared by health departments with CDC to provide national data on health.

**How funds are allocated or used:** Funds are awarded to state, territorial, local, and tribal health agencies through a competitive grant process to implement or upgrade to electronic, interoperable public health data systems. Improvements will be made to the National Notifiable Disease Surveillance System, electronic case reporting, syndromic surveillance, electronic vital records systems, and laboratory systems including Laboratory Information Management Systems and electronic laboratory reporting. Funds will also train the public health workforce to acquire new skills to understand and securely integrate health data.

**Public health impacts:** Currently, public health data is manually entered from paper-based data exchange which impede timely responses, perpetuate outbreaks, and can potentially cause loss of life. Funding to develop the 21st century data systems and train the public health workforce will ultimately improve Americans’ health through faster detection and response to emerging health threats. A modernized, enterprise-wide public health surveillance system will enable timely, accurate, and secure exchange of data for all diseases and conditions.

**Supporting organizations:** Association of Public Health Laboratories (APHL), Council of State and Territorial Epidemiologists (CSTE), National Association for Public Health Statistics and Information Systems (NAPHSIS), and the Healthcare Information and Management Systems Society (HIMSS)


**Contact information:** Erin Morton: emorton@dc-crd.com; 202-484-1100 x158

**Date** January 27, 2020
**Organization Name**  Association of Immunization Managers  
**Topic Area**  Immunization Funding  

**Name of Appropriations Bill**  Labor, Health and Human Services, Education, and Related Agencies  
**Agency**  Centers for Disease Control and Prevention  
**Program, Office or Center**  317 Immunization Program  

<table>
<thead>
<tr>
<th>Program line item</th>
<th>FY20 Enacted</th>
<th>FY21 President's Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>615,847</td>
<td>TBA</td>
<td>710,800</td>
</tr>
</tbody>
</table>

**Funding recommendation**: Appropriate $710.8 million, which is a $95 million or 13% increase for the Section 317 Immunization Program. This increase is critical to save lives, implement new vaccines, sustain and update Immunization Information Systems (IIS), and respond to the growing number of hepatitis A, measles, mumps, influenza and other outbreaks.

**Justification**: Vaccines help people avoid preventable deaths, reduce illness and suffering, and save lives. But without a robust public health support system assuring the administration of vaccines to recommended populations, proper storage of vaccines to maintain potency, education of providers and consumers, surveillance of diseases and control of outbreaks, and management of the federal Vaccines for Children Program serving millions of children each year; vaccines would just sit on the shelf. In 2019, the World Health Organization declared vaccine hesitancy as one of the top-ten global threats. State and local immunization programs can address this threat, but need adequate resources and are losing ground due to years of near-flat funding.

**Role of the state health agency**: The Section 317 program provides grants to state, local and territorial health agencies to purchase vaccine for uninsured adults and outbreak response; to enroll, educate and provide vaccine to over 40,000 private physicians in the Vaccines for Children Program (immunizing millions of children annually); to track vaccination rates and vaccine inventory; and to identify disease incidence and stop transmission of deadly, preventable disease.

- During January 1–October 1, 2019, a total of 1,249 measles cases and 22 measles outbreaks were reported in the United States. This represents the most U.S. cases reported in a single year since 1992, with 119 hospitalizations.
- Outbreaks of Hepatitis A have been declared in 32 states since 2016, with 30,525 cases, 18,604 hospitalizations, and 306 deaths.
- Millions of people get flu every year, hundreds of thousands of people are hospitalized and thousands to tens of thousands of people die from flu-related causes every year, including 39 pediatric deaths this season as of Jan. 20, 2020.
- 31,200 of 33,700 HPV-related cancers could be prevented each year in the U.S.
- 114% increase in hepatitis B cases in Kentucky, Tennessee and West Virginia due to opioid epidemic.
- The U.S. spends nearly $27 billion annually to treat four vaccine-preventable illnesses (flu, pertussis, pneumococcal, and shingles).
How funds are allocated or used: Funds are awarded to 64 state, local and territorial health agencies by formula based largely on population. The growth of electronic health records and compliance with associated regulations, new vaccines and school requirements, as well as continuing unpredictable disease outbreaks, has increased the complexity of vaccine management, and additional base funding is needed for each state to maintain sound and efficient immunization infrastructure. Funds are also used for activities such as tracing and contacting cases, providing tetanus shots after flooding, addressing Hepatitis A outbreaks, and providing birthing hospitals with initial recommended doses of Hepatitis B vaccine.

Public health impacts: For each dollar invested in the U.S. childhood immunization program, there are over ten dollars of societal savings and three dollars in direct medical savings. Moreover, childhood immunizations over the past twenty-five years have prevented 381 million illnesses, 855,000 deaths, and nearly $1.65 trillion in societal costs. In the 2017 – 2018 season alone, flu vaccination prevented an estimated 5.3 million illnesses. Prevention costs less than treatment: in 2017 and 2018 there were 410 hepatitis A related hospitalizations reported in Missouri. The total charges where Hepatitis A was the primary diagnosis were $4,858,040 and the total charges were $17 million where Hepatitis A was a secondary diagnosis. The cost of vaccine to immunize these cases would have been $12,611.60 ($30.76 per dose). Additional breakthroughs are possible with a range of preventable diseases, including certain cancers, with Australia is set to become the first country in the world to eliminate cervical cancer by 2035 following the success of their Human Papilloma Virus (HPV) vaccination program. Inadequate vaccination would result in preventable illness, suffering, and death.

Supporting organizations: Association of State and Territorial Health Officials (ASTHO), National Association of City and County Health Officials (NACCHO), American Immunization Registry Association (AIRA), Vaccinate Your Family (VYF), American Academy of Pediatrics (AAP), 317 Coalition, Adult Vaccine Access Coalition (AVAC), Immunization Action Coalition (IAC), Families Fighting Flu, Meningitis Angels, National Meningitis Association, Meningitis B Action Project


Stories on the Value of Immunizations:
Centers for Disease Control and Prevention Fact Sheet, “What are the reasons to vaccinate my child?” [https://www.cdc.gov/features/reasonstovaccinate/index.html]
Children’s Hospital of Philadelphia has a collection of personal stories [https://www.chop.edu/centers-programs/parents-pack/personal-stories]
Families Fighting Flu has collected numerous emotional family stories recounting how lives have been permanently altered by flu [https://www.familiesfightingflu.org/family-stories/]
Vaccinate Your Family has many stories from “vaccine advocates who are willing to share their painful stories in hopes of saving the lives of people of all ages.” [https://www.vaccinateyourfamily.org/why-vaccinate/personal-stories/]

Contact information: Claire Hannan, Executive Director, channan@immunizationmanagers.org
301-424-6080
Date: January 20, 2020.
Funding recommendation: Appropriate $715 million, which is a $27.3 million or 3.9% increase for the Maternal and Child Health Block Grant.

Justification: The MCH Block Grant is the only federal program of its kind devoted solely to improving the health of all women and children. The flexible nature of the MCH Block Grant is an invaluable resource for states to use to address the most pressing needs of MCH populations while maintaining high levels of accountability and utilizing evidence-based strategies.

Role of the state health agency: State maternal and child health agencies, usually located within a state health department, apply annually for Title V funding. States conduct needs assessments every five years and then use those findings to implement programs aimed at addressing critical needs for the maternal and child health population in their state, including for children and youth with special health care needs.

How funds are allocated or used: Title V funds are distributed to state and territorial maternal and child health agencies in 59 states and jurisdictions by formula, which considers the proportion of low-income children in each state. States and jurisdictions must match every $4 of federal Title V money that they receive with at least $3 of state and/or local money.

Public health impacts: In FY 2018, approximately 91 percent of pregnant women, 99 percent of infants, and 54 percent of children nationally benefitted from a Title V-supported service, translating to improvements in areas such as reducing infant mortality, reducing smoking during pregnancy, and increasing rates of preventive dental visits for children.

Background information: Another key component of the MCH Block Grant is the Special Projects of Regional and National Significance (SPRANS). SPRANS funding complements and helps ensure the
success of state Title V, Medicaid, and CHIP programs by driving innovation and building capacity to create integrated systems of care for mothers and children. Examples of innovative projects funded through SPRANS include guidelines for child health supervision from infancy through adolescence (i.e. Bright Futures); nutrition care during pregnancy and lactation; recommended standards for prenatal care; successful strategies for the prevention of childhood injuries; health safety standards for out-of-home childcare facilities; and maternal health innovation grants to reduce maternal mortality and morbidity.

For more information: www.amchp.org or www.mchb.hrsa.gov

Contact information: Amy Haddad, Director of Policy and Government Affairs
202-266-3045 or ahaddad@amchp.org

Date January 30, 2020
Funding recommendation: The CDC Division of Oral Health, which is located in the CDC National Center for Chronic Disease Prevention and Health Promotion, currently receives $19.5 million from Congress to distribute to states for oral health prevention programs. The Association of State and Territorial Dental Directors strongly recommends an appropriation of $36.5 million for the Division of Oral Health, which is a $17 million increase from their current funding. Of the additional $17 M, $8 M would go towards funding 12 more states for Component 1 (surveillance, community water fluoridation, dental sealants) and 6 more states for Component 2 (medical-dental integration), $1M would go toward supporting 4 additional tribal and territorial programs, $4 M would support the provision of program technical assistance and support for surveillance, evaluation, policy and communication activities, and $4 M would go towards research, epidemiologic analysis, translation of science to action, infection prevention, etc.

Justification: The mouth and teeth are integral to human health and well-being. When we lose the functions of the mouth and teeth, we lose our health. Oral diseases, including dental caries (tooth decay), periodontal disease (gum disease), and oral cancers, progress and become more complex over time, affecting people at every stage of life. This creates a significant personal and financial burden on individuals, public health systems and dental care systems. Oral diseases are considered chronic disease just like diabetes, hypertension (high blood pressure), asthma, and breast and other cancers. Oral diseases impact almost everyone who lives in the U.S. sometime during their lives. Oral diseases cause people to lose time from work and school, go to the emergency department for relief of pain, and impact some people’s ability to get a job or enlist in the military. And yet, while the CDC provides funding to every State Health Department for cancer, diabetes, and heart disease and stroke prevention programs, it funds less than half the states for oral disease prevention programs.

Role of the state health agency: State health agencies are responsible for assessing and tracking oral disease in the state’s population, developing and implementing policies and programs to prevent or minimize the disease, and ensuring that laws and regulations are in place to keep the public safe and healthy. To translate proven health promotion and disease prevention approaches into policy development, health care practice, and personal behaviors, state oral health programs must have adequate capacity and infrastructure.
How funds are allocated or used: In 2001, CDC began funding state health departments for state oral health program infrastructure and capacity building. Grants are competitively awarded to state health departments. The average grant size is $370,000 per state, per year. In 2018, 45 states applied but only 20 were funded. Twenty states have never been funded (Alabama, Arizona, California, Delaware, DC, Indiana, Kentucky, Massachusetts, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, South Dakota, Tennessee, Utah, Washington, Wyoming). Eleven states that were previously funded, are no longer funded (Alaska, Hawaii, Illinois, Maine, Michigan, Mississippi, Nevada, New York, Oregon, Texas, Wisconsin).

Public health impacts:

- Dental caries is one of the most common chronic diseases in the United States.
- About 1 of 5 (20%) children aged 5 to 11 years have at least one untreated decayed tooth.
- 1 of 7 (13%) adolescents aged 12 to 19 years have at least one untreated decayed tooth.
- Children aged 5 to 19 years from low-income families are twice as likely (25%) to have cavities, compared with children from higher-income households (11%).
- If dental sealants were used in combination with the optimal amount of fluoride, most tooth decay in children could be prevented.
- More than 1 in 4 (27%) adults in the United States have untreated tooth decay.
- Nearly half (46%) of all adults aged 30 years or older show signs of gum disease; severe gum disease affects about 9% of adults.
- Nationally, almost 100 million people, particularly older Americans, do not have dental insurance.
- On average, the nation spends more than $124 billion a year on costs related to dental care.
- More than $6 billion of productivity is lost each year because people miss work to get dental care.
- Oral health has been linked with other chronic diseases, like diabetes and heart disease. It is also linked with risk behaviors like using tobacco and eating and drinking foods and beverages high in sugar.
- Oral cancer accounts for a greater percentage of U.S. cases of cancer than ovarian, cervical, thyroid, or brain cancer.

State Oral Health Programs target long term reductions in population rates of dental caries, periodontal disease, and oral cancer and their related costs, and related increases in productivity and independence.


For more information: http://astdd.org
Contact information: Christine Wood, Executive Director, 775-626-5008, cwood@astdd.org
Date: January 31, 2020
Organization Name: Association of Public Health Laboratories, Council of State and Territorial Epidemiologists, and National Association of Vector-Borne Disease Control Officials

Topic Area: Epidemiology and Laboratory Capacity and Advanced Molecular Detection

Name of Appropriations Bill: Labor, Health and Human Services, Education and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, Office or Center: Emerging and Zoonotic Infectious Diseases

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20 Enacted</th>
<th>FY21 President's Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emerging and Zoonotic Infectious Diseases</td>
<td>622,372</td>
<td>TBA</td>
<td>687,000</td>
</tr>
</tbody>
</table>

Funding recommendation: Appropriate $687,000 which is a $64,628 million increase for Emerging and Zoonotic Infectious Diseases, which includes a $27 million increase for the Advanced Molecular Detection Program.

Bill or report language: The Epidemiology and Laboratory Capacity for Infectious Diseases Program (ELC) strengthens the epidemiologic and laboratory capacity in 50 states, six local health departments, and eight territories. This funding provides critical support to epidemiologists and laboratory scientists who are instrumental in discovering and responding to various food and vector-borne outbreaks. The Committee provides funding for ELC grants to sustain core surveillance capacity and ensure state and local epidemiologists are equipped to rapidly respond to emerging threats including antimicrobial resistant superbugs and novel coronaviruses such as the Wuhan virus.

Justification: Funding for the National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) is essential in combating new and emerging threats. Funding for NCEZID bolsters the ELC Cooperative Grant Program, the principal financing mechanism that strengthens surveillance for infectious diseases, early detection of newly emerging disease threats, and identification and response to outbreaks.

NCEZID also funds CDC’s Advanced Molecular Detection Program (AMD), which has been flat funded since FY 2014 at $30 million. The above request includes $57 million for CDC’s AMD program, which has enabled the agency to incorporate next generation sequencing (NGS) into CDC operations. The program’s success has demonstrated the critical importance to the nation’s health security of staying abreast of technologies that are both innovative and relevant.

- In FY19, public health departments funded under ELC requested $400 million to support public health surveillance and early detection of emerging disease threats but CDC was only able to award $231 million, leaving many projects and activities unfunded.
- Increased funding for CDC’s AMD program will promote innovation through improved metagenomics, data integration, and cross-cutting genomics infrastructure. Doing so will directly benefit states and localities.
The CDC AMD program is rapidly growing, and NGS-related technologies continue to advance at an astounding pace, giving us new and expanded tools to detect disease faster, identify outbreaks sooner, and protect people from emerging and evolving disease threats. Current funding has become insufficient to meet the demand for equipment, training and expertise required to support state and local health departments with precision public health and expanded collaborations.

**Role of the state health agency:** State and local health departments and laboratories are critical partners in these activities, and CDC is thus heavily vested in the strength of state and local epidemiology and laboratory surveillance capacity. These ELC funds ultimately serve a dual purpose. Funding provided to support communicable disease monitoring and response bolsters the overall epidemiology infrastructure needed to fight non-communicable diseases, which represent our nation’s leading causes of death.

**How funds are allocated or used:** In FY 2019, base funding for ELC was $231 million. It is important to note that within this total, nearly $50 million of total ELC funding stems from the Prevention and Public Health Fund. This continuation of this mandatory ELC funding is critical to the nation’s core surveillance capacity.

**Public health impacts:** Supported by funding from the ELC, 50 states, six local health departments, and eight territories quickly identified a nationwide measles outbreak; detected and implemented containment strategies for *Brucella* in unpasteurized dairy products; monitored the emerging Wuhan virus; tracked the spread of tickborne disease using new technologies; and strengthened detection of antibiotic resistant infections like drug resistant tuberculosis and “nightmare bacteria” carbapenem resistant Enterobacteriaceae.

**Supporting organizations:** Association of Public Health Laboratories; Council of State and Territorial Epidemiologists; National Association of Vector-Borne Disease Control Officials

**For more information:** A funding table summarizing ELC funding is available at: https://www.cdc.gov/ncezid/dpei/elc/history/elc-awards-by-grantee-2019.html

You may also visit www.cste.org or www.aphl.org for more information.

**Contact information:** Erin Will Morton, Senior Vice President, CRD Associates, emorton@dc-crd.com, (202) 484.1100 x158

**Date** January 27, 2020
Organization Name: National Association of Chronic Disease Directors  
Topic Area: Chronic Disease

Name of Appropriations Bill: Labor, Health and Human Services, Education Appropriations Bill  
Agency: Centers for Disease Control and Prevention  
Program, Office or Center: National Center for Chronic Disease Prevention and Health Promotion

Funding recommendation: NACDD strongly recommends appropriation of the amounts indicated to support evidenced-based state chronic disease prevention and control activities. Other appropriation recommendations are listed at the website below. This is proven to be an effective approach to reach high-need communities with strategies that work. The amounts requested reflect a restoration and modest increase in funds for the Prevent Block Grant to states, an increase in funds for obesity prevention, to address diabetes and heart disease and stroke prevention. The important role of states in the provision of healthcare, monitoring of health insurance, management of all public health initiatives, and built in linkage with local governments and provider communities make states the logical and most efficient vehicle to manage these critical public health programs.

Justification: These requests are made to support the public health efforts proven to address many of the nation’s major causes of death and disability. Chronic disease conditions contribute to early death, poor quality of life, reduction in economic output, increase in disability, increase in healthcare costs, reduction in military readiness, and increased risk of poverty. All of these factors can be reduced or prevented through proven strategies using state health agencies leading local communities to healthier more productive living. The increases requested are essential to maintain and expand current efforts in every state. Critical clinical community linkages and health promotion efforts are required to meet these needs.

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20 Enacted</th>
<th>FY20 President’s Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Health and Health Services Block Grant</td>
<td>$160,000</td>
<td>TBA</td>
<td>$170,000</td>
</tr>
<tr>
<td>Nutrition, Physical Activity, and Obesity</td>
<td>$56,920 + $15,000 high rate counties</td>
<td>TBA</td>
<td>$110,000 + $15,000 high rate counties</td>
</tr>
<tr>
<td>Diabetes Prevention and Control</td>
<td>$148,129</td>
<td>TBA</td>
<td>$185,000</td>
</tr>
<tr>
<td>Heart Disease and Stroke Prevention</td>
<td>$140,062</td>
<td>TBA</td>
<td>$160,037</td>
</tr>
</tbody>
</table>

Fast Facts:  
- Chronic diseases account for 75% of health care costs, more for seniors.  
- Much of the human and financial toll of chronic diseases is preventable.
goals.

**Role of the state health agency:** State Health Agencies have a unique role in efforts to coordinate activity and steer resources to communities most in need, creating linkages across systems with healthcare providers, insurers, educators, community organizations, and others. State participation is needed to maximize federal actions and assure most efficient mobilization of local organizations, while at the same time avoiding any duplication.

**How funds are allocated or used:** Funds are targeted to support State action to lead activities and evaluation and, in turn, grant funds to local health agencies and non-profit partner organizations.

**Public health impacts:** These programs target long term reduction in population rates of chronic conditions and related costs, and related increases in productivity and independence.

**Background information:** Focused on the nation’s most costly conditions in both human and financial terms, the prevention and control of chronic diseases and risk factors, the National Association of Chronic Disease Directors improves the health of the public by strengthening state-based leadership and expertise for chronic disease prevention and control in states and at the national level.

At the turn of the 20th century, the major causes of death and disease were markedly different from today. Modern challenges from infectious diseases have been far surpassed by chronic diseases such as diabetes, heart disease, stroke, and cancer. Significantly, seven out of ten people die of a chronic disease. Moreover, people who die of chronic diseases before age 65 lose a third of their potential lives. Death alone doesn’t convey the full impact of chronic disease. These serious diseases, by definition, are often lifelong conditions that are treatable but not curable. An even greater burden befalls Americans from the disability and diminished quality of life resulting from chronic disease. This burden is shared by adults, adolescents and children of all ages, and the attendant economic impact is borne primarily by taxpayers and employers.

**Supporting organizations:** NACDD works closely with many national partners to assure high quality and consistent approaches to address these public health challenges. These include the American Diabetes Association, American Heart Association, YMCA of the USA and many others.

**For more information:** [http://www.chronicdisease.org/](http://www.chronicdisease.org/)

**Contact information:** Amy Souders, Cornerstone Government Affairs; 202-448-9588, asouders@cgagroup.com

**See updates to this paper at** [https://chronicdisease.site-ym.com/page/h_governmentaffairs](https://chronicdisease.site-ym.com/page/h_governmentaffairs)

**Date** January 27, 2020
**Organization Name** National Association for Public Health Statistics and Information Systems  
**Topic Area** Electronic Vital Records Systems

**Name of Appropriations Bill** Labor, Health and Human Services, Education and Related Agencies  
**Agency** Centers for Disease Control and Prevention  
**Program, Office or Center** National Center for Health Statistics

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20 Enacted</th>
<th>FY21 President's Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Center for Health Statistics</td>
<td>160,397</td>
<td>TBA</td>
<td>175,000</td>
</tr>
</tbody>
</table>

**Funding recommendation:** Appropriate $175 million, which is a $14.6 million increase for the National Center for Health Statistics.

**Bill or report language:** Modernizing Vital Statistics Collection – Electronic birth and death registration systems are an essential tool in monitoring public health and fighting waste, fraud, and abuse in federal entitlement programs. Many states that were early adopters of electronic systems lack the resources to modernize and keep pace with new technology. The Committee provides the National Center for Health Statistics funding to support states to upgrade antiquated systems and improve the quality and timeliness of vital statistics, which will lead to more, better, faster data on opioid-related deaths, maternal mortality, and other public health priorities.

**Justification:** For many years, Congress has invested in modernizing the vital statistics infrastructure, working to move all states from paper-based records to electronic. Many electronic “early-adopter” states lack resources to modernize their existing electronic systems to keep pace with new technology. Continued investment will help maximize the potential of electronic systems and enhance data quality, specificity, accuracy, security, and timeliness.

Funding for the electronic vital records system would (1) expand broad scale, secure vital record systems implementation across jurisdictions, (2) support interoperability, integration, intelligent, and real-time reporting of data from multiple sources, including electronic health records and medical examiner/coroner systems and (3) deliver rapid, seamless exchange of birth and death data with CDC.

**Role of the state health agency:** Vital records are permanent legal records of life events, including live

**Fast Facts:**
- The vital records jurisdictions—50 states, five territories, District of Columbia, and New York City—are legally responsible for the registrations of vital events including births, deaths, and fetal deaths.
- National Center for Health Statistics (NCHS) enters into contracts with the jurisdictions to obtain data on these events and compile national vital statistics through the Vital Statistics Cooperative Program.
births, deaths, fetal deaths, marriages, and divorces. Consistent with the constitutional framework set forth by our founding fathers in 1785, states were assigned certain powers. The 57 vital records jurisdictions, not the federal government, have legal authority for the registration of these records, which are thus governed under state laws. The laws governing what information may be shared, with whom, and under what circumstances varies by jurisdiction. In an example of effective federalism, the vital records jurisdictions provide the federal government with data collected through birth and death records to compile national health statistics, facilitate secure Social Security number (SSN) issuance to newborns through the Enumeration at Birth (EAB) Program, and report individual's deaths.

**How funds are allocated or used:** NCHS provides more than $20 million per year to the states for the use of their birth, death, and fetal death records. Funding is $350,000, on average, across the 57 vital records jurisdictions.

**Public health impacts:** As headlines demonstrate—from the unexpected rise in death rates among middle-aged, white Americans due to substance abuse and suicide, to the impact of home births on infant mortality, to the rise in the age of first time mothers—vital records serve critical public health, civil registration, and administrative functions. These data are used to monitor disease prevalence and our nation’s overall health status, develop programs to improve public health, and evaluate the effectiveness of those interventions. Because of Congress’s longstanding leadership in supporting the modernization of the National Vital Statistics System—moving from paper-based to electronic filing of birth and death statistics—NCHS has funded states and territories to speed the release of birth and death statistics, including infant mortality and prescription drug overdose deaths. In fact, the percentage of mortality records reported within 10 days has increased from less than 10 percent in 2010 to 60 percent in 2018.

**Supporting organizations:** Friends of NCHS coalition ([www.friendsofnchs.org](http://www.friendsofnchs.org))

**For more information:** [www.naphsis.org](http://www.naphsis.org)

**Contact information:** Erin Will Morton, Senior Vice President, CRD Associates, 202-484-1100 x143

**Date** January 27, 2020
**Organization Name** NASTAD (National Alliance of State & Territorial AIDS Directors)

**Topic Area** HIV and Hepatitis Programs

**Name of Appropriations Bill** Labor, Health and Human Services, Education, and Related Agencies

**Agency** Centers for Disease Control and Prevention

**Program, Office or Center** Division of HIV Prevention

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20 Enacted</th>
<th>FY21 President's Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic HIV/AIDS Prevention and Research</td>
<td>928,000</td>
<td>TBA</td>
<td>1,012,000</td>
</tr>
</tbody>
</table>

**Funding recommendation:** Appropriate $1,012,000 which is a $84 million increase for Domestic HIV/AIDS Prevention and Research.

**Justification:** With the confluence of advances in science and policy, the United States has an unprecedented opportunity to achieve large-scale, measurable impact in a relatively short timeframe, drastically reduce health disparities, and end the HIV epidemic. To achieve this goal, the Domestic HIV/AIDS Prevention and Research program must see increased funding. 60 health departments receive this funding (all 50 states, Washington, D.C., Puerto Rico, U.S. Virgin Islands, Baltimore City, Chicago, Houston, Los Angeles County, Philadelphia, New York City, and San Francisco).

During the State of the Union address on February 5, 2019, President Trump announced an initiative to end the HIV epidemic by 2030. Ending the HIV Epidemic: A Plan for America intends to reduce new infections by 75% in the next five years, and by 90% in the next ten years by supporting 48 counties, Washington, DC, and San Juan, Puerto Rico, as well as seven states with high rates of HIV in rural geographic regions. This initiative will supplement existing resources and focus on the testing, linkage to care, and access to prevention modalities.

The number of new HIV infections must decrease to address to see meaningful improvements in individual and community level health outcomes, particularly among disproportionately impacted populations. It is clear that early detection, linkage to and retention in care, and adherence to treatment will suppress individual and community viral loads and reduce the incidence of HIV. Unfortunately, only 50 percent of people living with HIV have an undetectable viral load. Addressing interventions along the

Fast facts or highlights

- The annual number of new diagnoses decreased 9% from 2010 to 2016 in the 50 states and the District of Columbia.

- In 2018, gay, bisexual, and other men who have sex with men accounted for 69% of all new HIV diagnoses in the United States and 6 dependent areas.
HIV care continuum is our newest and most effective tool to get to zero new HIV infections; however, health departments need additional support to successfully implement these strategies.

Robust surveillance systems are essential for high-impact prevention, including using surveillance data for program planning and response, strategically directing resources to populations and geographic areas and linking and retaining individuals in care. Additional resources will allow improvements in core surveillance and expand surveillance for HIV incidence, behavioral risk and receipt of point of care information, including CD4 and viral load reporting. This will, in turn, contribute to improved testing and linkage to care, retention and re-engagement in care, and reducing risk behaviors.

Role of the state health agency: Health departments are the cornerstone implementers of federal public health policy and are essential to lowering HIV infections. HIV prevention activities and services are targeted to communities where HIV is most heavily concentrated, particularly among racial and ethnic minorities and gay men/men who sex with men of all races and ethnicities.

Health departments use proven, cost-effective strategies to reduce new HIV infections, such as HIV testing and diagnosis, expanded use of data-to-care efforts to ensure that people living with HIV remain engaged in care, preventing HIV among those most likely to acquire HIV, investing in surveillance programs, identifying, monitoring, and responding to HIV transmission clusters and outbreaks. Health departments also have flexibility to allocate funds based on local needs.

How funds are allocated or used: Category A Funds are awarded to state and eligible local health departments by formula and states and eligible local health departments may apply for Category B funds for demonstration projects through competitive awards. Health departments can provide sub-grant awards to local health departments and/or community-based organizations. Health departments that are eligible for Ending the Epidemic Initiative funds will received them based on formula.

Public health impacts: More than 1.1 million people are living with HIV in the United States. Due to sustained funding and investment in HIV prevention, new HIV infections fell 18% between 2008 and 2014. During this time, the percentage of people who were aware of their HIV status increased from 80% to 87%. However, further progress in preventing new HIV infections is imperative. An overwhelming percentage of HIV infections are among gay, bisexual, and other men who have sex with men (MSM).

Supporting organizations: The AIDS Budget and Appropriations Coalition supports this ask.

For more information: www.NASTAD.org

Contact information: Emily McCloskey, Director, Policy & Legislative Affairs, 202-897-0078, emccloskey@NASTAD.org

See updates to this paper: https://www.nastad.org/domestic/policy-legislative-affairs

Date: January 27, 2020
Organization Name NASTAD (National Alliance of State & Territorial AIDS Directors)
Topic Area HIV and Hepatitis Programs

Name of Appropriations Bill Labor, Health and Human Services, Education, and Related Agencies
Agency Centers for Disease Control and Prevention
Program, Office or Center Viral Hepatitis Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20 Enacted</th>
<th>FY20 President's Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viral Hepatitis Prevention</td>
<td>39,000</td>
<td>TBA</td>
<td>134,000</td>
</tr>
</tbody>
</table>

Funding recommendation: Appropriate $134,000 which is a $95 million increase for the Viral Hepatitis program at the Centers for Disease Control and Prevention.

Justification: Currently, 46 states, Chicago, New York City, Philadelphia and the District of Columbia receive funding for hepatitis prevention.

There are alarming increases in the number of new hepatitis B (HBV) and hepatitis C (HCV) cases, primarily associated with the opioid crisis. According to the CDC, the number of new cases of HCV increased 350% between 2010 and 2016, mainly due to the increase in injection drug use. The opioid crisis also reversed a steady decline in the number of new HBV cases, causing a 20% increase in 2015. There was a 32% increase in the rate of acute hepatitis C from 2015 to 2017.

Increasing funding would allow CDC’s hepatitis program would enhance existing, and create new, program and clinical infrastructure, increase education to high risk groups and affected communities, including pregnant women, about the intersection of the opioid crisis and infectious diseases, increase viral hepatitis surveillance infrastructure in state health departments to detect acute viral hepatitis infections and enhance ability to conduct cluster identification and investigations, increase capacity of community coalitions, state health departments, and community based organizations to implement effective primary infectious disease prevention programs and services tailored to persons who use drugs and have opioid use disorders and increase access to, and proper disposal of, sterile injection equipment, where legal and with community support.

Role of the state health agency: The state health department is the only government funded entity in most states that is focused on hepatitis prevention and provides the public health infrastructure to fight this epidemic. The state health agency provides education, works to prevent mother to child
transmission, coordinates surveillance efforts where funded, and coordinates testing and linkage to care for people living with hepatitis B or C.

**How funds are allocated or used:** 46 states, 3 cities, and the District of Columbia receive funding for hepatitis prevention to increase the number of persons living with hepatitis B and hepatitis C infection that are tested for these infections, made aware of their infection, and linked to recommended care and treatment services.

**Public health impacts:** The Centers for Disease Control and Prevention (CDC) estimates that up to 5.3 million people live with hepatitis B (HBV) and/or hepatitis C (HCV) in the U.S. As many as 75% are unaware of their infection. CDC also estimates that there are more HCV-related deaths annually than deaths from all other nationally notifiable infectious diseases, combined. In its 2016 Annual Report to the Nation on the Status of Cancer, CDC notes that both liver cancer cases – of which 20% are caused by hepatitis - and deaths are on the rise, in contrast to trends of most other cancers. Hepatitis disproportionately impacts several communities, particularly people who inject drugs, African Americans, Asian Americans, Latinos, Native Americans, men who have sex with men (MSM), residents of rural and remote areas, and people living with HIV. While people born between 1945 and 1965 represent the group with the highest HCV-related morbidity and mortality, there has been a rise in HCV infection among young people throughout the country. Some jurisdictions have noted that the number of people ages 15 to 29 being diagnosed with HCV infection now exceeds the number of people diagnosed in all other age groups combined, which is typically attributed to injection drug use.

**Supporting organizations:** The Hepatitis Appropriations Partnership supports this ask.

**For more information:** [www.NASTAD.org](http://www.NASTAD.org)

**Contact information:** Emily McCloskey, Director, Policy & Legislative Affairs, 202-897-0078, emccloskey@NASTAD.org

**See updates to this paper:** [https://www.nastad.org/domestic/policy-legislative-affairs](https://www.nastad.org/domestic/policy-legislative-affairs)

**Date** January 27, 2020
Organization Name: NASTAD (National Alliance of State & Territorial AIDS Directors)
Topic Area: HIV and Hepatitis Programs

Name of Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency: Health Resources and Services Administration
Program, Office or Center: Ryan White Part B

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20 Enacted</th>
<th>FY21 President’s Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ryan White Part B</td>
<td>1,315,000</td>
<td>TBA</td>
<td>1,380,300</td>
</tr>
</tbody>
</table>

Funding recommendation: Appropriate $1,380,000 for the Ryan White HIV/AIDS program Part B, inclusive of the AIDS Drug Assistance Program, which is $65,300,000 above the enacted level.

Justification: The Ryan White Program Part B funds all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the five U.S. Pacific Territories/Associated Jurisdictions to provide care, treatment and support services for low-income uninsured and underinsured individuals living with HIV. With these funds states and territories provide access to HIV clinicians, life-saving and life-extending therapies and a full range of vital coverage completion services to ensure adherence to complex treatment regimens. The state ADAPs provide medications to low-income PLWH who have limited or no coverage from private insurance, Medicare and/or Medicaid.

During the State of the Union address on February 5, 2019, President Trump announced an initiative to end the HIV epidemic by 2030. Ending the HIV Epidemic: A Plan for America intends to reduce new infections by 75% in the next five years, and by 90% in the next ten years by focusing on increasing diagnosis, access to care, access to biomedical prevention modalities, and rapid response to clusters and outbreaks. To achieve this goal, state health agencies will need additional funding.

Role of the state health agency: State health agencies provide both core medical and supportive services to people living with HIV. By HRSA’s definition “Core medical services include outpatient and ambulatory health services, AIDS Drug Assistance Program, AIDS pharmaceutical assistance, oral health care, early intervention services, health insurance premium and cost-sharing assistance, home health care, medical nutrition therapy, hospice services, home and community-based health services, mental health services, outpatient substance abuse care, and medical case management, including treatment-adherence services. Support services must be linked to medical outcomes and may include outreach, medical transportation, linguistic services, respite care for caregivers of people with HIV/AIDS, referrals

Fast Facts:

- 87% of Ryan White Program clients reached viral suppression, which far exceeds the national viral suppression rate.
- Nearly two-thirds of RWHAP clients are living at or below 100% of the Federal Poverty Level.
for health care and other support services, non-medical case management, and residential substance abuse treatment services. Grant recipients are required to spend at least 75% of their Part B grant funds on core medical services and no more than 25% on support services.”

**How funds are allocated or used:** All 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the five U.S. Pacific Territories/Associated Jurisdictions are eligible for Part B funding. Within the Part B award there is a base grant for core medical and support services, the AIDS Drug Assistance Program (ADAP) award, the ADAP Supplemental award, and the Part B supplemental award for recipients with demonstrated need.

**Public health impacts:** The Ryan White Program serves more than 500,000 people — over half of the people living with HIV (PLWH) in the United States who have been diagnosed. The Ryan White Program is crucial to meet the health care needs of PLWH and improve health outcomes. Part B of the Ryan White Program funds state health departments to provide care, treatment and support services and the AIDS Drug Assistance Program (ADAP) for low-income uninsured and underinsured individuals living with HIV. Sustained funding for the Ryan White Program is intergral to meeting the nation’s goals and to ending the HIV epidemic.

Services provided through Ryan White Part B and ADAPs are paramount to ending the HIV epidemic. There is conclusive scientific evidence that a person living with HIV who is on antiretroviral therapy (ART) and is durably virally suppressed (defined as having a consistent viral load of less than <200 copies/ml) does not sexually transmit HIV. In 2016, 85% of Ryan White Program clients had reached viral suppression. This figure exceeds the national PLWH viral suppression rate of 49%. This demonstrates the unique success of Ryan White in accelerating health outcomes for disproportionately impacted populations. Among the services necessary to improve health outcomes are linkage to, and retention in, care, as well as access to medications that suppress viral loads and thereby reduce transmission which leads to fewer new HIV infections.

Part B services are essential to retention in care and adherence to medication. With the access to medication and insurance provided through ADAP, the Ryan White Part B program is crucial to preventing new infections and improving health outcomes. This supportive system of care enables people to remain in care and adherent to medication. Underfunding the Ryan White Program system of care will only serve to exacerbate existing structural challenges such as the disproportionate impact of HIV on communities of color, greater poverty, lack of employment and educational opportunities, and lack of access to vital prevention, care, and treatment services.

**Supporting organizations:** The AIDS Budget and Appropriations Coalition supports this ask.

**For more information:** [www.NASTAD.org](http://www.NASTAD.org)

**Contact information:** Emily McCloskey, Director, Policy & Legislative Affairs, 202-897-0078, emccloskey@NASTAD.org

**See updates to this paper:** [https://www.nastad.org/domestic/policy-legislative-affairs](https://www.nastad.org/domestic/policy-legislative-affairs)

**Date:** January 28, 2020
Organization Name: National Coalition of STD Directors
Topic Area: Sexually Transmitted Diseases

Name of Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency: U.S. Department of Health and Human Services
Program, Office or Center: Centers for Disease Control and Prevention—Division of STD Prevention (DSTDP)

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20 Enacted</th>
<th>FY21 President’s Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division of STD Prevention</td>
<td>160,800</td>
<td>TBA</td>
<td>240,800</td>
</tr>
</tbody>
</table>

**Funding recommendation:** Appropriate an additional $60 million for base activities at the Division of STD Prevention (DSTDP), for a total of $220.8, to make up for the loss in buying power due to over 15 years of flat funding. The funding requests also includes $20 million for a new initiative to eliminate congenital (mother-to-child) syphilis, particularly as rates and deaths due to newborn death continue to increase.

**Bill or report language:** CDC - HIV, Viral, Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention: Sexually Transmitted Infections (STIs). – The Committee is concerned with the continued rise in STIs. For the fifth year in a row STDs have reached an all-time high, resulting in nearly 2.5 million cases a year, up 30 percent over the past five years. The Committee directs the CDC to increase funding to State and local health departments to provide resources for identifying, tracking, and treating those infected with an STI. Direct funding to States and local health departments is critical in order to reverse this trend.

**Congenital Syphilis (CS) Prevention Initiative:** The Committee is concerned regarding the increased rates of CS. According to the CDC the cases of CS are at the highest rate in 20 years, with an increase of 71.4 percent in the last six years. Deaths associated with congenital syphilis increased by 22 percent between 2017 and 2018. To address this concern, the Committee has included $20 million for a congenital syphilis prevention initiative, with funds distributed to all STD funded health departments for CSD prevention, with a priority given to jurisdictions with the highest prevalence of CS cases. The Committee urges the CDC to work with State and local authorities to design an initiative that will strengthen prenatal outreach programs. The Committee further urges the CDC to increase awareness of CS through community organizations and STD and drug addiction clinics of the importance of multi-testing throughout pregnancy.

**Justification:** STDs are currently at their highest levels ever and have dire health consequences. The Division of STD Prevention at CDC funds all 50 state health departments and seven large local health departments to engage in STD prevention and control. In most jurisdictions, this is the only funding

---

Fast facts or highlights
- For the fifth year in a row STDs are at a record high.
- Deaths due to congenital syphilis increased 22% between 2017 to 2018.
- STD programs have lost 40% in buying power due to 15 years of flat funding.
stream for STD prevention. For over 17 years STD programs were level funded, resulting in a 40% reduction in buying power, we need to rebuild STD health infrastructure. STD programs need $220.8 million annually to conduct the following STD work.

- **Screen:** STD programs are responsible for tracking and monitoring trends in STD cases throughout their state, including high risk individuals and groups for targeted prevention outreach. Part of this work includes identifying and contacting persons, and their partners who test positive for STDs to ensure they receive proper treatment.

- **Treat:** STD programs at health departments are a reliable source for free and accessible screening and testing for all STDs. No one is turned away due to their ability to pay, and all are treated with respect. Testing and treatment are the primary way that Health Departments can prevent future spread of STD services.

- **Protect:** Health department staff are trained to ensure that all cases of STDs are reported in a timely fashion to break the chain of infection. Through identifying, interviewing, and confirming treatment of STD cases programs can prevent the spread of future STD cases, and protect the health of thousands of citizens.

Furthermore, Maternal to child transmission of syphilis (congenital syphilis) increased by more than 40 percent between 2017 and 2018, resulting in a 22 percent increase in newborn deaths. Congenital syphilis is fully preventable with early prenatal care and STD testing. We can see an elimination of congenital syphilis in our lifetime, but something must be done now. $20 million is needed to establish a new congenital syphilis elimination initiative at the CDC Division of STD Prevention. This funding will be used to support all states in: screening, treatment, training, partnerships and reporting.

**Role of the state health agency:** To stop the spread of STDs requires early diagnosis and prompt treatment. CDC’s Division of STD Prevention partners with all 50 state health departments and seven large urban areas to support STD prevention. This includes STD monitoring, outbreak response, assurance of appropriate screening and treatment by health care providers, contact tracing, linkage to care, and providing STD prevention information to the general public. In most jurisdictions, the state health agency is the sole entity doing this essential work.

**How funds are allocated or used:** Funds are awarded to state and city health agencies by a formula based on STD morbidity.

**Public health impacts:** STDs are a growing threat to our nation’s health. Chlamydia, gonorrhea, and syphilis infections are nearing 2.4 million cases a year – up 30 percent in five years. STDs can have life-changing and life-threatening consequences, including infertility, cancer, ectopic pregnancy, and pelvic inflammatory disease. Increasing cases of syphilis in newborns (congenital syphilis) are particularly worrisome. Cases of congenital syphilis increased 40 percent between 2017 and 2018, according to the CDC report, and deaths associated with congenital syphilis increased 22 percent.

**For more information:** www.ncsddc.org

**Contact information:** Taryn Couture, Associate Director, Policy and Government Relations, tcouture@ncsddc.org

**Date** January 28, 2020
**Organization Name** Safe States Alliance  
**Topic Area** Injury and Violence Prevention  

**Name of Appropriations Bill** Labor, Health and Human Services, Education, and Related Agencies  
**Agency** Centers for Disease Control and Prevention  
**Program, Office or Center** Core State Violence and Injury Prevention Program (SVIPP)

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20 Enacted</th>
<th>FY21 President’s Request</th>
<th>FY21 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core SVIPP</td>
<td>6,723</td>
<td>TBA</td>
<td>20,000</td>
</tr>
</tbody>
</table>

**Funding recommendation:** Appropriate $20 million, which is a $13.3 million for the Core SVIPP

**Justification:** Only 23 of 50 states are funded under a competitive process, and this increase would allow every state, D.C. and U.S. Territories to have basic program funding for coordinated and comprehensive injury and violence prevention programs. The 23 currently funded states receive base program funding to focus on four priority areas: motor vehicle injury prevention, youth sports concussion/traumatic brain injury, child abuse and neglect, and sexual violence/intimate partner violence. These topics have shared risk and protective factors across the different mechanisms of injury. Historically, Core grantees have been able to leverage their expertise to respond to high burden issues as they arise.

**Role of the state health agency:** State public health departments use Core SVIPP funding to build a public health infrastructure to support violence and injury prevention programs, collect and analyze relevant data, design, implement and evaluate program and policy strategies, and provide technical support, training, and education.

**How funds are allocated or used:** Grants are competitively awarded to state health departments. Grantees receive $250,000 due to limited availability of federal funds and support basic program funding for coordinated and comprehensive state injury and violence prevention programs.

**Public health impacts:** Core SVIPP states are making significant strides toward reducing injuries and violence in their communities, including:

- More than 231,191 deaths
- 3 million hospitalizations
- 32 million emergency department visits
- $671 billion in medical and work loss costs
• Piloting prescription drug misuse and abuse initiative in three Arizona counties;
• Enhancing Colorado’s Prescription Drug Monitoring Program through statewide policy and systems changes;
• Implementing an online surveillance system in the Twin Cities (MN) for concussion in high school athletes;
• Preventing infant abuse by spreading the Period of Purple Crying Program in hospitals in Oklahoma; and,
• Reaching record high seatbelt use after passage of a permanent primary seatbelt law in Rhode Island.

For more information: https://www.cdc.gov/injury/stateprograms/index.html

Contact information: Paul Bonta, Director of Government Relations, 202-679-8646, paul.bonta@safestates.org

Date January 27, 2020
Organization Name: Safe States Alliance
Topic Area: Injury and Violence Prevention

Name of Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency: Centers for Disease Control and Prevention
Program, Office or Center: Firearm Injury and Mortality Prevention Research

<table>
<thead>
<tr>
<th>dollars in thousands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program</td>
</tr>
<tr>
<td>Firearm Injury &amp; Mortality Prevention Research</td>
</tr>
</tbody>
</table>

Funding recommendation: Appropriate $50 million, which is a $37.5 million for Firearm Injury and Mortality Prevention Research.

Justification: Today there are bipartisan calls for research to better understand the root causes of gun violence in the United States in order to inform evidence-based gun violence prevention programs. To address gaps in knowledge about firearm injury prevention, the Institute of Medicine and the National Research Council developed a set of research questions in a 2013 Consensus Report. The research questions address youth access to firearms, risk factors for firearm violence, and the risks and benefits of firearm ownership, among other issues.

Role of the state health agency: State public health departments play an important role in coordinating the broader public health system’s efforts to address the causes of injury and violence. These state agencies are well suited to unite community partners to address the root causes of gun violence through policy, environment, and system change. The public health approach to gun violence prevention includes working to: define the problem; identify risk and protective factors; develop and test prevention strategies; and, assure widespread adoption of targeted programs.

How funds are allocated or used: Funds will be used to provide grants to conduct research into the root causes and prevention of gun violence; focusing on those questions with the greatest potential for public health impact.

Each year in the U.S., gun violence accounts for:

- Over 38,000 firearm-related deaths
- More than 81,000 non-fatal firearm injuries treated in emergency departments
- $47 billion in medical and lost productivity costs
**Public health impacts:** Funds to support gun violence research will identify evidence-based approaches aimed at the prevention of gun violence. This effort will stem the continued rise of gun violence in communities across the country and decrease the occurrence of mass shootings in our nation’s schools.


**Contact information:** Paul Bonta, Director of Government Relations, 202-679-8646, paul.bonta@safestates.org

**Date** January 27, 2020