FY22 Governmental Public Health Appropriations Book
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.

The current COVID-19 pandemic response is a stark reminder of the impact chronic underfunding of public health has on our ability to protect and promote the health of all Americans. While we are grateful for emergency supplemental appropriations to address the COVID-19 pandemic, it is critical that Congress provide long term, sustained, and increased discretionary funding to support the public health workforce, modernize our data systems, and build laboratory capacity, among many other priorities. 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 FY22 so this important work can continue.

This book compiles top federal funding priorities and recommendations for nonprofit public health associations in FY22. 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
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**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:** Center for Public Health Preparedness and Response

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**Funding recommendation:** Appropriate $824 million, a $129 million—or 18.5%—increase over FY21 enacted levels for the Public Health Emergency Preparedness Cooperative Agreement, and reverse years of funding cuts to the CDC Center for Preparedness and Response by providing $149 million for the “All Other CDC Preparedness” funding line.

**Bill or report language:** Recent events, such as the response the COVID-19 pandemic, demonstrate the need to invest in these programs to rebuild and bolster 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. America’s public health preparedness systems are stretched to the brink and will need increased and stable base funding for years to rebuild and improve.

**Justification:** The CDC Preparedness and Response experts provide expertise and support to all CDC preparedness activities. Over the past few years, the Center for Preparedness response was cut by $10 million overall, eroding its ability to provide personnel support and expertise, as well as innovate and share best practices to state and territorial health departments. ASTHO is requesting a restoration of these funds. Within this center, the PHEP has invested in states and territories to create and maintain foundational capabilities since its establishment in 2002. More than ever, it is essential that Congress provide stable and sufficient health emergency preparedness funding to maintain a standing set of core capabilities so that jurisdictions are ready when needed. Cycles of emergency funding and then level funding or budget cuts hinder our public health system from improving over time and improve based on data from exercises and real-life responses. The program in 2002 was originally funded at $918 million, the high-water mark, and is now currently 24% lower in 2021, at $695 million. Our public health system

**Fast Facts or Highlights:**

- There are 62 PHEP cooperative agreement awardees: all 50 states, four metropolitan areas (Chicago, Los Angeles County, New York City, and Washington, D.C.), and eight U.S. territories and freely associated states.
- PHEP supports states and local jurisdictions to ensure they are prepared to receive and provide life-saving medicines and supplies.
is stretched beyond its ability due to inadequate base funding year over year. Despite emergency supplemental funding for the COVID-19 response, predictable increases are necessary to rebuild and maintain a public health system, which includes critical staff and programmatic investments across the enterprise.

**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 because of the PHEP funding. However, as witnessed during the response to the COVID-19 pandemic, this infrastructure is vital to our economic prosperity and stable, dependable, increased base funding for this program should reflect this.

**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. 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. This program continues to plan and execute joint exercises with the Hospital Preparedness Program through the Assistant Secretary of Preparedness and Response to enhance jurisdictional coordination and collaboration between the public health and health care systems.

**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. Over the years, this program works closely with the healthcare preparedness efforts to bring forward a stronger public health preparedness stance. 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 also supports this funding requestion.

**For more information:** ASTHO’s and CDC’s Preparedness web pages, [http://www.astho.org/Programs/Preparedness/](http://www.astho.org/Programs/Preparedness/) and [https://www.cdc.gov/cpr/readiness/phep.htm](https://www.cdc.gov/cpr/readiness/phep.htm)

**Contact information:**
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**See updates to this paper:** [https://www.astho.org/Advocacy-Materials/](https://www.astho.org/Advocacy-Materials/)

**Date:** Feb. 1, 2021
**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)

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**Funding recommendation:** Appropriate $474 million, which is a $198.5 million—or 70.77%—increase over the FY21 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 for healthcare system preparedness and response, HPP promotes a consistent national focus to improve patient outcomes during emergencies and disasters and enables rapid recovery. The program received a slight increase in FY21 and a total of $350 million in emergency supplemental funding for the COVID-19 response. Core HPP funds support healthcare systems planning and response efforts usually convened or in collaboration with the state/territorial health department. Emergency funds support hospitals and healthcare entities to expand telemedicine, staff departments, procure equipment and supplies, and coordinate regionally and work to ensure equal distribution across jurisdictions.

**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.

**How funds are allocated or used:** The current five-year project period is from 2017-2022. The state or 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.

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**Fast Facts or Highlights:**
- HPP prepares the nation’s healthcare system to save lives during emergencies and disasters.
- Most recent ASPR data show that approximately 85% of hospitals nationwide participate in healthcare coalitions through HPP and there are 476 healthcare coalitions across the nation.
Public health impacts: HPP has contributed to healthcare system progress throughout the years, and especially to the COVID-19 response, allowing hospitals to share PPE and other resources and coordinate among the coalitions to increase the efficiency of their services to the communities. HPP also supports responses and drills for 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
For more information: See ASTHO’s preparedness web page
(https://www.astho.org/Programs/Preparedness/) or the HSS HPP web page
(https://www.phe.gov/Preparedness/planning/hpp/Pages/default.aspx).
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See updates to this paper: https://www.astho.org/Advocacy-Materials/
Date: Feb. 4, 2021
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

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*This funding is “not less than” and for the National Emerging Special Pathogen Training and Education Center and the 10 existing regional Ebola and other special pathogen treatment centers.

Funding recommendation: States’ immediate and comprehensive responses to the COVID-19 pandemic 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 $45.6 million for the National Emerging Special Pathogen Training and Education Center and the 10 existing regional Ebola and other special pathogen treatment centers. Currently, emergency funding is supporting advancement in the mission, capacity, and capability to respond to highly infectious diseases, but consistent and increased funding is necessary for our national response capability to continue, expand, and improve.

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.

Justification: In FY15, Congress provided $239.5 million via an emergency supplemental bill for HHS to establish and maintain this critical system as multiyear initiatives until May 2020. Regular appropriations for FY21 included $11 million. Currently, the vast majority of the system is maintained through emergency funding and therefore base funding should be increased to ensure the sustainability of this valuable network. As we all have learned over the last year, it is absolutely 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.

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 CDC to prepare and support a broad system of healthcare facilities to better respond to these diseases.
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 Emerging Special Pathogen Training and Education Center; the 10 existing regional Ebola and other special pathogen treatment centers; 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. In response to the COVID-19 pandemic, the NETEC and the 10 U.S. Regional Emerging Special Pathogen Treatment Centers (RESPTC) are playing a pivotal role in the COVID-19 response from on-the-ground isolation of patients, conducting clinical research of COVID-19 therapeutics, and translating emerging science for rapid optimization of patient care and healthcare worker safety strategies.

**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 69 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, in collaboration with CDC, ASPR’s HPP also funds the National Ebola Training and Education Center (NETEC). NETEC is co-led by Emory University in Atlanta, Georgia; University of Nebraska Medical Center/Nebraska Medicine in Omaha, Nebraska; and Bellevue Hospital Center in New York City, New York, all three of which have successfully treated patients with Ebola. NETEC offers training, resources, readiness assessments, and expertise to help members of the Regional Treatment Network for Ebola and Other Special Pathogens prepare for pandemics and other emerging threats related to infectious disease outbreaks.

**Supporting organizations:** Society for Healthcare Epidemiology of America.

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

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

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

**Date:** Feb. 4, 2021
**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 (CDC)  
**Program, office, or center:** Cross-Cutting Activities and Program Support

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**Funding recommendation:** Appropriate $170 million, a $10 million—or 6.25%—increase over FY21 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 non-categorical funding for states and territories. It provides resources 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 funded 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. In some cases, this funding serves as seed funding for innovative projects a state or territorial health department wishes to provide to meet community health goals that are not funded through other means.

**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, Washington, D.C., two American Indian tribes, and 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. In 2019, 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 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.

**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.

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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 funding by grantees in 2019 supported critical public health needs, including:

- Public health infrastructure (e.g., vital statistics and disease registries).
- Educational and community-based programs.
- Nutrition and weight status.
- Injury and violence prevention.
- Immunization and infectious diseases.
- Maternal, infant, and child health.
- Heart disease and stroke.

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 Chronic Disease Directors also supports this request.

For more information: See CDC’s Preventive Health and Health Services Block Grant website at https://www.cdc.gov/phhsblockgrant/about.htm

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

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

Date: Feb. 1, 2021
Organization name: Association of Public Health Laboratories, Council of State and Territorial Epidemiologists, National Association of Public Health Statistics and Information Systems
Topic area: Data Modernization Initiative
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 Scientific Services

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Funding recommendation: Appropriate $100 million, which is a $50 million increase for the Data Modernization Initiative.

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 lead 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 2022 to CDC to continue to modernize IT systems and recruit and retain skilled data scientists both at CDC, and state, local, and territorial health departments and acknowledges the need for significant, sustained funding to complete public health data modernization efforts.

Justification: Sluggish, manual processes—paper records, spreadsheets, faxes, and phone calls—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 need to upgrade our nation’s public health surveillance systems was apparent long before the onset of the COVID-19 pandemic and this effort was already underway. Then, COVID-19 exposed deadly gaps in our nation’s public health data infrastructure. The nation faces an unprecedented challenge in
addressing the global COVID-19 pandemic and a responsibility to create an infrastructure that is capable of responding to future public health emergencies. Now, more than ever, it is critical for CDC to have a strong national public health surveillance system that detects and facilitates immediate response to and containment of emerging health threats. The need is not unique to COVID-19 and will continue as our public health workforce responds to future outbreaks.

Congress has recognized the importance of upgrading our public health data infrastructure, providing an injection of $500 million in funding through the CARES Act to support the foundation of these critical efforts. This significant investment will not bear fruit without sustained, robust funding for DMI through annual appropriations. Congress included authorizing language in the FY2021 Consolidated Appropriations Act allowing for a $100 million annual investment in DMI and ensuring future appropriated funds are properly directed within CDC.

**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 exchanges 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. COVID-19 has demonstrated how perilous it is to rely on antiquated public health data systems. 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, Council of State and Territorial Epidemiologists, National Association for Public Health Statistics and Information Systems.


**Contact information:** Erin Morton, Senior Vice President, CRD Associates: emorton@dc-crd.com

**Date:** Feb. 3, 2021
**Topic area:** Immunization Funding

**Name of appropriations bill:** Labor-HHS-Education Appropriations Bill

**Agency:** Centers for Disease Control and Prevention (CDC)

**Program, office, or center:** Immunization Program

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**Funding recommendation:** Appropriate $1.13 billion, which is a $400 million or 35% increase for the Section 317 Immunization Program. This increase is critical to sustain and build upon improvements made to conduct the COVID-19 vaccination campaign. It will support urgent routine vaccination catch-up efforts, as well as enhanced activities to save lives, implement new vaccines, sustain and update Immunization Information Systems (IIS), and respond to the threat of future hepatitis A, measles, mumps, influenza, and other outbreaks.

**Justification:** The need to establish and maintain a robust public health immunization infrastructure has never been greater. Data reporting challenges, limited workforce, lack of enrolled adult providers, vaccine hesitancy, and health disparities have hampered the efficient rollout of the COVID-19 vaccination campaign. Increased and sustained investment is needed to modernize immunization information systems, establish state-to-state IIS data sharing, provide aggregate doses administered data from IIS to CDC in real time, increase and sustain a network of adult immunization providers reporting data into IIS, and engage with communities to build vaccine confidence and reduce disparities. In 2019, the World Health Organization declared vaccine hesitancy one of the top 10 global threats. This threat is not going away and must be aggressively addressed by every state and local community. Congress can assert leadership now to assure that our nation’s public health system does not repeat past mistakes of under-funding and cycles of emergency surges followed by reduced or stagnant investment. Because the future course of the pandemic includes possible virus variations and potential need for booster or annual COVID-19 vaccinations, now is the time to sustain improvements being made through emergency supplemental funding. This will ensure that both routine immunization is restored and future preparedness is assured.

- An effective vaccine campaign is the best path to controlling the COVID-19 pandemic.
- Millions of children and adults have fallen behind on routine vaccinations due to the pandemic.
- Other infectious disease threats remain; 1,282 measles cases were confirmed in 2019, the greatest number of cases reported in the United States since 1992.
- Millions of people get the 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.
- 31,200 of 33,700 HPV-related cancers could be prevented each year in the United States.
- Prior to COVID-19, there was a 114% increase in hepatitis B cases in Kentucky, Tennessee, and West Virginia due to the opioid epidemic.
Role of the state health agency: The Section 317 program provides cooperative agreements to state, local, and territorial health agencies to purchase vaccine for uninsured adults; conduct outbreak response; enroll, educate, and provide vaccine to over 40,000 private physicians in the Vaccines for Children Program (vaccinating millions of children annually); track vaccination rates and vaccine inventory; and identify disease incidence and stop transmission of deadly, preventable disease.

How funds are allocated or used: Funds are awarded to 64 state, local, and territorial health agencies by formula based largely on population. In addition to the immense challenges of the COVID-19 pandemic, recent growth of electronic health records and compliance with associated regulations, new vaccines and school requirements, as well as continuing unpredictable disease outbreaks have increased the complexity of vaccine management. Additional base funding is needed for each state to sustain improvements supported by emergency funding and 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 10 dollars of societal savings and three dollars in direct medical savings. Moreover, childhood immunizations over the past 25 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. Additional breakthroughs are possible with a range of preventable diseases, including certain cancers, with Australia 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: The 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.


Contact information: Claire Hannan, Executive Director, channan@immunizationmanagers.org (301) 424-6080
Date: Feb. 3, 2021.
Organization name: Association of Maternal & Child Health Programs (AMCHP)
Topic area: Maternal and Child Health
Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies
Agency: HHS
Program, office, or center: Health Resources and Services Administration/Maternal and Child Health Bureau

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Funding recommendation: Appropriate $750 million which is a 5% 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 2019, approximately 92% of pregnant women, 98% of infants, and 60% 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
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](http://www.amchp.org) or [www.mchb.hrsa.gov](http://www.mchb.hrsa.gov)

**Contact information:** Amy Haddad, Chief Government Affairs Officer [ahaddad@amchp.org](mailto:ahaddad@amchp.org) or (202) 266-3045

**Date:** Feb. 2, 2021
Organization name: Association of State and Territorial Dental Directors
Topic area: Oral Health
Name of appropriations bill: Labor, Health and Human Services, Education Appropriations Bill
Agency: Centers for Disease Control and Prevention (CDC)
Program, office, or center: National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health

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**Funding recommendation:** The CDC Division of Oral Health (DOH), 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 $34.5 million for the Division of Oral Health, which is a $15 million increase from their current funding over FY20 levels. Of the additional $15 million, $3 million would go towards 30 states (not currently funded by CDC DOH) to conduct oral health surveillance, $0.5 million is allocated for provision of TA and packaging of data for the 30 states above, $3 million would support the provision of program technical assistance and support for surveillance, evaluation, policy, and communication activities, $3 million would go towards research, epidemiologic analysis, and translation of science to action, $2 million would be allocated for review and update of infection prevention and control guidelines for dental setting and develop materials to increase adherence, $1 million is for investment in innovation, $1.5 million would be to expanded national, state, and community partner support, and $1 million would be for mini-grants to improve oral health literacy.

**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 United States 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 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
development, healthcare 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, Washington, D.C., Indiana, Kentucky, Massachusetts, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, South Dakota, Tennessee, Utah, Washington, and Wyoming). Eleven states that were previously funded, are no longer funded (Alaska, Hawaii, Illinois, Maine, Michigan, Mississippi, Nevada, New York, Oregon, Texas, and 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://www.astdd.org](http://www.astdd.org)

**Contact information:** Christine Wood, Executive Director, (775) 626-5008, cwood@astdd.org

**See updates to this paper:** [www.yourwebsite.org/advocacy](http://www.yourwebsite.org/advocacy)

**Date:** Jan. 12. 2021
**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 Program, Advanced Molecular Detection, and Vector-borne Diseases  
**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:** Emerging and Zoonotic Infectious Diseases

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**Funding recommendation:** Appropriate at least $943,864 million, which is a $295.592 million increase for Emerging and Zoonotic Infectious Diseases (EZID) and includes a $261 million increase to the base funding for the Epidemiology and Laboratory Capacity Program; a $27 million increase for Advanced Molecular Detection (AMD); and recognizes the FY 2021 President’s Budget request of $66.195 million for vector-borne diseases.

**Bill or report language:** The Committee provides increased funding for CDC’s Epidemiology and Laboratory Capacity program to sustain core surveillance capacity; ensure state and local epidemiologists are equipped to respond to emerging threats including antimicrobial resistant superbugs, tick and other vector-borne diseases, and novel coronaviruses such as COVID-19; and to build the epidemiology workforce in states, territories, and localities.

**Justification:** Funding for CDC’s EZID program is essential in combating new and emerging threats. Funding across EZID bolsters the Epidemiologic and Laboratory Capacity for Infectious Diseases (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, again including COVID-19.

The ELC Program 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 ELC program is critical to U.S. health departments’ ability to combat

- In FY20, public health departments requested $500 million through the ELC program to support public health surveillance and early detection of emerging disease threats, but CDC was only able to award $238 million.
- This $261 million gap must be addressed to bolster our public health response and ensure states are not forced to rely only on emergency funding to prepare for disasters like COVID-19.
- The ELC budget line is funded through the PPHF but must be increased to $301 million and funded through CDC’s budget authority, not the PPHF.
infectious diseases, a need that has become more extreme as states and localities respond to the global COVID-19 pandemic. Significantly, the ELC program was successful in dispensing over $30 billion in emergency funding to state, local, and territorial health departments to combat the COVID-19 pandemic. At the same time, ELC issued over $238 million in FY 2020 funding for health departments to carry out critical core surveillance programs. Currently, though ELC disseminates resources from across CDC, the ELC budget line is only $40 million in total, all from the Prevention and Public Health Fund (PPHF). Given the immense need for epidemiology and laboratory capacity grants, the ELC budget line should be increased to $301 million and funded through CDC’s budget authority, not the PPHF. Increased funding will help build the epidemiology workforce allowing state and local health departments to begin to move towards establishing a minimum epidemiology workforce; to promote and offer training for state and local chronic disease epidemiologists; and to monitor needs in state-based chronic disease epidemiology capacity.

EZID also funds CDC’s AMD program, 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. AMD 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, serving on the front lines, conducting surveillance and epidemiologic investigations. These data are shared with CDC and CDC is thus heavily vested in the strength of state and local epidemiology and laboratory surveillance capacity. 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 2020, ELC disseminated $238.5 million to states, territories, and localities. The increase in base funding for ELC to $301 million 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 monitored and responded to COVID-19 as it emerged and then surged across the country; quickly identified a nationwide measles outbreak; detected and implemented containment strategies for Brucella in unpasteurized dairy products; 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 table summarizing ELC funding is available here.

Contact information: Erin Will Morton, Senior Vice President, CRD Associates, emorton@dc-crd.com.

Date: Feb. 3, 2021
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 (CDC)
Program, office, or center: National Center for Chronic Disease Prevention and Health Promotion

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Funding recommendation: The National Association of Chronic Disease Directors strongly recommends an appropriation of $170 million, which is a $10 million increase for the Preventive Health and Health Services Block Grant.

Justification: NACDD strongly recommends appropriation of the amounts indicated to support evidence-based state chronic disease prevention and control activities. The increase in funding will support 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. Increased funding is essential to maintain and expand current efforts in every state. Critical clinical community linkages and health promotion efforts are required to meet these goals.

- Chronic diseases account for 75% of healthcare costs, and more for seniors.
- Much of the human and financial toll of chronic diseases is preventable.

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 ensure most efficient mobilization of local organizations, while at the same time avoiding any duplication. 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.

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. The Preventive Health and Health Services Block Grant allows grantees to address emerging health issues and gaps by focusing on their specific needs at the state level. States use Block Grant funding to reduce
premature deaths and disabilities by focusing on the leading preventable risk factors in their specific population. The flexibility afforded grantees allows them to address the social determinants of health with the aim of achieving health equity in the long-term.

**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:** 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 10 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 ensure 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) 488-9500 or asouders@cgagroup.com

**See updates to this paper:** [https://chronicdisease.org/page/appropriations_fs/](https://chronicdisease.org/page/appropriations_fs/)

**Date:** Jan. 29, 2021
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 (CDC)

Program, office, or center: National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity

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Funding recommendation: The National Association of Chronic Disease Directors strongly recommends an appropriation of $110 million with an additional $15 million for high rate counties, which is a $53.08 million increase for Nutrition, Physical Activity, and Obesity.

Justification: An increase in funding in FY 2022 for the Division of Nutrition, Physical Activity, and Obesity (DNPAO) will continue efforts to improve nutrition and increase physical activity across the lifespan, with a special focus on young children ages zero to five years. Currently, only 15 states receive funding to support physical activity and healthy eating through state-based public health programs. Public health programming per capita expenditure is approximately $0.25, far below the estimated $1,429 per capita cost of obesity-related medical care.

CDC directs funding to evidence-based interventions that promote nutrition and physical activity and obesity prevention, including increasing access to healthy food and beverages, increasing physical activity access and outreach, designing communities that support safe and easy places for people to walk, improving nutrition and increasing physical activity in the Early Care and Education (ECE) settings, and improving support for mothers who choose to breastfeed. A sustained and sufficient level of investment in nutrition and physical activity interventions through state-based public health programs can improve health outcomes, quality of life, and help individuals maintain optimal health at every age.

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 ensure most efficient mobilization of local organizations, while at the same time avoiding any duplication.

- Obesity costs the U.S. healthcare system $147 billion a year.
- Despite the proven health benefits of physical activity, only half of American adults and about a quarter of adolescents get enough aerobic physical activity to maintain good health and avoid disease.
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: At $110 million, DNPAO and states will:
- Increase the proportion of infants that are breastfed at six months.
- Increase the contribution of vegetables to the diets of the population aged two years and older.
- Increase the proportion of adults (age 18 and older) that engage in physical activity.
- Reduce the age-adjusted proportion of adults (age 20 years and older) who are obese.
- Reduce the proportion of children and adolescents (ages two through 19) who are obese.
- Increase the number of states with nutrition standards for foods and beverages provided in ECE centers.
- Increase the number of states with physical education standards that require children in early care and education centers to engage in vigorous- or moderate-intensity physical activity.

Background information: Despite the proven health benefits of physical activity, only half of American adults and about a quarter of adolescents get enough aerobic physical activity to maintain good health and avoid disease. Physical activity saves lives, saves money, and protects health. If Americans met the recommended physical activity levels, 1 in 10 premature deaths could be prevented. In addition, meeting physical activity recommendations could prevent:
- $117 billion in annual healthcare expenditures.
- 1 in 8 cases of breast and colorectal cancers.
- 1 in 15 cases of heart disease.

Obesity rates are still too high. In 2015-2016, 40% of adults had obesity and 19% of all children and adolescents (ages two to 19 years). Almost half (45%) of children who became obese between the ages of five and 14 years were overweight when they entered kindergarten, and 76% of Americans one year and older do not consume recommended amounts of fruit and 87% do not consume the recommended amount of vegetables.

Obesity costs the U.S. healthcare system $147 billion a year. Obesity and related chronic diseases cost employers up to $93 billion per year in health insurance claims. Persons with obesity are at higher risk for hypertension, high cholesterol, type 2 diabetes, heart disease, certain cancers, and early death. Obesity also negatively impacts our nation’s businesses, economy, and military readiness. Nearly 1 in 4 young adults are too heavy to serve in our military.

Supporting organizations: NACDD works closely with many national partners to ensure high quality and consistent approaches to address 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
Contact information: Amy Souders, Cornerstone Government Affairs. (202) 488-9500 or asouders@cgagroup.com
See updates to this paper: https://chronicdisease.org/page/appropriations_fs/
Date: Jan. 29, 2021
**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 (CDC)  
**Program, office, or center:** National Center for Health Statistics

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**Funding recommendation:** Appropriate $200 million, which is approximately a $25 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 to monitor public health and fight waste, fraud, and abuse in federal entitlement programs. The Committee encourages NCHS to collaborate with the Data Modernization Initiative (DMI) at CDC to support states in upgrading vital statistics systems, which will lead to more, better, and faster data on key public health priorities.

**Justification:** Electronic Vital Records Systems are one of the five core pillars of the U.S. public health surveillance enterprise that require modernization now to protect the health security of all Americans. The Electronic Vital Records System is a national system of 57 vital records jurisdictions that provide secure electronic collection of birth and death data from hospitals, funeral homes, physicals, and medical examiners. It allows for timely and accurate reporting of birth outcomes and causes of death, which serve to monitor and respond to public health crises as they arise in communities, including reducing preventable deaths and infant and maternal mortality rates.

NCHS plays a direct role in the DMI at CDC. 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 to 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.
Increased funding for NCHS will help to address other unmet data needs, such as creating a Virtual Research Data Center; adding geo-identifiers to public use NCHS data; adding COVID-19 modules to NHIS and NHANES to assess the health of survivors; and linking geocodes to individual NHIS and NHANES records. Funding will also facilitate improved infrastructure and data access, providing better access for researchers; data collection transformation focused on speedier survey data; and enhanced modeling and analysis.

Role of the state health agency: Vital records are permanent legal records of life events, including live 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 issuance to newborns through the Enumeration at Birth Program, and report individuals’ 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 growing number of deaths from COVID-19 and the disparate impact COVID-19 has had on minority populations, 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% in 2010 to 60% in 2018. NCHS data is essential for achieving health equity and responding to COVID-19, both critical public health efforts that will be impeded without a robust investment in data.

Supporting organizations: Friends of NCHS (www.friendsofnchs.org)
For more information: https://www.cdc.gov/nchs/about/budget.htm
Contact information: Erin Will Morton, Senior Vice President, CRD Associates, emorton@dc-crd.com;
(202) 484-1100
Date: Feb. 3, 2021
**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 (CDC)  
**Program, office, or center:** Division of HIV Prevention

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**Funding recommendation:** Appropriate $1.293 billion which is a $329 million increase for Domestic HIV/AIDS Prevention and Research. Of the HIV Prevention funding, $371 million is for year two of Ending the HIV Epidemic Initiative Implementation.

**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).

HIV prevention programs have been severely impacted by the COVID-19 pandemic. HIV prevention has challenges in maintaining access to services, reporting significant decreases in testing, and other prevention services. HIV prevention programs are shifting to begin at-home testing programs to ensure that people are still being tested for HIV and linked to care. To scale up innovative programs that are able to reach individuals during this time, investments must be made in the public health system to ensure continuity of services during public health emergencies.

Launched in 2019, *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 10 years by supporting 48 counties, Washington, D.C., 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. Of the HIV Prevention funding, $371 million is for year three of Ending the HIV Epidemic Initiative Implementation.

The number of new HIV infections must decrease 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 56% of people living with HIV have an undetectable viral load. Addressing interventions along the 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.

**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; and 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 receive 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.

**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:** Feb. 3, 2021
**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 (CDC)  
**Program, office, or center:** Viral Hepatitis Programs

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**Funding recommendation:** Appropriate $134 million, which is a $94.5 million increase for the Viral Hepatitis program at CDC.

**Justification:** Currently, 58 jurisdictions receive funding for hepatitis prevention and surveillance.

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 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 to 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.

The COVID-19 pandemic has severely impacted hepatitis programs. People living with liver disease are at increased risk for COVID-19 complications, so it is incredibly important that people living with hepatitis are tested and linked to care. Unfortunately, hepatitis programs are increasingly strained by the pandemic and have seen a significant decrease in their ability to do outreach, education, testing, and linkage services. Hepatitis programs are similarly seeking innovative ways to continue hepatitis testing, including integrating hepatitis testing with COVID-19 testing. To scale up innovative programs that are able to reach individuals during this time, investments must be made in the public health system to

**Fast Facts or Highlights**
- Over 80% of state health department hepatitis staff have been detailed to the COVID-19 response.
- Nearly 70% of viral hepatitis programs stated that more funding for viral hepatitis surveillance.
ensure continuity of services during public health emergencies. Hepatitis prevention programs have important testing expertise to offer to the COVID-19 response, but they also play an important role in addressing racial disparities and stigma through a focus on community-based networks and services.

**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, addresses hepatitis A outbreaks, coordinates surveillance efforts, and coordinates testing and linkage to care for people living with hepatitis B or C.

**How funds are allocated or used:** 58 jurisdictions receive funding for hepatitis prevention to increase the number of persons living with hepatitis A, 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:** CDC estimates that up to 5.3 million people live with hepatitis B (HBV) and/or hepatitis C (HCV) in the United States. 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, 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

**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:** Feb. 3, 2021
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 (HRSA)
Program, office, or center: Ryan White Part B

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Funding recommendation: Appropriate $1,405,300,000 for the Ryan White HIV/AIDS program Part B, inclusive of the AIDS Drug Assistance Program, which is $90,300,000 above the enacted level.

Justification: The Ryan White Program Part B funds all 50 states, Washington, D.C., 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.

The Ryan White Program has been severely impacted by the COVID-19 pandemic. Programs are working to quickly innovate to provide services in accordance with social distancing recommendations, including investing in telehealth and provider capacity to alter service delivery procedures. Over 50% of RWHAP respondents are using their emergency CARES Act Funding to invest in this type of innovation at the provider level. The related economic downturn is also impacting RWHAP client needs. A majority of RWHAP ADAP/Part B Programs have seen an increased demand for emergency financial assistance for housing and food. A majority of respondents also reported anticipating increased burden to the RWHAP as people lose their health insurance and income due to the economic downturn. These strains to the program are already causing cost containment measures and could result in ADAP waitlists. This directly in opposition to the success of people’s individual health, the nation’s public health, and the Ending the HIV Epidemic Initiative.

- 77% of RWHAP ADAP/Part B Programs reported that more funding was needed for either ADAP or Part B to accommodate strains from the COVID-19 pandemic.
- Over 70% of Ryan White ADAP/Part B Programs anticipate an increase in the uninsured rate in their jurisdiction, bringing new clients into the program.

Launched in 2019, 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 10 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.
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 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, Washington, D.C., 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 integral 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 2018, 87% of Ryan White Program clients had reached viral suppression. This figure exceeds the national PLWH viral suppression rate. 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. 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

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: Feb. 3, 2021
**Organization name:** National Coalition of STD Directors (NCSD)  
**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 (CDC), Division of STD Prevention (DSTDP)

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**Funding recommendation:** Invest a total of $272.9 million at the Division of STD Prevention at the Centers for Disease Control and Prevention (CDC) – an increase of $91.1 million – to boost base program funding with an additional $20 million in new funding to launch a congenital syphilis eradication initiative.

**Bill or report language:** CDC - HIV/AIDS, VIRAL HEPATITIS, SEXUALLY TRANSMITTED DISEASES, AND TUBERCULOSIS PREVENTION:  
*Sexually Transmitted Infections [STIs].* —The Committee continues to be concerned about the high STI rates throughout the U.S. According to a survey by the National Coalition of STD Directors, 80 percent of sexual health screening clinics were forced to reduce hours or shut down because of understaffing while their contract tracers and disease intervention specialists (DIS) were diverted to address the COVID-19 pandemic. Direct funding to States and local health departments is critical in addressing STIs. Over the last 20 years, STI rates have skyrocketed and are currently at their highest levels ever. Over this period, federal funding for STD prevention has decreased by $16 million. The $91.1 million increase proposed by the Committee will restore the funding level to the FY2003 buying power. The Committee further directs that all of the STI grantees receive at least the amount of funding they received in fiscal year 2021.

**Fast facts or highlights:**
- For the sixth 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 nearly 40% in buying power over the past two decades.

*Congenital Syphilis (CS).* — The Committee is troubled by the increased rates of CS, with cases expected to rise further in 2020 due to undetected cases during the COVID-19 pandemic. According to the CDC, the cases of CS are at the highest rate in 20 years, an increase of 40 percent from 2017 to 2018, with over 100 babies stillborn or dying shortly after birth. The Committee is aware that the STI clinics are one of the main public health lines of defense to prevent congenital syphilis, but according to the National Coalition of STD Directors, 83 percent of their programs reported massive interruptions in STI care and preventive services due to the pandemic. To address this concern, the Committee has included $20,000,000 for a congenital syphilis prevention initiative, with funds distributed to all STI-funded health departments for CS prevention, with priority given to jurisdictions...
experiencing 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, including increasing awareness of the importance of multi-testing throughout pregnancy through community organizations and STD and drug addiction clinics.

*Ending the HIV Epidemic (EHE).* – The Committee is aware that having an STI puts individuals at greater risk of contracting HIV. The Committee commends the CDC for including dedicated funding in the EHE initiative for STI clinics to increase prevention services. To stop the spread of HIV and increase capacity at STI clinics, the Committee recommends that part C of the EHE initiative be funded at a minimum of $20,000,000 of EHE funds be dedicated to increasing the number of STI clinics to aid in the diagnosis and HIV infections.

**Justification:** STDs are currently at their highest levels ever and have dire health consequences. The Fast facts or highlights: 33 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 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 works 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.

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 through an STD morbidity-based formula

**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% 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% between 2017 and 2018, according to the CDC report, and deaths associated with congenital syphilis increased 22%.

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

**Contact information:** Stephanie Arnold Pang, Director, Policy and Government Relations
[saarnold@ncsddc.org](mailto:saarnold@ncsddc.org)
Kenneth W. Westberry, Senior Manager, Policy and Government Relations [kwestberry@ncsddc.org](mailto:kwestberry@ncsddc.org)

**Date:** Feb. 3, 2021
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 (CDC)
Program, office, or center: Core State Violence and Injury Prevention Program (SVIPP)

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Funding recommendation: Appropriate $11.65 million, which is a $5 million increase for the Core SVIPP.

Justification: Administered by the CDC’s National Center for Injury Prevention and Control (NCIPC), the Core SVIPP is a unique program that helps states implement, evaluate, and disseminate strategies that address the most pressing injury and violence prevention issues. The program is intended to provide funds to support states’ “core” or baseline capacity.

Building core capacity is an important and necessary goal – a true foundation for injury and violence prevention in every state and territory. However, this goal has never been adequately realized.

At the current level of support, Core SVIPP is only able to fund 23 states. While these states have achieved important accomplishment, the program is not nearly large enough to meet its goal of impacting injury and violence at the population level.

Base funding levels have been capped at $250,000 per state for more than a decade. Core SVIPP also includes requirement that funded states address four topic areas that were prioritized by the NCIPC in 2016, which include child maltreatment, traumatic brain injury, sexual violence, and motor vehicle-related injury.

Despite its limitations, Core SVIPP could be returned to its original intention and is the best foundation for building a true national injury and violence prevention program in every state and territory.

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

Each year in the U.S., injury and violence account for:
- More than 243,000 deaths
- 3 million hospitalizations
- 25 million emergency department visits
- $840 billion in medical and work loss costs
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:

- Piloting prescription drug misuse and abuse initiative in three Arizona counties;
- Collaborating with its Rape Prevention and Education (RPE) programs to engage youth in violence prevention efforts in Colorado by implement Shifting Boundaries – Building Component in schools and communities across the state.
- Collecting and analyzing Adverse Childhood Experiences (ACEs) data in New York;
- Infusing injury into the Massachusetts State Highway Strategic Plan;
- Implementing an online surveillance system in the Twin Cities (MN) for concussion in high school athletes;
- Increased access to child passenger safety technicians within tribal communities in Arizona;
- Targeting child abuse in Wisconsin by implementing the Triple P Positive Parenting Program for formerly incarcerated mothers who plan to return to their families;
- 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: Jan. 26, 2021
**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 (CDC)  
**Program, office, or center:** Firearm Injury and Mortality Prevention Research

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**Funding recommendation:** Appropriate $25 million, which is a $12.5 million increase for Firearm Injury and Mortality Prevention Research.

**Justification:** Firearm violence is a serious public health problem in the United States that impacts the health and safety of Americans. Despite initial funding in FY 2021 to address firearm violence, significant gaps remain in our knowledge about the problem and ways to prevent it. Addressing these gaps is an important step toward keeping individuals, families, schools, and communities safe from firearm violence and its consequences.

Today there are bipartisan calls for research to better understand the root causes of gun violence to inform evidence-based gun violence prevention programs. Additional funding is needed to inform policies that address topics such as, youth access to firearms, risk factors for firearm violence, and the risks and benefits of firearm ownership.

**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:**

- Nearly 40,000 firearm-related deaths
- More than 86,000 non-fatal firearm injuries treated in emergency departments
- $229 billion in medical and lost productivity costs
Public health impacts: The National Center for Injury Prevention and Control (NCIPC) funding opportunities are intended to support research that addresses:

- The characteristics of firearm violence;
- The risk factors and protective factors for interpersonal and self-directed firearm violence; and,
- The effectiveness of interventions to prevent firearm violence.

Current surveillance grantees include:

- District of Columbia Department of Health
- Florida Department of Health
- Georgia Department of Public Health
- New Mexico Department of Health
- North Carolina Department of Health and Human Services
- Oregon Health Authority Public Health Division
- Utah Department of Health
- Virginia Department of Health
- Washington State Department of Health
- West Virginia Department of Health and Human Resources

Current research grantees include:

- Henry M. Jackson Foundation
- University of Michigan at Ann Arbor
- University of California at Davis
- Rand Corporation
- Baylor College of Medicine
- Research Triangle Institute
- University of Colorado
- University of South Alabama
- Brown University
- University of Washington
- Northwestern University at Chicago
- Virginia Commonwealth University
- University of Connecticut Storrs

The goal of this research it to stem the continued rise of firearm violence in communities across the country and decrease the occurrence of mass shootings.

For more information: https://www.cdc.gov/violenceprevention/firearms/index.html
Contact information: Paul Bonta, Director of Government Relations, (202) 679-8646, paul.bonta@safestates.org
Date: Jan. 26, 2021
**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:** National Violent Death Reporting System (NVDRS)

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**Funding recommendation:** Appropriate $29.5 million, which is a $5 million increase for the NVDRS.

**Justification:** To prevent violent deaths, Congress established the National Violent Death Reporting System (NVDRS), a surveillance system designed to collect information on the “who, when, where, and how” surrounding violent deaths. NVDRS is the only state-based surveillance system that pools more than 600 unique data elements from multiple sources into a usable, anonymous database. The system captures all types of violent deaths – including homicides and suicides – in all settings for all age groups.

The National Violent Death Reporting System (NVDRS) has seen many successes as increased funding and support have led to tremendous growth in the program; however, its ongoing evolution means that opportunities for improving program implementation and expanding utilization of the data in the field grow alongside the program.

Following a broad NVDRS stakeholder convening, it was determined that current funding is not sufficient for long-term program success. States have voiced a need for additional resources to address various implementation challenges and support investments in program infrastructure, as well as program growth and innovation.

As NVDRS continues to expand, the program’s infrastructure must be improved to allow states to analyze violent deaths across their entire population, capture complete data sets, and meet the needs of a true nationwide program. Moreover, for NVDRS to solidify its standing as the premier data repository used to inform violent death research and practice, additional resources are needed to support greater data utilization, while testing innovative approaches that improve data collection, timeliness, and analysis.

**In the United States:**

- More than seven lives are lost per hour due to violence.
- Nearly 20,000 people were victims of homicide.
- Over 47,000 people died by suicide in 2017 alone.
**Role of the state health agency:** In a majority of states, the public health department is the sole grantee charged with implementing the NVDRS program. Public health department officials must cement data sharing agreements with their partners to facilitate the collection of data from death certificates, coroners/medical examiners, law enforcement, and toxicology reports into one database. The combined data provides states with valuable context about violent deaths, such as relationship problems; mental health conditions and treatment; toxicology results; and life stressors, including recent money- or work-related problems or physical health problems. With this more complete picture, public health officials are more effective at working together to identify those at risk and putting into place effective prevention policies and programs that may save lives.

**How funds are allocated or used:** States receive funding from the National Center for Injury Prevention and Control based on the size of their population and rate of violent deaths.

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

- The Colorado Department of Health used NVDRS data on suicide among middle-aged men to develop a web-based suicide prevention initiative to engage and help connect men with appropriate resources.
- Oklahoma used NVDRS data on intimate partner violence homicides to evaluate the effectiveness of a pilot lethality assessment program. Police responding to domestic violence incidents connected victims at high risk for homicide with a local domestic violence service provider.
- NVDRS data in Rhode Island showed the adult working age population as being at increased risk for suicide. As a result, a symposium was conducted with the two largest employers in the state to increase awareness of depression and suicide and provide strategies for integrating suicide prevention into worksites.
- The Utah Department of Health’s Violence and Injury Prevention Program used NVDRS data to develop a suicide awareness toolkit to equip local media to more adequately report on suicide trends in the state.

**For more information:** [https://www.cdc.gov/violenceprevention/datasources/nvdrs/index.html](https://www.cdc.gov/violenceprevention/datasources/nvdrs/index.html)

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