



FY23

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 ongoing COVID-19 pandemic response highlights the costly impact that 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 FY23 so that this important work can continue.

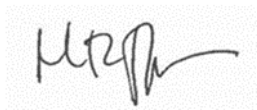
This book compiles top federal funding priorities and recommendations for nonprofit public health associations in FY23. It is designed to ensure that Congress appropriates the necessary resources for CDC and HRSA and includes appropriations forms from the following organizations:

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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Organization name: Association of State and Territorial Health Officials

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

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Public Health Emergency Preparedness Cooperative Agreement	\$695,000	N/A	N/A	\$824,000

(Dollars in thousands)

FUNDING RECOMMENDATION:

Appropriate \$824 million, a \$129 million—or 18.5%—increase over FY21 enacted levels for the Public Health Emergency Preparedness Cooperative Agreement.

BILL OR REPORT LANGUAGE:

The committee recognizes that the ongoing response to the COVID-19 pandemic has stretched our state, local, territorial, and tribal public health preparedness programs immensely. Public health professionals cannot maintain active response postures to a growing number of natural disasters, infectious diseases, and person-made incidents—while also improving systems—with small increases to baseline funding. America's public health preparedness systems need increased and stable base funding for years to rebuild, improve, and continue preparing for future public health emergencies.

JUSTIFICATION:

ASTHO members are grateful for the increased funding provided for this program in the previous fiscal year. These funds enabled the creation of a national network of directly funded CDC epidemiologists with experience in surveillance, epidemiology, preparedness, research, training, and policy development to strengthen state, tribal, local, and territorial epidemiology capacity by directly placing preparedness epidemiological experts in 62 state and local health departments. This replaces the previous patchwork coverage across the country. However, the ongoing response to the COVID-19 pandemic demonstrates 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. Public health departments are grateful for previous increases to this funding line. America's public health preparedness systems continue to be stretched to the brink and will need increased and stable base funding for years to rebuild and improve. Cycles of emergency funding and then level funding or budget cuts hinder our public health system from improving over time and based on data from exercises and real-life responses.

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

FAST FACTS OR HIGHLIGHTS:

PHEP supports states and local jurisdictions to ensure they are prepared to receive and provide life-saving medicines and supplies.

There are 62 PHEP cooperative agreement awardees: all 50 states, four metropolitan areas (Los Angeles County, Chicago, New York City, and Washington, D.C.), and eight U.S. territories and freely associated states.

The Cities Ready Initiative (CRI), which is funded with PHEP dollars, aims to strengthen the preparedness posture of 72 of the nation's largest population centers, where approximately 60% of the U.S. population resides. The CRI addresses all 15 Public Health Emergency Preparedness and Response Capabilities within these large metropolitan areas.

FOR MORE INFORMATION:

www.astho.org

to protect and promote the health, safety, and general welfare of their populations. Over the last 20 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 current COVID-19 pandemic, this infrastructure is vital to our economic prosperity, and stable, dependable. Increased base funding for this program should be commensurate with this need.

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 non-federal contributions 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. This program's increase in funding in FY21 allowed for enhanced investments in the Cities Ready Initiative (CRI). The CRI aims to strengthen the preparedness posture of 72 of the nation's largest population centers, where approximately 60% of the U.S. population resides. The CRI addresses all 15 Public Health Emergency Preparedness and Response Capabilities within these large metropolitan areas.

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 has worked closely with the healthcare preparedness efforts to bring forward a more robust public health preparedness stance. The PHEP cooperative agreement funds programs that strengthen the state, local, tribal, and territorial public health preparedness and response capabilities through a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action. An effective public health preparedness structure will prevent or reduce morbidity and mortality from threats and emergencies whose scale, rapid onset, or unpredictability stresses the public health system. A robust public health emergency response capability ensures a strong recovery and returns to pre-incident levels or improved functioning.

CONTACT INFORMATION:

Carolyn McCoy,
ASTHO senior director of
government affairs,
cmccoy@astho.org,
202-487-9441

SEE UPDATES TO THIS PAPER AT

[www.astho.org/Advocacy-
Materials](http://www.astho.org/Advocacy-Materials)

DATE: Jan. 13, 2022



Organization name: Association of State and Territorial Health Officials

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)

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Hospital Preparedness Program (HPP)	\$280,500	N/A	N/A	\$474,000

(Dollars in thousands)

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:

HPP is the only source of federal funding for healthcare delivery system readiness. HPP-funded activities act as a catalyst for integrated planning, training, and preparedness investments. For these operations to succeed, increases in funding are necessary to meet the current mission at hand and support key readiness programs to prepare for and respond to health security threats as well as other peacetime missions. These investments improve our healthcare system and move us toward a more safe and secure America for future generations.

ROLE OF THE STATE HEALTH AGENCY:

HPP and the coalitions that serve their communities operate and coordinate activities across the local, state, regional, and federal level to ready healthcare delivery systems for disasters and emergencies. These include developing mechanisms for effective patient movement, communicating situational awareness, and providing resource-sharing across disparate healthcare entities. HPP enables individual healthcare facilities and healthcare coalitions to access a truly national response network, enabling the system to save lives and protect Americans from 21st-century health security threats.

HOW FUNDS ARE ALLOCATED OR USED:

The current five-year project period is from 2017 to 2022. The state or territory is required to make nonfederal contributions 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.

FAST FACTS OR HIGHLIGHTS:

326 healthcare coalitions (HCC) are funded across the nation.

There are recipients in all 50 states, 8 territories, freely associated states, Los Angeles County, Chicago, New York City, and Washington, D.C.

HCCs bring together individual health care and response organizations in a geographic area such as acute care in hospitals, emergency medical service providers, emergency management agencies, and public health agencies, to prepare health care delivery systems to respond to emergencies and disasters.

FOR MORE INFORMATION:

www.astho.org

CONTACT INFORMATION:

Carolyn McCoy,
 ASTHO senior director of government affairs,
cmccoy@astho.org,
 202-487-9441

PUBLIC HEALTH IMPACTS:

HPP is a cooperative agreement (CoAg) program administered by ASPR's National Healthcare Preparedness Programs (NHPP) Branch. It establishes the foundation for national healthcare readiness, promotes a consistent national focus to improve patient outcomes during emergencies, and enables rapid healthcare service resilience and recovery. Since 2002, investments administered through HPP have improved individual healthcare entities' preparedness and have built a system for coordinated healthcare system readiness and response through healthcare coalitions (HCCs). These coalitions work collaboratively with critical partnerships, such as the Regional Disaster Health Response System (RDHRS) demonstration project and the National Special Pathogen System (NSPS).

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DATE: Jan. 13, 2022



Organization name: Association of State and Territorial Health Officials

Topic area: Core Public Health Funding

Name of appropriations bill: 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

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Preventive Health and Health Services Block Grant	\$160,000	N/A	N/A	\$170,000

(Dollars in thousands)

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. 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 64 grantees: all 50 states, Washington, D.C., two American Indian tribes, eight U.S. territories, and three freely associated states. Grantees set their own goals and program objectives and implement strategies to address national health priorities. In 2020, grantees received a total of \$149,098,135 in Prevent Block Funding. Of this funding, \$131,668,884 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 and rape prevention activities. The remaining \$10,429,251 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 noncategorical 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.

SUPPORTING ORGANIZATIONS:

National Association of Chronic Disease Directors also supports this request.

FOR MORE INFORMATION:

<https://www.cdc.gov/phhsblockgrant/about.htm>

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.
- Heart disease and stroke.
- Maternal, infant, and child health.
- Diabetes.
- Emergency medical services.
- Health communication and health information technology.

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.

CONTACT INFORMATION:

Jeffrey O. Ekoma,
ASTHO senior director of
government affairs,
jekomo@astho.org,

SEE UPDATES TO THIS PAPER AT

www.astho.org/Advocacy-Materials

DATE: Feb 1, 2022



Organization name: Association of State and Territorial Health Officials

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

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Public Health Infrastructure and Capacity	N/A	N/A	N/A	\$1,000,000

(Dollars in thousands)

FUNDING RECOMMENDATION:

Appropriate \$1 billion for public health infrastructure and capacity. It is important to note that as of February 2022, President Biden proposed \$400 million in his FY22 request, the House FY22 LHHS bill proposed \$1 billion and Senate proposed \$600 million. The FY23 request is consistent with previously introduced legislation.

JUSTIFICATION:

State and territorial public health departments have traditionally operated under a boom-and-bust cycle when it comes to how they are funded. The “boom” occurs during a public health emergency, such as the COVID-19 pandemic, when policymakers increase public health funding to mobilize a response. It is then followed by the “bust,” or return to chronic underfunding of agencies when the acute public health threat subsides, and the crisis is deemed to be “solved.”

This funding will support efforts within agencies that build capacity to detect and respond to threats both domestically and globally while improving and supporting activities in core public health capabilities including assessment, policy, preparedness and response, community partnership, communications, equity, accountability, and performance management. Moreover, funding will support agencies in their efforts to invest in a highly-trained workforce that is ready to support emerging public health threats. It’s also important to ensure that funding is disease-agnostic, flexible, and sustainable to support the transition from sporadic influxes of funding that accompany the response to public health emergencies.

ROLE OF THE STATE HEALTH AGENCY:

State and territorial health departments are best equipped to understand the unique needs of their respective communities. In addition to addressing, revitalizing, and modernizing core functionalities of agencies, public health infrastructure resources will also allow for necessary planning to transition from the COVID-19 response to addressing fundamental and ongoing public health challenges, as well as preparing for the next pandemic. This includes:

- Building capacity to assess risks as they arise in patients and communities and gather the right information at the right time.
- Strengthening workforce capability by hiring additional highly skilled epidemiologists, intervention specialists, biostatisticians, and other specialists to meet national quality standards.
- Improving protocols and processes for disease detection and containment.

FAST FACTS OR HIGHLIGHTS (PRIOR TO THE COVID-19 PANDEMIC):

Between 2008 and 2018, federal funding for state public health decreased from an average of \$282 to \$254 million.

Simultaneously, there was a 15% decrease in state and local contributions to public health funding.

Between 2012 and 2019, the public health workforce decreased by 10,079 FTE.

FOR MORE INFORMATION:

<https://www.cdc.gov/pghsblockgrant/about.htm>

CONTACT INFORMATION:

Jeffrey O. Ekoma,
ASTHO senior director of government affairs,
jekoma@astho.org,

SEE UPDATES TO THIS PAPER AT

www.astho.org/Advocacy-Materials

DATE: Feb 1, 2022



Organization name: Association of State and Territorial Health Officials

Topic area: Social Determinants of Health

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: Chronic Disease Prevention and Health Promotion

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Social Determinants of Health	\$3,000	N/A	N/A	\$153,000
<i>(Dollars in thousands)</i>				

FUNDING RECOMMENDATION:

Appropriate \$153 million, a \$150 million increase over FY21 enacted levels for the social determinants of health (SDOHs).

JUSTIFICATION:

Currently, only 20 state, local, tribal, and territorial jurisdictions are funded under a competitive application process that limits funding to no more than three state and local applicants per HHS region. An increase in funding will support the expansion of activities that address SDOHs in state, local, tribal, and territorial jurisdictions that include expanding and implementing accelerator plans and building the evidence base to better understand health disparities.

ROLE OF THE STATE HEALTH AGENCY:

State and territorial health agencies play a significant role in leading, developing, and coordinating interventions that seek to bring economic and community sectors together to create conditions that foster vibrant health for all.

One such example of the role of agencies is the partnership between ASTHO, CDC, and the National Association of County and City Health Officials to identify multi-sector coalitions that have improved SDOH in their communities. Overall, 42 community multi-sector partnerships and coalitions were selected to receive over \$2 million as part of the *Improving Social Determinants of Health – Getting Further Faster* pilot project. An analysis of selected communities found that local partnerships and coalitions demonstrated tangible outcomes related to the improvement of SDOH contributing factors. Over half of the coalitions in the cohort reported health outcomes data for their SDOH initiatives, including changes in health behaviors, clinical outcomes, overall health and wellness, and healthcare utilization and costs. Most coalitions were also able to affect policy, systems, and/or environmental changes, such as integrating health-related social needs screening and referrals to community resources into healthcare setting workflows; building new community walking trails, sidewalks, bike lanes, and playgrounds; and the adoption of a county comprehensive tobacco-free policy.

FAST FACTS OR HIGHLIGHTS:

Chronic diseases are leading causes of death and illness in the United States and leading drivers of the nation's annual \$3.8 trillion in health care costs (CDC, 2021).

Some populations, including those with low socioeconomic status and those of certain racial and ethnic groups, including African American, Hispanic, and Native American, have a disproportionate burden of chronic disease, SARS-CoV-2 infection, and COVID-19 diagnosis, hospitalization, and mortality (CDC, 2021).

FOR MORE INFORMATION:

<https://www.cdc.gov/nccdphp/dnpao/state-local-programs/sdoh-2111/SDOH-accelerator-planning.html>

CONTACT INFORMATION:

Jeffrey O. Ekoma,
ASTHO senior director of government affairs,
jekoma@astho.org

HOW FUNDS ARE ALLOCATED OR USED:

Administered by CDC's Division of Nutrition, Physical Activity, and Obesity, funds are awarded to approximately 20 state, local, and tribal jurisdictions, with no more than three state and local applicants per HHS region eligible to receive awards. The award ceiling for grants is \$125,000 and funds are used to develop multisector accelerator plans to address SDOHs that assist in fast-tracking improvements in health and social outcomes related to chronic health conditions among population groups experiencing health disparities and inequity.

BACKGROUND INFORMATION:

The COVID-19 pandemic presented unprecedented challenges to our nation through sickness, loss of life, and loss of livelihood. In addition, it further highlighted the inequities in our nation. Our recovery efforts provide an important opportunity to address those inequities head-on with new investments, greater attention to the role of public health and prevention, and the urgent need to rebuild communities in ways that promote optimal health for all. Much of our health is influenced by non-medical, non-clinical factors like the environments we live in, where we work, the quality of our housing, our access to meaningful employment and education, and access to healthy foods and recreational areas. These non-medical factors contribute to the social determinants of health.

Even before the pandemic, conditions were less than optimal for many Americans, and especially for individuals living in poverty, racial and ethnic minority communities, and other marginalized groups that experience profound inequities in health and well-being. These inequities are not only the result of differential access to quality healthcare but have deeper roots in equal access to quality educational opportunities, neighborhood safety and community resources, limited availability of public transportation, insufficient economic opportunities, and institutional racism and discrimination.

SEE UPDATES TO THIS PAPER AT

www.astho.org/Advocacy-Materials

DATE: Feb 1, 2022



Organization name: Association of Public Health Laboratories, Council of State and Territorial Epidemiologists, National Association for Public Health Statistics and Information Systems

Topic area: Data Modernization Initiative (DMI)

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

Agency: Center for Disease Control and Prevention

Program, office, or center: Public Health Scientific Services

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Public Health Data Modernization Initiative	\$50,000	N/A	N/A	\$250,000

(Dollars in thousands)

FUNDING RECOMMENDATION:

Appropriate \$250 million, a \$200 million increase over the FY 2021 enacted level.

JUSTIFICATION:

The CDC's DMI is a commitment to building a world-class data workforce and data systems that are ready for the next public health emergency. Congress has provided nearly \$1 billion to date for CDC's DMI through annual and supplemental appropriations. Now, we need robust, sustained, annual funding to ensure we are investing in public health systems and infrastructure—including at state and local health departments—that will keep pace with evolving technology and stand ready to combat any emerging threat to public health.

The need to upgrade our nation's public health surveillance systems was apparent long before the onset of the COVID-19 pandemic. Then, COVID-19 exposed deadly gaps in our nation's public health data infrastructure. 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.

The nation faces an unprecedented challenge in addressing the global COVID-19 pandemic and a responsibility to create an infrastructure capable of responding to future public health emergencies. 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.

To date, the investments made by Congress will not bear fruit without sustained annual funding for DMI.

The Data: Elemental to Health Campaign partners have estimated that actual annual costs for DMI implementation at the state and local level are [\\$1.57 billion per year for at least five years](#). **We are calling on Congress to invest at least \$250 million in FY23 appropriations funding for DMI**—an important annual commitment towards the total funding needed through additional federal sources.

FAST FACTS OR HIGHLIGHTS:

21st century data systems and the public health workforce needed to operate and maintain them have been woefully underfunded, leaving our nation unprepared to respond to COVID-19 and future pandemics.

Sustained investment at CDC and health departments would transform public health surveillance into a state of the art, secure, rapid response system.

SUPPORTING ORGANIZATIONS:

In addition to the organizations listed above, the Data: Elemental to Health Campaign includes the Big Cities Health Coalition, NACCHO, ASTHO, and HIMSS. More than [100 organizations](#) in total support DMI.

FOR MORE INFORMATION:

[CDC's Data Modernization Initiative](#), [Driving Public Health in the Fast Lane](#).

Funding for DMI will also make possible the critical work of the newly established Center for Forecasting and Outbreak Analytics (CFA) under CDC's Office of the Director. A \$50 million appropriation for CFA in FY 2023 will help fund the center to facilitate the use of data, modeling, and analytics to improve pandemic preparedness and response.

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 healthcare providers via health records, vital records, and laboratory samples. These data are shared by health departments with CDC to provide national data on health. This flow of data from state health agencies to the federal government is important for several reasons, including ensuring that data are de-identified so that no personally identifiable data is shared directly with the federal government. While it is important for data to be available at the federal level, case-specific, identifiable data should be protected by state and local health departments.

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:

While progress has been made on electronic lab reporting and electronic case reporting in many jurisdictions, much public health data is still entered manually from paper-based data exchanges. 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 support automated reporting from healthcare organizations to public health, improving the quality and timeliness of data and reducing the burden on medical providers and healthcare facilities to manually report cases.

CONTACT INFORMATION:

Erin Morton,
Senior Vice President,
CRD Associates
emorton@dc-crd.com,

SEE UPDATES TO THIS PAPER AT:

<https://www.cste.org/page/DM-2021>

DATE: Jan. 31, 2022



Association of
Immunization
Managers

Organization name: Association of Immunization Managers

Topic area: Immunization Funding

Name of appropriations bill: Section 317 Immunization Funding

Program, office, or center: Labor-HHS-Education Appropriations Bill

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Section 317 Immunization Funding	\$613,640	N/A	N/A	\$1,130,000

(Dollars in thousands)

FUNDING RECOMMENDATION:

Appropriate \$1.13 billion, which is a \$516.3 million or 84% increase over FY21 enacted levels 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 and enhance 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.

COMMITTEE REPORT LANGUAGE:

"The Committee recognizes that the COVID-19 pandemic has exposed critical gaps in our nation's immunization infrastructure resulting from years of stagnant funding. Furthermore, base awards for state and local grantees have not substantially changed for a number of years, and the increased use of component funding has increased the complexity and burden of grants administration. We direct CDC to apply increased resources to awardee base awards."

JUSTIFICATION:

The need to establish and maintain a robust public health immunization infrastructure has never been greater. Jurisdictions need significant new resources to implement recent recommendations from the CDC Advisory Committee on Immunization Practices for expanded adult vaccination against hepatitis B, pneumococcal, and shingles. Additional new program requirements from CDC for all jurisdictions to report all vaccine doses to CDC in real-time cannot happen without new investments. Lessons learned from the COVID-19 vaccination campaign illustrate the impact of data reporting challenges, limited workforce, lack of enrolled adult providers, vaccine hesitancy, and health disparities on the efficiency of the initial rollout of COVID-19 vaccines. 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 as one of the top-ten global health 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 followed by cycles of emergency surges, followed by reduced or stagnant investment. Now is the time to sustain

FAST FACTS OR HIGHLIGHTS:

An effective vaccine campaign is the best path to controlling the COVID-19 pandemic.

Millions of children and adults have fallen behind on routine vaccination due to the pandemic.

Other infectious disease threats remain- 1,282 measles cases were confirmed in 2019, the greatest number of cases reported in U.S. since 1992.

Millions of people get flu every year, hundreds of thousands of people are hospitalized, and thousands to tens of thousands of people die from flu-related causes every year.

31,200 of 33,700 HPV-related cancers could be prevented each year in the U.S.

The U.S. spends nearly \$27 billion annually to treat four vaccine-preventable illnesses (flu, pertussis, pneumococcal, and shingles).

improvements being made through emergency supplemental funding. This will ensure that both routine immunizations are restored, and future preparedness is assured.

ROLE OF THE STATE HEALTH AGENCY:

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

HOW FUNDS ARE ALLOCATED OR USED:

Funds are awarded to 64 states, local, and territorial health agencies by a formula based largely on population. In addition to the immense challenges of the COVID-19 pandemic, the recent growth of electronic health records and compliance with associated regulations, new vaccines, and school requirements, and continuing unpredictable disease outbreaks have increased the complexity of vaccine management.

PUBLIC HEALTH IMPACTS:

A [study](#) by the non-partisan Commonwealth Fund found that in the absence of a vaccination program, there would have been approximately 1.1 million additional COVID-19 deaths and more than 10.3 million additional hospitalizations in the U.S. by Nov. 2021. Moreover, childhood immunizations over the past twenty-five years have prevented 381 million illnesses, 855,000 deaths, and nearly \$1.65 trillion in societal costs. In the 2017 – 2018 season alone, flu vaccination prevented an estimated 5.3 million illnesses. 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:

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

FOR MORE INFORMATION:

www.immunizationmanagers.org,
www.VaccinateYourFamily.org,
www.cdc.gov/vaccines,
<https://immunizations.aap.org>,
www.317coalition.org,
www.adultvaccinesnow.org,
www.immunize.org.

CONTACT INFORMATION:

Claire Hannan,
 Executive Director
channan@immunizationmanagers.org,
 301-424-6080



Organization name: Association of Maternal and Child Health Programs (AMCHP)

Topic area: Maternal and Child Health

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

Agency: Health and Human Services

Program, office, or center: HRSA/MCHB

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
HRSA/MCHB	\$712,700	N/A	N/A	\$1,000,000

(Dollars in thousands)

FUNDING RECOMMENDATION:

Appropriate \$1,000,000,000 which is a \$287,000,000 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 make it 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 use those findings to implement programs to address 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 they receive with at least \$3 of state and/or local money.

PUBLIC HEALTH IMPACTS:

In FY 2020, approximately 93% of pregnant women, 98 percent 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 Regional and National Significance (SPRANS). SPRANS funding complements and helps ensure the success of state Title V, Medicaid, and CHIP programs by driving innovation and building capacity to create integrated systems of care for mothers and children. Examples of

PLAYING A CRITICAL ROLE IN COVID-19 RESPONSE:

Ensuring equitable access to universal testing of pregnant patients.

Offering virtual childbirth, breastfeeding and parenting classes.

Communications campaigns around child abuse prevention and continuing routine childhood immunization.

FOR MORE INFORMATION:

www.amchp.org

CONTACT INFORMATION:

Amy Haddad,
Chief Government Affairs Officer,
ahaddad@amchp.org,
202-266-3045

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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.



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: Center for Disease Control and Prevention

Program, office, or center: National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
CDC Division of Oral Health	\$19,500	N/A	N/A	\$34,500

(Dollars in thousands)

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 \$15.0 million increase from their current funding over FY20 levels.

Of the additional \$15.0M, \$3.0M would go towards 30 states (not currently funded by CDC DOH) to conduct oral health surveillance, \$0.5M is allocated for provision of TA and packaging of data for the 30 states above, \$3.0M would support the provision of program technical assistance and support for surveillance, evaluation, policy and communication activities, \$3.0M would go towards research, epidemiologic analysis, and translation of science to action, \$2.0M would be allocated for review and update of infection prevention and control guidelines for dental setting and develop materials to increase adherence, \$1.0M is for investment in innovation, \$1.5M would be to expand the national, state, and community partner support, and \$1.0M 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 diseases, like diabetes, hypertension (high blood pressure), asthma, and breast and other cancers. Oral diseases impact almost everyone who lives in the U.S. sometime during their lives. Oral diseases cause people to lose time from work and school, to go to the emergency department for relief of pain, and impact some people's ability to get a job or enlist in the military. And yet, while the CDC provides funding to every state health department for cancer, diabetes, heart disease, and stroke prevention programs, it funds less than half the states for oral disease prevention programs.

SUPPORTING ORGANIZATIONS:

American Association of Public Health Dentistry, American Dental Hygienists' Association, American Network of Oral Health Coalitions, Association of State and Territorial Dental Directors, DentaQuest Partnership for Oral Health Advancement, Families USA, Hispanic Dental Association, Justice in Aging, Medicaid-CHIP State Dental Association, National Dental Association, National Network for Oral Health Access, Oral Health Progress and equity Network, Sargent Shriver National Center on Poverty Law, Special Care Dentistry Association

FOR MORE INFORMATION:

<http://astdd.org>

CONTACT INFORMATION:

Christine Wood,
Executive Director,
cwood@astdd.org,
775-626-5008

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ROLE OF THE STATE HEALTH AGENCY:

State health agencies are responsible for assessing and tracking the oral disease in the state's population, developing and implementing policies and programs to prevent or minimize the disease, and assuring that laws and regulations are in place to keep the public safe and healthy. To translate proven health promotion and disease prevention approaches into policy development, health-care practice, and personal behaviors, state oral health programs must have adequate capacity and infrastructure.

HOW FUNDS ARE ALLOCATED OR USED:

In 2001, CDC began funding state health departments for state oral health program infrastructure and capacity building. Grants are competitively awarded to state health departments. The average grant size is \$370,000 per state per year. In 2018, 45 states applied, but only 20 were funded. Twenty states have never been funded (Alabama, Arizona, California, Delaware, DC, Indiana, Kentucky, Massachusetts, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, South Dakota, Tennessee, Utah, Washington, Wyoming). Eleven previously funded states are no longer funded (Alaska, Hawaii, Illinois, Maine, Michigan, Mississippi, Nevada, New York, Oregon, Texas, Wisconsin).

PUBLIC HEALTH IMPACTS:

- Dental caries is one of the most common chronic diseases in the United States.
- About 1-of-5 (20%) children aged 5 to 11 years have at least one untreated decayed tooth.
- 1-of-7 (13%) adolescents aged 12 to 19 years have at least one untreated decayed tooth.
- Children aged 5 to 19 years from low-income families are twice as likely (25%) to have cavities than children from higher-income households (11%).
- If dental sealants were combined 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, oral cancer and their related costs, and associated increases in productivity and independence.



Organization name: Association of Public Health Laboratories, Council of State and Territorial Epidemiologists, National Association for Public Health Statistics and Information Systems, and National Association of Vector-Borne Disease Control Officials

Topic area: Epidemiology and Laboratory Capacity (ELC) Program

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

Agency: Center for Disease Control and Prevention

Program, office, or center: Emerging and Zoonotic Infectious Diseases

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Emerging and Zoonotic Infectious Diseases	\$648,272	N/A	N/A	\$1,300,467

(Dollars in thousands)

FUNDING RECOMMENDATION:

Appropriate at least \$1.3 billion for the Center for Emerging and Zoonotic Infectious Diseases, including at least \$800 million in available funding for the ELC program.

BILL OR REPORT LANGUAGE:

The Epidemiology and Laboratory Capacity program provides core surveillance capacity, ensuring 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.

ELC serves as the financing mechanism for the CDC's Data Modernization Initiative (DMI); to ensure an enterprise approach to DMI implementation, the Committee encourages CDC to ensure that the ELC program includes expertise in all focus areas the DMI, including vital statistics modernization.

JUSTIFICATION:

Funding for CDC's EZID program is essential in combating new and emerging threats. Funding across EZID bolsters the ELC program, the principal financing mechanism that strengthens surveillance for infectious diseases, early detection of newly emerging disease threats, identification and response to outbreaks, and the DMI. Increased funding across EZID will contribute to the necessary increase in ELC funding, including for the Vector-borne disease program, which works to control viruses and bacteria spread by vectors such as mosquitoes, ticks, and fleas.

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, entomologists, and laboratory scientists who are instrumental in discovering and responding to food and vector-borne outbreaks. It also supports cross-cutting epidemiologists that can respond to and support outbreaks for multiple disease threats. The ELC program is critical to U.S. health departments' ability to combat infectious diseases, a need that has become more extreme as states and localities respond to the COVID-19 pandemic. In 2019, ELC received funding applications totaling more than \$500 million, likely representing an underestimate of the true public health need. However, ELC was only able to issue just over \$238 million in FY 2020 funding for health departments to carry out critical core surveillance programs.

FAST FACTS OR HIGHLIGHTS:

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 gap must be addressed.

Additional funds for ELC could also be used to expand funding to local health departments in coordination with states where additional needs are identified.

FOR MORE INFORMATION:

<https://www.cdc.gov/ncezid/dpei/elc/history/elc-awards-by-grantee-2020.html>

CONTACT INFORMATION:

Erin Morton,
Senior Vice President,
CRD Associates
emorton@dc-crd.com

DATE: Jan. 31, 2022

With increased funds, CDC can provide additional support to reinforce everyday infectious disease programs and ensure they can adequately respond to future infectious disease outbreaks. Increased funding will also help build the epidemiology workforce, allowing state and local health departments to begin to establish a minimum epidemiology workforce. Funds are also needed to support Laboratory Response Network for Biological Threats laboratories to strengthen public health preparedness and response capabilities. Additional funds will also allow ELC to expand funding to local health departments in coordination with states. The COVID-19 response has shown us that additional funds are needed for the most basic public health tools, including staff, technology, data systems, and physical space and facilities—increased funding across the ELC program is the most effective way to support state health departments in these areas to prepare them for everyday response capacity and the next pandemic.

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 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, representing 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 funding for ELC to \$800 million is critical to the nation's core surveillance capacity. It will allow ELC to fund more essential projects and expand its reach to more local health departments.

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 surged across the country, and regularly respond to infectious viruses and bacterial outbreaks across the country.



Organization name: National Association of Chronic Disease Directors

Topic area: Chronic disease

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

Agency: Centers for Disease Control and Prevention

Program, office, or center: National Center for Chronic Disease Prevention and Health Promotion

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
National Center for Chronic Disease Prevention and Health Promotion	\$ 160,000	N/A	N/A	\$ 170,000

(Dollars in thousands)

FUNDING RECOMMENDATION:

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

JUSTIFICATION:

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. These can be reduced or prevented through proven strategies using state health agencies to lead local communities to healthier, more productive living. Increased funding is essential to maintain and expand current efforts in every state. To meet these goals, critical clinical community linkages and health promotion efforts are required.

ROLE OF THE STATE HEALTH AGENCY:

State health agencies have a unique role in efforts to coordinate activity and steer resources to communities most in need, creating linkages across systems with healthcare providers, insurers, educators, community organizations, and others. State participation is needed to maximize federal actions and assure the 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 linkages 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 nonprofit 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 their specific population's leading preventable risk factors. The flexibility afforded grantees allows them to address the social determinants of health to achieve health equity in the long term.

FAST FACTS OR HIGHLIGHTS:

Chronic diseases account for 75% of healthcare costs, more for seniors.

Much of the human and financial toll of chronic diseases is preventable.

SUPPORTING ORGANIZATIONS:

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

FOR MORE INFORMATION:

www.chronicdisease.org

CONTACT INFORMATION:

Amy Souders,
 Cornerstone Government Affairs
asouders@cgagroup.com,
 202-488-9500

DATE: Jan. 24, 2022

PUBLIC HEALTH IMPACTS:

These programs target long-term reduction in population rates of chronic conditions and related costs and increased 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 ten people die of 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.



Organization name: National Association of Chronic Disease Directors

Topic area: Chronic disease

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

Agency: Centers for Disease Control and Prevention

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

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Nutrition, Physical Activity, and Obesity	\$71,920	N/A	N/A	\$125,000

(Dollars in thousands)

FUNDING RECOMMENDATION:

The National Association of Chronic Disease Directors strongly recommends an appropriation of \$125 million, a \$53.08 million increase, for Nutrition, Physical Activity, and Obesity.

JUSTIFICATION:

An increase in funding in FY 2023 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 0-5 years. Currently, only 16 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.

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. The 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 Early Care and Education (ECE) settings, and improving support for mothers who choose to breastfeed.

ROLE OF THE STATE HEALTH AGENCY:

State health agencies have a unique role in efforts to coordinate activity and steer resources to communities most in need, creating linkages across systems with healthcare providers, insurers, educators, community organizations, and others. State participation is needed to maximize federal actions and assure the most efficient mobilization of local organizations.

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 nonprofit partner organizations.

FAST FACTS OR HIGHLIGHTS:

Obesity costs the U.S. healthcare system \$147 billion a year.

Despite the proven health benefits of physical activity, 25% of U.S. adults are not active enough to protect their health.

FOR MORE INFORMATION:

www.chronicdisease.org

CONTACT INFORMATION:

Amy Souders,
 Cornerstone Government Affairs
asouders@cgagroup.com,
 202-488-9500

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https://chronicdisease.org/page/appropriations_fs/

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PUBLIC HEALTH IMPACTS:

At \$125 million, DNPAO and states will:

- Reduce the age-adjusted proportion of adults (age 20 years and older) who are obese.
- Reduce the proportion of children and adolescents (ages 2 through 19) who are obese.
- Increase the contribution of vegetables to the diets of the population ages 2 years and older (cup equivalents per 1,000 calories).
- Increase the proportion of adults (age 18 and older) that engage in physical activity.
- Increase in the number of states with nutrition standards for foods and beverages provided in early care and education 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.
- Increase the proportion of infants that are breastfed at 6 months.

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, one in ten 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 2017-2018, 42% of adults had obesity as did 19% of all children and adolescents (ages 2 to 19 years). Over the last two decades, obesity rates for adults over 60 have steadily increased from 24% in 1988-1994 to almost 43% in 2017-2018.

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 one in four young adults are too heavy to serve in our military.



Organization name: National Association for Public Health Statistics and Information Systems
Topic area: Electronic Vital Records Systems
Name of appropriations bill: Labor, Health and Human Services, Education and Related Agencies
Agency: Centers for Disease Control and Prevention
Program, office, or center: National Center for Health Statistics

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
National Center for Health Statistics	\$175,397	N/A	N/A	\$210,000

(Dollars in thousands)

FUNDING RECOMMENDATION:

Appropriate \$210 million, an approximately \$35 million increase over FY 2021 for the National Center for Health Statistics.

BILL OR REPORT LANGUAGE:

Modernizing Vital Statistics Collection – Electronic birth and death registration systems are essential tools 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:

All NCHS statistical systems need to be significantly changed over the next three to four years. However, statistical systems need to stay in place while upgrades are implemented. For now, the data from current systems are the gold standard for measuring health status, changes in health outcomes for the most vulnerable, and emerging health issues for the nation—all of which are critical during a pandemic. Funds are needed to test and innovate while NCHS continues to fulfill current data needs.

In addition, Electronic Vital Records Systems, overseen by NCHS, are one of the five core pillars of the U.S. public health surveillance enterprise that require immediate modernization 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, physicians, 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 Data Modernization Initiative (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 maximize the potential of electronic systems and enhance data quality, specificity, accuracy, security, and timeliness.

FAST FACTS OR HIGHLIGHTS:

CDC’s Data Modernization Initiative is working across CDC and states to improve vital records systems, which capture data from about six million births and deaths annually and can signal changes in trends, monitor urgent public health events, and more rapidly provide notification of cause of death.

SUPPORTING ORGANIZATIONS:

Friends of NCHS
www.friendsofnchs.org

FOR MORE INFORMATION:

<https://www.cdc.gov/nchs/about/budget.htm>

CONTACT INFORMATION:

Erin Morton,
 Senior Vice President,
 CRD Associates,
emorton@dc-crd.com,
 202-484-1100

DATE: Jan. 31, 2022

Increased funding for NCHS will also assist in addressing health equity issues, by allowing for expanded data collections and real-time surveys.

ROLE OF THE STATE HEALTH AGENCY:

NCHS is the nation's principal health statistics agency, whose mission is to provide statistical information that will guide actions and policies to improve the health of the American people.

Of particular importance, NCHS collects vital records information. 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 the legal authority to register these records, which are thus governed under state laws. The laws governing what, when, and with whom information may be shared varies by jurisdiction. In an example of effective federalism, the vital records jurisdictions provide the federal government with data collected through birth and death records to compile national health statistics, facilitate secure Social Security number (SSN) issuance to newborns through the Enumeration at Birth (EAB) Program, and report individual's deaths.

HOW FUNDS ARE ALLOCATED OR USED:

NCHS provides more than \$20 million per year to the states to use their birth, death, and fetal death records. Funding is \$350,000, on average, across the 57 vital records jurisdictions.

PUBLIC HEALTH IMPACTS:

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.

For example, as our public health officials continue to respond to the COVID-19 pandemic, vital records have illuminated the disparate impact of COVID-19 on minority populations. Because of Congress' longstanding leadership in supporting the modernization of the National Vital Statistics System—moving from paper-based to electronic filing of birth and death statistics—NCHS has funded states and territories to speed the release of birth and death statistics, including infant mortality and prescription drug overdose deaths. In fact, the percentage of mortality records reported within 10 days has increased from less than 10 percent in 2010 to 60 percent in 2018. 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.



Organization name: National Alliance of State and Territorial AIDS Directors (NASTAD)
Topic area: HIV and Hepatitis Programs
Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies
Agency: Health Resources and Services Administration
Program, office, or center: Ryan White Part B

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Ryan White Part B <i>(Dollars in thousands)</i>	\$1,315,000	N/A	N/A	\$1,455,000

FUNDING RECOMMENDATION:

Appropriate \$1,455,000,000 for the Ryan White HIV/ AIDS program Part B, inclusive of the AIDS Drug Assistance Program (ADAP), which is \$140,000,000 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 people living with HIV (PLWH). 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 COVID-19 pandemic has heavily impacted the Ryan White HIV/AIDS Program (RWHAP). Programs are quickly innovating 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 use 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. Most respondents also anticipated an increased burden to the RWHAP as people lose 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 is in direct opposition to the success of people's individual health, the nation's public health, and the Ending the HIV Epidemic Initiative.

Launched in 2019, Ending the HIV Epidemic: A Plan for America intends to reduce new transmissions by 75% in the next five years and by 90% in the next 10 years by focusing on increasing diagnoses, 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

FAST FACTS OR HIGHLIGHTS:

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.

SUPPORTING ORGANIZATIONS:

The AIDS Budget and Appropriations Coalition supports this ask.

FOR MORE INFORMATION:

www.NASTAD.org

CONTACT INFORMATION:

Emily McCloskey,
 Senior Director,
 Policy and Legislative Affairs,
emccloskey@NASTAD.org,
 202-897-0078

health services, AIDS Drug Assistance Program, AIDS pharmaceutical assistance, oral healthcare, early intervention services, health insurance premium and cost-sharing assistance, home healthcare, 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. They may include outreach, medical transportation, linguistic services, respite care for caregivers of people with HIV/AIDS, referrals for healthcare 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 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 PLWH in the United States who have been diagnosed. The RWHAP is crucial to meet the healthcare 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, as well as ADAPs 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 ending the HIV epidemic. Services provided through Ryan White Part B, and ADAPs are key to ending the HIV epidemic. There is conclusive scientific evidence that a person living with HIV who is on antiretroviral therapy and is durably virally suppressed (defined as having a consistent viral load of less than <200 copies/ml) does not sexually transmit HIV. In 2020, 89.4% of Ryan White Program clients had reached viral suppression, which exceeds the national PLWH viral suppression rate. This demonstrates Ryan White's unique success in accelerating health outcomes for disproportionately impacted populations. Among the services necessary to improve health outcomes are linkage to and retention, care, and access to medications that suppress viral loads and reduce transmission, leading to fewer new HIV transmissions. Underfunding the Ryan White Program system of care will only 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.

SEE UPDATES TO THIS

PAPER AT:

[https://www.nastad.org/
domestic/policy-legislative-affairs](https://www.nastad.org/domestic/policy-legislative-affairs)

DATE: Jan. 30, 2022



Organization name: National Alliance of State and Territorial AIDS Directors (NASTAD)

Topic area: HIV and Hepatitis Programs

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

Agency: Centers for Disease Control and Prevention

Program, office, or center: Division of HIV Prevention

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Domestic HIV Prevention	\$964,700	N/A	N/A	\$1,293,000

(Dollars in thousands)

FUNDING RECOMMENDATION:

Appropriate \$1.293 billion, a \$328 million increase for the Division of HIV Prevention (DHP). Of the HIV Prevention funding, \$371 million is for the Implementation of the Ending the HIV Epidemic Initiative.

JUSTIFICATION:

With the confluence of advances in science and policy, the United States has an unprecedented opportunity to achieve a large-scale, measurable impact in a relatively short timeframe, drastically reduce health disparities, and end the HIV epidemic. The Domestic HIV Prevention and Research program must see increased funding to achieve this goal. Sixty 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 faces challenges maintaining access to services, reporting significant decreases in testing, and other prevention services. HIV prevention programs are shifting to at-home testing programs to ensure that people are still being tested for HIV and linked to care. To scale up innovative programs that can reach individuals, 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 (EHE) intends to reduce new transmissions by 75% in the next five years and by 90% in the next 10 years by supporting 48 counties, Washington, DC, and San Juan, Puerto Rico, as well as seven states with high rates of HIV in rural geographic regions. EHE will supplement existing resources and focus on the testing, linkage to care, and access to prevention modalities. Of the HIV Prevention funding, \$275 million is for year four of EHE Implementation.

The number of new HIV diagnoses must decrease to see meaningful improvements in individual and community-level health outcomes, particularly among disproportionately impacted populations. Early detection, linkage to and retention in care, and treatment adherence will suppress individual and community viral loads and reduce the incidence of HIV. Unfortunately, only 56% percent of people living with HIV have an undetectable viral load.

FAST FACTS OR HIGHLIGHTS:

Due to the COVID-19 pandemic, over 80% of HIV Prevention programs anticipate a decrease in program participation and retention.

60% of HIV prevention programs anticipate cuts to their state funding in the upcoming fiscal years.

SUPPORTING ORGANIZATIONS:

The AIDS Budget and Appropriations Coalition supports this ask.

FOR MORE INFORMATION:

www.NASTAD.org

CONTACT INFORMATION:

Emily McCloskey,
Senior Director,
Policy and Legislative Affairs,
emccloskey@NASTAD.org,
202-897-0078

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DATE: Jan. 30, 2022

ROLE OF THE STATE HEALTH AGENCY:

Health departments are the cornerstone implementers of HIV prevention, coordinating federal, state, and local public health programs and policy efforts. These efforts are essential for meeting high-impact prevention and the nation's established goals to combat the HIV epidemic: reducing the annual number of new HIV diagnoses and HIV-related health disparities, particularly among communities of color and gay, bisexual, and other men who have sex with men (GBM) of all races and ethnicities. CDC's single largest investment in HIV prevention is providing funding to health departments, with 53% of HIV prevention funding going to health department activities. Fortunately, we have the tools and strategies to prevent HIV, but continued funding for CDC's DHP is critical to continue our progress.

Pre-exposure prophylaxis (PrEP) is a course of medications used to prevent the transmission of HIV in people who have not yet been diagnosed with HIV. The use of non-occupational post-exposure prophylaxis (PEP) in a safe and timely manner is an intervention for individuals recently exposed to HIV. PrEP alone has the potential to avert approximately 48,000 additional HIV diagnoses over the next five years. Unfortunately, PrEP utilization goals, particularly among vulnerable communities, have not been achieved due to a lack of investment. Health departments require additional funding for these interventions to ensure their success.

HOW FUNDS ARE ALLOCATED OR USED:

Category A Funds are awarded to state and eligible local health departments based on a formula. 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 eligible for EHE funds receive them based on a formula.

PUBLIC HEALTH IMPACTS:

More than 1.2 million people are living with HIV in the United States. The implementation of high-impact prevention has correlated with many successes in preventing new HIV transmissions. However, since 2013, new HIV diagnoses have plateaued at around 38,000 per year. From 2015 to 2019, new HIV diagnoses decreased by 9%, though unevenly. New diagnoses among women decreased 15%. During this time, the percentage of people aware of their HIV status increased from 80% to 87%. However, further progress in preventing new HIV transmissions is imperative. An overwhelming percentage of new HIV diagnoses are among GBM.



Organization name: National Alliance of State and Territorial AIDS Directors (NASTAD)

Topic area: HIV and Hepatitis Programs

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

Agency: Centers for Disease Control and Prevention

Program, office, or center: Viral Hepatitis Programs

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Viral Hepatitis Prevention	\$39,500	N/A	N/A	\$134,000

(Dollars in thousands)

FUNDING RECOMMENDATION:

Appropriate \$134,000,000, an increase of \$94.5 million for the Viral Hepatitis Prevention program at the Centers for Disease Control and Prevention (CDC) Division of Viral Hepatitis (DVH).

JUSTIFICATION:

Currently, 59 jurisdictions receive funding for hepatitis prevention and surveillance. The nation is committed to eliminating viral hepatitis by 2030, as laid out in the Department of Health and Human Services (HHS) Viral Hepatitis National Strategic Plan.

Despite these commitments, CDC's viral hepatitis program has been underfunded for decades. Recent increases in the number of new hepatitis B (HBV) and hepatitis C (HCV) cases driven by injection drug use, as well as the workforce strains caused by the COVID-19 pandemic, place a new urgency for increasing funding to viral hepatitis prevention programs. According to the CDC 2019 Viral Hepatitis Surveillance Report, the number of new cases of HCV increased by 93% from calendar years 2013 to 2018, with new cases in 2019 significantly exceeding CDC's targeted cap to set the nation on a path to achieving viral elimination. Available data suggest that up to 70% of new HCV infections are attributable to injection drug use and shared injection equipment. Additionally, despite the availability of preventive HBV vaccines, declining rates of HBV prevention have stagnated and are beginning to reverse.

Increasing funding would allow CDC's hepatitis program to: enhance existing and create a new program and clinical capacity and state and territorial health departments; increase provider education on updated HBV screening and vaccination recommendations; increase viral hepatitis surveillance infrastructure in health departments to detect acute viral hepatitis infections and enhance the ability to conduct cluster identification and investigations; increase capacity of health departments to work in coalition with community-based organizations to implement effective primary infectious disease prevention programs and services tailored to at-risk communities and persons who use drugs, and increase access to, and proper disposal of, sterile injection equipment, in areas where health departments and community-based harm reduction programs are authorized to operate.

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

FAST FACTS OR HIGHLIGHTS:

A 2016 Professional Judgement Budget from the CDC determined that a comprehensive hepatitis prevention program would require nearly \$4 billion over 10 years, or \$365 million per year—far short of current funding levels.

CDC DVH anticipates that it could immediately operationalize an increase of \$94.5 million, or \$134 million, for FY23.

Health departments need more resources to ensure that the nation is on track to eliminate Viral Hepatitis by 2030.

SUPPORTING ORGANIZATIONS:

The Hepatitis Appropriations Partnership supports this ask.

FOR MORE INFORMATION:

www.NASTAD.org

CONTACT INFORMATION:

Emily McCloskey,
Senior Director,
Policy and Legislative Affairs,
emccloskey@NASTAD.org,
202-897-0078

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 similarly seek innovative ways to continue hepatitis testing, including integrating hepatitis testing with COVID-19 testing. To scale up innovative programs that can reach individuals, investments must be made in the public health system to ensure continuity of services during public health emergencies. Hepatitis prevention programs have important testing disease intervention expertise to offer to the COVID-19 response. They also play a role in addressing racial disparities and stigma by focusing 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 focused on hepatitis prevention and elimination 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, HBV, and/or HCV infection that is 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 HBV and/or HCV in the United States. As many as 75% are unaware of their infection. CDC also estimates 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 noted that liver cancer cases – of which 20% are caused by hepatitis - and deaths are on the rise, in contrast to trends of most other cancers. Hepatitis disproportionately impacts several communities, particularly people who inject drugs, African Americans, Asian Americans, Latinos, Native Americans, men who have sex with men (MSM), residents of rural and remote areas, and people living with HIV. While people born between 1945 and 1965 represent the group with the highest HCV-related morbidity and mortality, there has been a rise in HCV infection among young people throughout the country. Some jurisdictions have noted that the number of people ages 15 to 29 diagnosed with HCV infection now exceeds the number of people diagnosed in all other age groups combined. This is typically attributed to injection drug use.

SEE UPDATES TO THIS PAPER AT:

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DATE: Jan. 30, 2022



National Coalition of STD Directors

Organization name: National Coalition of STD Directors
Topic area: Sexually transmitted diseases - clinical services
Name of appropriations bill: Labor, Health and Human Services
Agency: Health Resources and Services Administration
Program, office, or center: Office of Regional Operations

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Office of Regional Operations	N/A	N/A	N/A	\$200,000

(Dollars in thousands)

FUNDING RECOMMENDATION:

Appropriate \$200 million for a new program at the Health Resources and Services Administration to provide the first direct federal support for STI clinics.

BILL REPORT LANGUAGE:

STI Clinical Services – The Committee has included \$200,000,000 to support grants and contracts to public and private nonprofit STI clinics, to carry out demonstration projects to address staffing, training, clinical services and expand capacity to address shortages in the provision of STI clinical services in the public health system.

BILL LANGUAGE:

Provided, that \$200,000,000 to remain available until expended, shall be to carry out a program to award grants or contracts to public and private nonprofit sexually transmitted disease clinics for clinical services, pursuant to demonstration project authority under section 318(b)(2) of the Public Health Service Act (42 U.S.C. 247c(b)(2)).

JUSTIFICATION:

As STD rates continue to rise, neither private nor public healthcare systems have effectively addressed these epidemics. STDs represent a growing public health concern, especially as the COVID-19 pandemic has stretched thin existing infectious disease resources and has discouraged individuals from seeking preventive healthcare. STDs are also tied to health disparities and social need, with the populations most impacted by COVID-19 seeing disproportionately high rates of STDs, especially in communities of color.

Black non-Hispanic individuals contracted 30% of all chlamydia, gonorrhea, and syphilis cases in 2019 despite representing only 13% of the United States population. This is due to a lack of access to quality, affordable STD care. HHS has recognized that the epidemic is serious enough to warrant a new federal STI National Strategic Plan, but there is currently no dedicated federal funding stream to address the need for STD clinical services. Existing funding from the Centers for Disease Control and Prevention is targeted for surveillance and prevention, with a cap of 10% at the discretion of each state for clinical services.

FOR MORE INFORMATION:

www.ncsddc.org

CONTACT INFORMATION:

Stephanie Arnold Pang,
 senior director, policy and
 government relations
sarnold@ncsddc.org,
 612-220-2446

DATE: Feb. 8, 2022

ROLE OF THE STATE HEALTH AGENCY:

Our nation's safety net clinical services are funded through HRSA, and HRSA is the clinical service expert in HHS. This makes HRSA the best agency to run this first-ever dedicated federal STI clinical funding stream. This new funding stream would also provide an opportunity to further integrate STI clinical services into the activities of HRSA.

HOW FUNDS ARE ALLOCATED OR USED:

The project would be administered through HRSA's Office of Regional Operations that oversees the ten Regional Offices. Funds would be distributed in accordance with the STI National Strategic Plan, which identifies the South and West as having the largest burden of STD disease. A funding formula would be established, with allocations to regions based on morbidity and awarded by a competitive application process administered by the regional offices. Regions with higher morbidity (i.e., HHS Regions 4, 6 and 9) would receive higher levels of funding.

Public health clinics or private non-profit clinics who have demonstrated the ability to provide sexual health services to target populations would receive the funding. Clinics must demonstrate the ability to provide key STD clinical services (in accordance with the CDC recommendations for quality clinical services for STDs in STD specialty care settings) or develop the capacity to do so within twelve months of receipt of funds. To sustain and expand this investment, clinics must have the ability to bill public and/or private insurance or develop the ability to do so also within twelve months of receiving funds. Clinics cannot be excluded for reasons unrelated to their qualifications to provide the required services and effectively serve individuals in need.

PUBLIC HEALTH IMPACTS:

This project will provide an innovative change in our national STD response and determine if a federal investment in clinical STD services can reverse the current upward trend in STD rates. This project will work in conjunction with the recent Department of Health and Human Services investment to rebuild the Disease Intervention Workforce (DIS), which is dedicated to control STDs and other infectious diseases. Expanding clinical services funding will support the expanded DIS workforce as well as sexual healthcare providers, working in-sync to reduce STDs. This vital need for additional STD clinical care was identified in the National Academies of Science, Engineering, and Medicine (NASEM) report Sexually Transmitted Infections: Adopting a Sexual Health Paradigm, which stated: "[HHS]...should identify and support innovative programs to assure that STD... treatment services are available through multiple venues and assure that [the] federal government maximize[s] access opportunities for individuals who face healthcare access barriers."



National Coalition of STD Directors

Organization name: National Coalition of STD Directors

Topic area: Sexually transmitted diseases

Name of appropriations bill: Labor, Health and Human Services

Program, office, or center: National Center for HIV, Viral Hepatitis, STD and TB Prevention - Division of STD Prevention

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
National Center for HIV, Viral Hepatitis, STD and TB Prevention - Division of STD Prevention	\$ 161,810	N/A	N/A	\$329,200

(Dollars in thousands)

FUNDING RECOMMENDATION:

Appropriate a total of \$329.2 million at the Division of STD Prevention at the Centers for Disease Control and Prevention (CDC), an increase of \$167.4 million over FY21 funding. This includes \$50 million in one-time funding to move the grant year for State health departments engaged in STD prevention and control activities from January to July.

BILL REPORT LANGUAGE:

Sexually Transmitted Infections [STIs] – The Committee has included \$279,200,000 000 to combat the high incidence of (STIs).

The Committee recommends that CDC provide State and local funding at a larger percentage of STI prevention funding to address the high rates of STIs and plan for future public health emergencies. The Committee further directs that a portion of these funds be used to ensure that none of the grantees receives less than the amount received in fiscal year 2022 as well as to increase funding for training centers. The Committee has also included an additional amount of \$50,000,000, in one time funding, to move the grant year from January to July to provide for more efficient expenditure of funds and to permit grantees to better plan for and utilize appropriated monies.

JUSTIFICATION:

STDs are currently at their highest levels ever and have dire health consequences. The Division of STD Prevention at CDC funds all 50 state health departments and seven large local health departments to engage in STD prevention and control. In most jurisdictions, this is the only funding stream for STD prevention. For over 17 years STD programs were level funded, resulting in a 40% reduction in buying power and the resulting need to rebuild the STD health infrastructure. In addition, COVID-19 emergency response continues to have significant impacts on STD prevention efforts across the nation. During the pandemic response, 78 percent of the STD/HIV health department workforce were redeployed to COVID-19 emergency response, including a large portion of the disease intervention specialists (DIS)/contact tracers who were tracking STDs. The disruptions to STD prevention efforts due to the COVID-19 response has a direct correlation to the increase in STD rates.

A one-time investment of \$50,000,000 must also be made to change the current grant year, from January to July, for state health departments engaged in STD prevention and control activities. Under the current timetable, state health departments must submit

FAST FACTS OR HIGHLIGHTS:

STDs are currently at the highest levels ever.

The COVID-19 pandemic has greatly disrupted STD health department and clinical STD rates.

STD programs have lost nearly 40% in buying power over the last two decades.

SUPPORTING ORGANIZATIONS:

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

grant applications by Jan 1, based on the previous year's funding level, because final appropriations have not been enacted. Once appropriations are enacted, states must file additional paperwork before any funds added by Congress can be distributed. Moving the grant year to July—which is a common application date for many grant programs—would lessen the administrative burden on state health departments and ensure more efficient use of funds.

ROLE OF THE STATE HEALTH AGENCY:

Stopping 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 healthcare 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. Grants to health departments range from \$300,000 to \$6.9 million.

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 have increased 279% since 2015, and deaths associated with congenital syphilis increased 22%.

FOR MORE INFORMATION:

www.ncsddc.org

CONTACT INFORMATION:

Stephanie Arnold Pang,
senior director, policy and
government relations
sarnold@ncsddc.org,
612-220-2446

DATE: Jan 31, 2022



Organization name: Safe States Alliance

Topic area: Injury and Violence Prevention

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

Agency: Centers for Disease Control and Prevention

Program, office, or center: Core State Injury Prevention Program (SIPP)

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Core SIPP	\$ 6,650	N/A	N/A	\$ 11,650

(Dollars in thousands)

FUNDING RECOMMENDATION:

Appropriate \$11.65 million, a \$5 million increase for the Core SVIPP.

JUSTIFICATION:

Administered by the CDC's National Center for Injury Prevention and Control (NCIPC), the Core SIPP 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 SIPP can only fund 23 states. While these states have achieved important accomplishments, the program is not nearly large enough to impact injury and violence at the population level.

Base funding levels have been capped at \$250,000 per state for more than a decade. Six of the 23 states receive additional funds of approximately \$150,000 under an Enhanced Component. Core SIPP also includes a requirement that funded states address three topic areas prioritized by the NCIPC in 2021: traumatic brain injury, Adverse Childhood Experiences (ACEs), and transportation-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 SIPP 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.

HOW FUNDS ARE ALLOCATED OR USED:

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

FAST FACTS OR HIGHLIGHTS:

Core SIPP helps health departments identify and respond to existing and emerging injury threats:

- Injuries are the leading cause of death for Americans age 1 to 44.
- More than 240,000 die each year due to a sustained injury.
- 27 million suffer non-fatal injuries requiring and ED visit.

FOR MORE INFORMATION:

<https://www.cdc.gov/injury/stateprograms/index.html>

CONTACT INFORMATION:

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

DATE: Jan. 26, 2022

PUBLIC HEALTH IMPACTS:

Core SIPP 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 implementing *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 concussions 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**.
- Reaching record high seatbelt use after passage of a permanent primary seatbelt law in **Rhode Island**.



Organization name: Safe States Alliance

Topic area: Injury and Violence Prevention

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

Agency: Centers for Disease Control and Prevention

Program, office, or center: Firearm Injury and Mortality Prevention Research

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
Firearm Injury and Mortality Prevention Research	\$12,500	N/A	N/A	\$50,000

(Dollars in thousands)

FUNDING RECOMMENDATION:

Appropriate \$50 million in FY 2023 to support 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.

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 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, environmental, and system change. The public health approach to gun violence prevention includes defining the problem, identifying risk and protective factors, developing and testing prevention strategies, and assuring widespread adoption of targeted programs.

HOW FUNDS ARE ALLOCATED OR USED:

Funds will be used to support grants that examine the root causes and prevention of gun violence, focusing on those questions with the most significant potential for public health impact.

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.

FAST FACTS OR HIGHLIGHTS:

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

- Nearly 40,000 fire-arm-related deaths.
- More than 86,000 non-fatal firearm injuries treated in emergency departments.
- \$229 billion in medical and lost productivity costs.

FOR MORE INFORMATION:

<https://www.cdc.gov/violenceprevention/firearms/index.html>

CONTACT INFORMATION:

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

DATE: Jan. 26, 2022

- The risk factors and protective factors for interpersonal and self-directed firearm violence.
- 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
- The University of Michigan at Ann Arbor
- The University of California, 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

This research aims to stem the continued rise of firearm violence in communities across the country and decrease the occurrence of mass shootings.



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)

Program	FY21 Enacted	FY22 Enacted	FY23 President's Request	FY23 Recommendation
National Violent Death Reporting System	\$24,500	N/A	N/A	\$34,500

(Dollars in thousands)

FUNDING RECOMMENDATION:

Appropriate \$34.5 million for the NVDRS program in FY 2023.

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.

NVDRS has seen many successes as increased funding and support have led to tremendous growth in the program. However, its ongoing evolution means opportunities for improving program implementation and expanding utilization of the data in the field to 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 and 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.

ROLE OF THE STATE HEALTH AGENCY:

In most 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 provide 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

FAST FACTS OR HIGHLIGHTS:

In the United States

- More than 7 lives are lost per hour due to violence.
- Nearly 20,000 people were victims of homicide.
- More than 47,000 people died by suicide in 2019 alone.

FOR MORE INFORMATION:

<https://www.cdc.gov/violenceprevention/datasources/nvdrs/index.html>

CONTACT INFORMATION:

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

DATE: Jan. 26, 2022

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 the rate of violent deaths.

PUBLIC HEALTH IMPACTS:

NVDRS data helps build the evidence base that informs the design and implementation of violent death prevention programs. Examples include:

- 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 lethality assessment pilot program. Police respond 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 is at increased risk for suicide. As a result, a symposium was conducted with the two largest employers in the state to raise 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 suicide trends in the state.



National Headquarters: 2231 Crystal Dr #450, Arlington, VA 22202
Regional Office: 600 Peachtree Street NE, Suite 1000, Atlanta, GA 30308



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