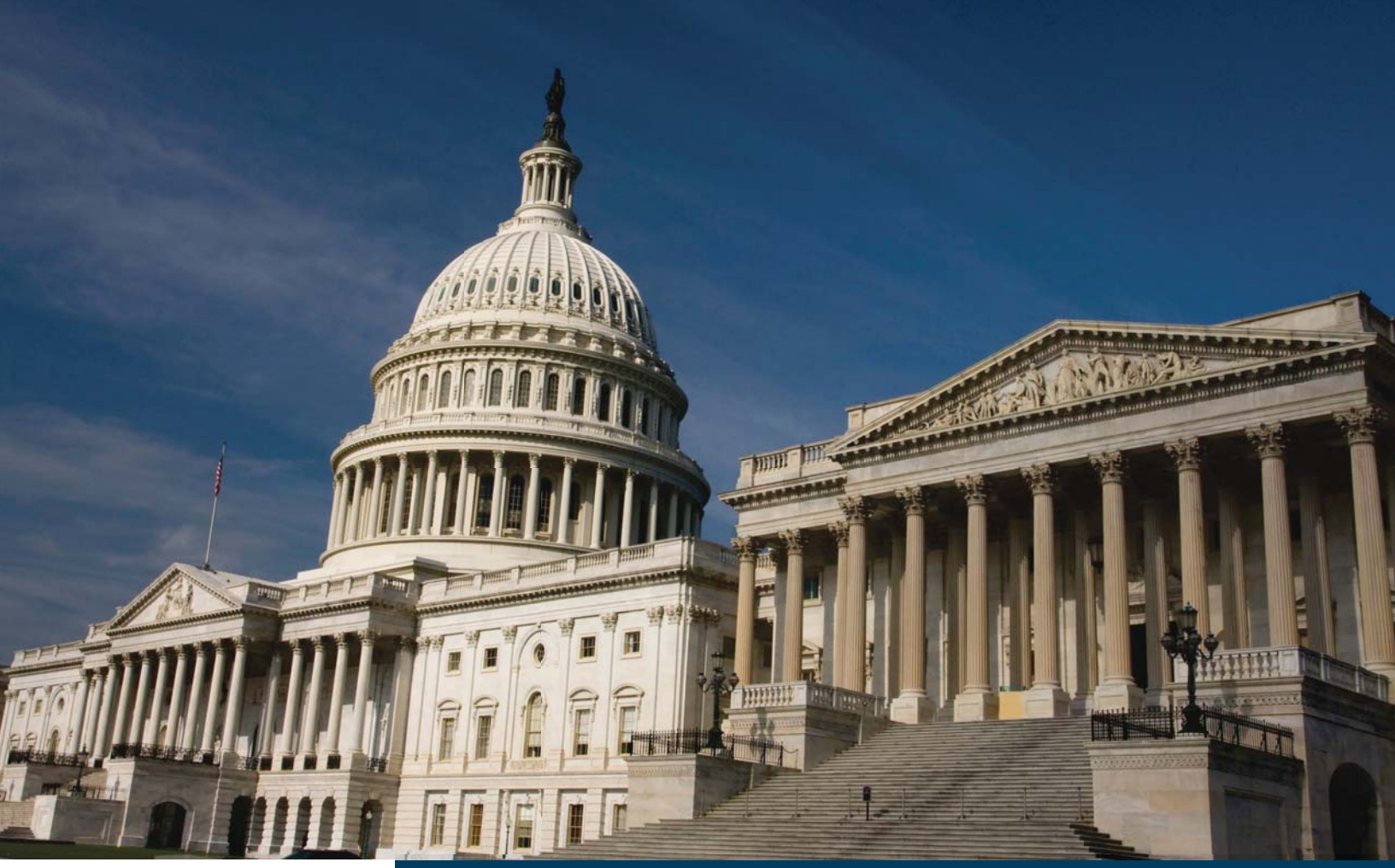

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

FY20 Governmental Public Health Appropriations Book

astho™

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 21 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.

State and territorial public health agencies face considerable challenges in the current fiscal environment. Federal resources account for nearly half of all state and territorial health department funding. ASTHO and its affiliates strongly urge Congress to prioritize funding for public health programs in FY20 so that this important work can continue.

This book compiles top federal funding priorities and recommendations for nonprofit public health associations in FY20. 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 Association of Chronic Disease Directors
National Alliance of State and Territorial AIDS Directors
National Association for Public Health Statistics and Information Systems
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 Carolyn Mullen (cmullen@astho.org).

Sincerely,

Michael Fraser, PhD, MS, CAE, FCPP
Chief Executive Officer, ASTHO

Table of Contents

Association of State and Territorial Health Officials
Topic Area: Public Health Preparedness

Labor, Health and Human Services, Education, and Related Agencies
Assistant Secretary for Preparedness and Response (ASPR)
Hospital Preparedness Program

(dollars in thousands)

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
Hospital Preparedness Program (HPP)	$265,000	$257,555	$474,000

Funding recommendation: Appropriate $474 million which is a $209 million or a 79% increase over FY19 enacted levels 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 health care coalitions.

Justification: As the only source of federal funding that supports regional health care system preparedness, HPP promotes a sustained national focus to improve patient outcomes, minimize the need for supplemental state and federal resources during emergencies, and enable rapid recovery. This funding request does not yet return levels seen since 2003, however, the demand on the health care system remains the same, if not more.

HPP prepares the nation's healthcare system to save lives during disasters and emergencies.

HPP is the only source of federal funding for health care delivery system readiness.

Healthcare coalitions incentivize diverse health care organizations to work together.

98% of HPP awardees say that HPP funding has been critical to health care preparedness and response.

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

How funds are allocated or used: The average one-year award amount is $5.7 million with a total project length of five years. The current five-year project period is from 2017-2022. The state/territory is required to make nonfederal contributions in the amount of 10 percent ($1 for each $10 of federal funds provided in the cooperative agreement) of the award. Funds for preparedness activities go to 62

state, local, and territorial public health systems from the ASPR Division of Grants Management. Awardees include state health departments, select large U.S. cities, and eight U.S. territories and freely associated states.

Public health impacts: HPP contributes to the progress of healthcare systems through the years in response to Ebola, active shooters, chemical explosions, hurricanes and more have saved lives by supporting training, coordination to ensure medical readiness, medical response coordination, continuity of health care services delivery, and medical surge.

Supporting organizations: Trust for America's Health (TFAH) and National Association of County and City Health Officials (NACCHO) also support this request.

For more information: http://www.astho.org/Programs/Preparedness/

Contact information:
Carolyn Mullen, Chief, Government Affairs and Public Relations, cmullen@astho.org, 571-318-5402
Carolyn McCoy, Senior Director, Federal Government Relations, cmccoy@astho.org, 571-522-2307

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

Date: April 4, 2019

Association of State and Territorial Health Officials
Topic Area: Public Health Preparedness

Labor, Health and Human Services, Education, and Related Agencies
Centers for Disease Control and Prevention
Public Health Preparedness and Response

(dollars in thousands)

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
Public Health Emergency Preparedness (PHEP) Cooperative Agreement	$675,000	$675,000	$824,000

Funding recommendation: Appropriate $824 million which is a $149 million or 22% increase over FY19 enacted levels for the Public Health Emergency Preparedness Cooperative Agreement.

Bill or report language: The PHEP cooperative agreement provides critical funding to state, territorial, and local health departments to enhance and improve their capabilities to prepare for and respond to a range of public health threats including infectious diseases, natural disasters, and biological, chemical, nuclear, and radiological events. The federal dollars delivered through PHEP help develop emergency-ready public health departments that are flexible, adaptable, and resilient.

Justification: Since its establishment in 2002, the program has invested in states and territories to create and maintain foundational capabilities. It is critical to provide stable and sufficient health emergency preparedness funding to maintain a standing set of core capabilities, so they are ready when needed. The program funding once at $918 million in 2002 is 36% lower at $675 million, with public health threats not experiencing similar declines.

Even small reductions in funding – such as the 2016 redirection of $44 million from PHEP for the federal Zika response – have major impacts on workforce, training, and readiness. These cuts cannot be backfilled with short-term funding after an event.

The PHEP cooperative agreement program funds 62 state, local, and territorial public health systems.

Funding provided through the PHEP cooperative agreement has supported more than 8,000 state and local public health emergency operations center activations since 2005.

Since September 11, 2001, the PHEP program has saved lives by building and maintaining a nationwide public health emergency management system that enables communities to rapidly respond to public health threats.

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 legal authority to protect and promote the health, safety, and general welfare of their populations. Over the last 15 years, 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.

How funds are allocated or used:
The average one-year award amount is $10 million with a total project length of five years. The state/territory is required to make nonfederal contributions in the amount of 10% ($1 for each $10 of federal funds provided in the cooperative agreement) of the award. CDC's Division of State and Local Readiness administers funds for preparedness activities to 62 state, local, and territorial public health systems through the PHEP cooperative agreement program. Awardees include state health departments, select large U.S. cities, and eight U.S. territories and freely associated states. The PHEP program funds almost 4,000 full- and part-time public health preparedness personnel across the country, including nurses, laboratorians, epidemiologists, IT specialists, planners, trainers, educators, and communications specialists.

Public health impacts: Since September 11, 2001, the PHEP program has saved lives by building and maintaining a nationwide public health emergency management system that enables communities to rapidly respond to public health threats. In the last decade, funding provided through the PHEP cooperative agreement has supported over 4,000 doctors, nurses, and emergency response specialists serving in more than 8,000 state and local public health emergency operations center activations.

Supporting organizations: Trust for America's Health (TFAH) and National Association of County and City Health Officials (NACCHO) also support this request.

For more information: http://www.astho.org/Programs/Preparedness/

Contact information:
Carolyn Mullen, Chief, Government Affairs and Public Relations, cmullen@astho.org, 571-318-5402
Carolyn McCoy, Senior Director, Federal Government Relations, cmccoy@astho.org, 571-522-2307

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

Date: April 4, 2019

Association of State and Territorial Health Officials
Topic Area: Core Public Health Funding

Labor, Health and Human Services, Education, and Related Agencies
Centers for Disease Control and Prevention
Cross-Cutting Activities and Program Support

(dollars in thousands)

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
Preventive Health and Health Services Block Grant	$160,000	$0	$170,000

Funding recommendation: Appropriate $170 million, which is a $10 million or 6.25% increase for the Preventive Health and Health Services Block Grant (Prevent Block Grant).

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

Justification: For more than 30 years the Prevent Block Grant has served as an essential source of funding for state and territorial health agencies. Peak funding was in 1999 at $194.9 million, meaning funding 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 use these flexible dollars to offset funding gaps in programs that address the leading causes of death and disability. These funds also enable states to respond to unanticipated or emerging public health threats.

Role of the state health agency: State and territorial health agencies are 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.

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 Prevent Block Grant is a non-categorical source of funding to address any of the 1,200+ national health objectives available in the nation's *Healthy People 2020* health improvement plan.

One hundred percent of funding for the Prevent Block Grant is provided through the Prevention and Public Health Fund.

How funds are allocated or used: Administered by the CDC's Center for State, Tribal, Local, and Territorial Support, the Prevent Block Grant funds 61 grantees: all 50 states, the District of Columbia, 2 American Indian tribes, 5 U.S. territories and 3 freely associated states. Grantees set their own goals and program objectives and implement strategies to address national health priorities. For FY17, grantees received a total of $147,109,167 in Prevent Block Grant funding. Of this funding, $130,348,208 is

discretionary health topic area funding which is allocated by grantees based on their priority public health needs. In addition, $7,000,000 is legislatively mandated for sexual violence/rape prevention activities. The remaining $9,760,959 is used for grantee administrative costs.

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

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

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

Supporting organizations: National Association of County and City Health Officials (NACCHO) also support this request.

For more information: http://www.astho.org/

Contact information:
Carolyn Mullen, Chief, Government Affairs and Public Relations, cmullen@astho.org, 571-318-5402
Carolyn McCoy, Senior Director, Federal Government Relations, cmccoy@astho.org, 571-522-2307

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

Date: April 4, 2019

Topic Area: Biosafety/Biosecurity

Labor, Health and Human Services, Education and Related Agencies
Centers for Disease Control and Prevention
Emerging and Zoonotic Infectious Diseases

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
Ebola Supplemental	$10 million	$0	$10 million

Funding recommendation: Appropriate $10 million which is a level funding from 2017 and 2018 for biosafety/ biosecurity efforts by public health laboratories.

Report language: Provide increased ELC funding in fiscal year 2020 for CDC to continue biosafety/biosecurity practices including outreach to the private sector.

Justification: Biosafety and biosecurity are an integral part of a quality laboratory system. Issues such as incorrect packaging and shipping of biological agents, discovering long forgotten smallpox samples stored in freezers, inappropriate inactivation of anthrax potentially exposing workers and the response to the Ebola outbreak have shown serious gaps within existing biosafety and biosecurity programs. Specific gaps such as the inability to correctly package and ship samples exposed unmet needs within the laboratory system.

Funding for the CDC to sustain biosafety and biosecurity

Support PH laboratory outreach and training to clinical laboratories

Bridge the lack of connectivity between healthcare and public health systems.

State and local public health laboratories are working closely with CDC to strengthen biosafety and biosecurity in the nation's laboratories by providing:

1. Subject matter experts who develop and provide guidance and tools to public health laboratories and maintain a community of practice for over 140 public health biosafety professionals.
2. Laboratory coordination and outreach to ensure a more robust public health system capable of safely responding to all threats, convening workshops covering all 62 CDC-funded jurisdictions, and providing tools such as risk assessment templates for outreach to private sector clinical laboratories.
3. Creation of the Biosafety and Biosecurity Committee, which has representatives from public health laboratories, private clinical laboratories, partner organizations, and other biosafety experts.

Role of the state health agency:
With CDC funds state and local public health laboratories:

1. Hire biosafety officers; these professionals play a key role across public health and sentinel clinical laboratories - like hospitals - to lead biosafety and biosecurity activities.
2. Update biosafety guidelines and plans.
3. Conduct risk assessments to ensure highly infectious specimens can be safely handled and disposed.
4. Identify gaps and implement mitigation strategies.
5. Collaborate with other public health laboratory staff and clinical partners to develop and ensure access to biosafety tools and training for sentinel clinical labs. This program allowed 45 public health laboratories to provide over 240 biosafety training courses, reaching over 2,700 clinical laboratorians, and 49 public health laboratories provided packaging and shipping certification to clinical laboratories in their jurisdiction reaching over 2,900 laboratorians

How funds are allocated or used: Centers for Disease Control and Prevention (CDC) provided funds to state and local health departments via the Domestic Ebola Supplemental to Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) - Building and Strengthening Epidemiology, Laboratory and Health Information Systems Capacity in State and Local Health Departments. Specifically, CDC allocated $21 million over the course of FY16, FY17 and FY18 to enhance laboratory biosafety and biosecurity across the nation. This funding reaches 62 state, local and territorial public health laboratory awardees.

Public health impacts: Public health and clinical laboratories play a pivotal role in surveillance, outbreak response and disease detection. To ensure that laboratories can safely and quickly detect threats, it is imperative to have a long-term sustainable funding strategy for biosafety and biosecurity to make laboratories safer for scientists and communities while assuring clinical facilities provide the appropriate standard of care.

For more information: APHL 2019 Fact Sheet on Biosafety/Biosecurity; APHL 2018 Document on Biosafety/Biosecurity.

Contact information: Peter Kyriacoploulos**,** Senior Director, Public Policy, Association of Public Health Laboratories, 240-485-2766, peter.kyriacopoulos@aphl.org

Date: April 4, 2019

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Topic Area: Chronic Disease

Labor, Health and Human Services, Education Appropriations Bill
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

(dollars in thousands)

Program	FY19	FY20 President's Request	FY20 Recommendation
Preventive Health and Health Services Block Grant	$160,000	$0	$170,000
Nutrition, Physical Activity, and Obesity	$56,920 + $15,000 high rate counties	$0	$110,000 + $15,000 high rate counties
Diabetes Prevention and Control	$148,129	$0	$185,000
Heart Disease and Stroke Prevention	$140,062	$0	$160,037

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

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

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

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

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

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

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

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

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

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

For more information: http://www.chronicdisease.org/

Contact information: Amy Souders, Cornerstone Government Affairs; asouders@cgagroup.com

See updates to this paper at: https://chronicdisease.site-ym.com/page/h_governmentaffairs

Date: April 4, 2019

Topic Area: Epidemiology and Laboratory Capacity

Labor, Health and Human Services, Education and Related Agencies
Centers for Disease Control and Prevention
Emerging and Zoonotic Infectious Diseases

(dollars in thousands)

Program	FY19	FY20 President's Request	FY20 Recommendation
Emerging and Zoonotic Infectious Diseases	$612,372	$509,472	$660,000

Funding recommendation: Appropriate $660 million, which represents a roughly $40 million increase over FY19.

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

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

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

How funds are allocated or used: In FY 2018, base funding for ELC was $208 million. It is important to note that within this total, nearly $40 million of total ELC funding stems from the Prevention and Public Health Fund. The continuation of this mandatory ELC funding is critical to the nation's core surveillance capacity.

ELC grants are awarded to state health agencies competitively. In FY 2018, grant sizes ranged from $192,000 (Marianna Islands) to $9.8 million (Texas) and were used to build and maintain an effective public health workforce for rapid response to infectious disease outbreaks; strengthen cross-cutting national surveillance systems; boost laboratory infrastructure with the latest diagnostic technologies; and improve health information systems to efficiently transmit, receive, and analyze infectious disease-related data electronically.

Public health impacts: Supported by funding from the ELC, 50 states, six local health departments, and eight territories quickly identified a nationwide E coli outbreak linked to romaine lettuce; detected and implemented containment strategies for emerging resistant threats like Candida auris; investigated rare but serious cases of Acute flaccid myelitis (AFM); tracked the spread of tickborne disease using new technologies; continued to monitor for Zika virus to prevent its spread; and strengthened detection of antibiotic resistant infections like drug resistant tuberculosis and "nightmare bacteria" carbapenem-resistant Enterobacteriaceae.

Supporting organizations: Council of State and Territorial Epidemiologists; Association of Public Health Laboratories

For more information: A funding table summarizing ELC funding is available at: https://www.cdc.gov/ncezid/dpei/elc/elc-awards-by-grantee-2018.html

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

Contact information: Emily Holubowich, Senior Vice President, CRD Associates, 202-484-1100 ext 143, eholubowich@dc-crd.com

Date: April 4, 2019

NASTAD (National Alliance of State & Territorial AIDS Directors)
Topic Area: HIV and Hepatitis Programs

Labor, Health and Human Services, Education, and Related Agencies
Centers for Disease Control and Prevention
Division of Viral Hepatitis

(dollars in thousands)

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
Viral Hepatitis Prevention	$39,000	$39,000	$134,000

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

Justification: Currently, 48 states and the District of Columbia receive funding for hepatitis prevention. The United States lacks a national, coordinated surveillance system for hepatitis and most states are unable to fund surveillance activities.

64% of new HCV infections are among people who inject drugs

Hepatitis A cases increased 44.4% from 2015-2016.

There are alarming increases in the number of new hepatitis B (HBV) and hepatitis C (HCV) cases, primarily associated with the opioid crisis According to the CDC, the number of new cases of HCV increased 350% between 2010 and 2016, mainly due to the increase in injection drug use. The opioid crisis also reversed a steady decline in the number of new HBV cases, causing a 20% increase in 2015. There was a 22% increase in the rate of acute hepatitis C from 2015 to 2016. It is imperative to act on the urgent need for additional funding at CDC to respond appropriately to the recent explosion of opioid use in the United States that has created tremendous risk for HCV, HBV and HIV outbreaks.

Outbreaks of HIV and HCV related to the shared use of syringes have occurred in Indiana, San Diego, Kentucky and elsewhere in the past two years. The CDC has identified 220 counties across 26 states that are vulnerable to outbreaks of HCV and HIV. Over 93% of those 220 counties vulnerable to outbreaks do not currently have comprehensive syringe service programs. Without these programs and the resources needed to provide sterile injection materials, transmission rates will continue to increase. Multiple studies have shown that, the presence of comprehensive syringe service programs at the community level is effective at decreasing HIV prevalence.

Increasing funding would allow CDC's hepatitis program would enhance existing, and create new, program and clinical infrastructure, increase education to high risk groups and affected communities, including pregnant women, about the intersection of the opioid epidemic and infectious diseases, increase viral hepatitis surveillance infrastructure in state health departments to detect acute viral

hepatitis infections and enhance ability to conduct cluster identification and investigations, increase capacity of community coalitions, state health departments, and community based organizations to implement effective primary infectious disease prevention programs and services tailored to persons who use drugs and have opioid use disorders and increase access to, and proper disposal of, sterile injection equipment, where legal and with community support.

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

How funds are allocated or used: 48 states and the District of Columbia receive funding for hepatitis prevention.

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

Supporting organizations: The Hepatitis Appropriations Partnership supports this ask.

For more information: www.NASTAD.org

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

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

Date: April 4, 2019

NASTAD (National Alliance of State & Territorial AIDS Directors)
Topic Area: HIV and Hepatitis Programs

Labor, Health and Human Services, Education, and Related Agencies
Centers for Disease Control and Prevention
Division of HIV Prevention

(dollars in thousands)

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
Domestic HIV/AIDS Prevention and Research	$788,700	$928,712	$872,000

Funding recommendation: Appropriate $872.7 million which is an $83 million increase for Domestic HIV/AIDS Prevention and Research above FY19 enacted levels.

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

HIV diagnoses are decreasing, though unevenly.

Blacks/African Americans accounted for 44% of HIV diagnoses.

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

The number of new HIV infections must decrease to address to see meaningful improvements in individual and community level health outcomes, particularly among disproportionately impacted populations. It is clear that early detection, linkage to and retention in care, and adherence to treatment will suppress individual and community viral loads and reduce the incidence of HIV. Unfortunately, only 50 percent of people living with HIV have an undetectable viral load. Addressing interventions along the HIV care continuum is our newest and most effective tool to get to zero new HIV infections; however, health departments need additional support to successfully implement these strategies.

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

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

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

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

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

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

For more information: www.NASTAD.org

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

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

Date: April 4, 2019

NASTAD (National Alliance of State & Territorial AIDS Directors)
Topic Area: HIV and Hepatitis Programs

Labor, Health and Human Services, Education, and Related Agencies
Health Resources and Services Administration
Ryan White HIV/AIDS

(dollars in thousands)

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
Ryan White HIV/AIDS program Part B	$1,315,000	$1,315,000	$1,380,300

Funding recommendation: Appropriate $1.38 billion for the Ryan White HIV/ AIDS program Part B, inclusive of the AIDS Drug Assistance Program, which is $65,300,000 above the FY19 enacted level.

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

85% of Ryan White Program clients had reached viral suppression. This figure exceeds the national PLWH viral suppression rate of 49%.

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

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

abuse treatment services. Grant recipients are required to spend at least 75% of their Part B grant funds on core medical services and no more than 25% on support services."

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

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

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

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

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

For more information: www.NASTAD.org

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

Date: April 4, 2019

ASSOCIATION OF IMMUNIZATION MANAGERS

Topic Area: Immunization

Labor-HHS-Education Appropriations Bill
Centers for Disease Control and Prevention
Immunization

(dollars in thousands)

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
Section 317 Immunization Program	$610,847	$532,673	$710,847

Funding recommendation: Appropriate $710.847 million, which is a $100 million or 16% increase for the Section 317 Immunization Program above FY19 enacted levels. This increase is critical to implement new vaccines, sustain and update Immunization Information Systems (IIS), and respond to the growing number of hepatitis A, measles, mumps, influenza and other outbreaks.

Justification: Vaccines save lives, but without a public health support system assuring the administration of vaccines to recommended populations, proper storage of vaccines to maintain potency, education of providers and consumers, surveillance of diseases and control of outbreaks, and management of the federal Vaccines for Children Program serving millions of children each year; vaccines would just sit on the shelf.

Last year's deadly flu season resulted in 185 childhood flu-related deaths
31,200 of 33,700 HPV-related cancers could be prevented each year in the U.S.

The opioid epidemic has led to a 114% increase in hepatitis B cases in Kentucky, Tennessee and West Virginia

As of July 25 2019, there have been 1,164 measles cases confirmed in 30 states in 2019—a dramatic increase from the 372 measles cases in 2018.

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

How funds are allocated or used: Funds are awarded to 64 state, local and territorial health agencies by formula based largely on population. The growth of electronic health records, new vaccines and school requirements, as well as continuing unpredictable disease outbreaks, has increased the complexity of vaccine management, and additional base funding is needed for each state to maintain sound and efficient immunization infrastructure.

Public health impacts: For each dollar invested in the U.S. childhood immunization program, there are over ten dollars of societal savings and three dollars in direct medical savings. Moreover, childhood

immunizations over the past twenty-five years have prevented 381 million illnesses, 855,000 deaths, and nearly $1.65 trillion in societal costs. In the 2017 – 2018 season alone, flu vaccination prevented an estimated 5.3 million illnesses. Maintaining high vaccination coverage is vital for preventing epidemics of diseases that cause preventable illness, disability and death.

Supporting organizations: National Association of City and County Health Officials (NACCHO), Every Child By Two (ECBT), American Academy of Pediatrics (AAP), 317 Coalition, Adult Vaccine Access Coalition (AVAC), Immunization Action Coalition (IAC)

For more information: www.immunizationmanagers.org, Vaccinate Your Family (www.vaccinateyourbaby.org), www.VaccinateYourFamily.Org, www.cdc.gov/vaccines, American Academy of Pediatrics https://immunizations.aap.org, www.317coalition.org, www.adultvaccinesnow.org, www.immunize.org

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Date: April 4, 2019

SAFE STATES

Topic Area: Injury and Violence Prevention

Labor, Health and Human Services, Education and Related Agencies
Center for Diseases Prevention and Control
Core State Violence and Injury Prevention Program (SVIPP)

(dollars in thousands)

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
Core SVIPP	$6,723	$6,723	$20,000

Funding recommendation: Appropriate $20 million to support the nationwide expansion of CDC's Core State Violence and Injury Prevention Program (SVIPP).

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

Each year in the U.S., injury and violence account for:

- More than 231,191 deaths
- 3 million hospitalizations
- 32 million emergency department visits
- $671 billion in medical and work loss costs

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

How funds are allocated or used: Grants are competitively awarded to state health departments and funds are awarded based on grant requests. Average grant size is $250,000.00 and support basic program funding for coordinated and comprehensive state injury and violence prevention programs.

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

- Piloting prescription drug misuse and abuse initiative in three Arizona counties;

- Enhancing Colorado's Prescription Drug Monitoring Program through statewide policy and systems changes;
- Implementing an online surveillance system in the Twin Cities (MN) for concussion in high school athletes;
- Preventing infant abuse by spreading the Period of Purple ® Crying Program in hospitals in Oklahoma; and,
- Reaching record high seatbelt use after passage of a permanent primary seatbelt law in Rhode Island.

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

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Date: April 4, 2019

SAFE STATES

Topic Area: Injury and Violence Prevention

Labor, Health and Human Services, Education and Related Agencies
Center for Diseases Prevention and Control
Gun Violence Prevention Research

(dollars in thousands)

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
Gun Violence Prevention Research	$0	$0	$50,000

Funding recommendation: Appropriate $50 million in new funding to support gun violence prevention research.

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

Each year in the US, gun violence accounts for:

- Over 38,000 firearm-related deaths
- More than 81,000 non-fatal firearm injuries treated in emergency departments
- $47 billion in medical and lost productivity costs

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

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

Public health impacts: Funds to support gun violence research will identify evidence-based approaches aimed at the prevention of gun violence. This effort will stem the continued rise of gun violence in communities across the country and decrease the occurrence of mass shootings in our nation's schools.

For more information: http://www.nationalacademies.org/hmd/Reports/2013/Priorities-for-Research-to-Reduce-the-Threat-of-Firearm-Related-Violence.aspx

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Date: April 4, 2019

Topic Area: Maternal and Child Health

Labor-HHS-Education Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau

(dollars in thousands)

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
Title V Maternal & Child Health Services Block Grant	$677,700	$660,700	$712,000

Funding recommendation: Appropriate $712 million, which is the amount provided for the Title V Maternal & Child Health Services Block Grant in the House-passed Labor-HHS appropriations legislation.

Justification: The MCH Block Grant is the only federal program of its kind devoted solely to improving the health of all women and children in the United States. The flexible nature of the MCH Block Grant is an invaluable resource for states to use to address the most pressing needs of MCH populations while maintaining high levels of accountability and utilizing evidence-based strategies. Currently, Title V programs are also being called upon to invest additional resources to address emerging issues such as the opioid epidemic.

States use Title V MCH Block Grant funding for activities such as:

- Conducting maternal mortality reviews
- Reducing low-risk cesarean deliveries
- Promoting adolescent well-visits

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

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

Public health impacts: Although funding for the MCH Block Grant has slightly increased in recent years, it is still funded at $53.6 million less than FY2002, when the program was funded at $731.3 million. This reduced investment comes at a time when the United States continues to witness rising maternal mortality rates and persistent disparities in maternal and infant health outcomes.

Background information: Another key component of the MCH Block Grant is the Special Projects of Regional and National Significance (SPRANS). SPRANS funding complements and helps ensure the success of state Title V, Medicaid, and CHIP programs by driving innovation and building capacity to create integrated systems of care for mothers and children. Examples of innovative projects funded through SPRANS include the new state maternal health innovation grants; 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; and health safety standards for out-of-home childcare facilities.

For more information: www.amchp.org

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Date: August 1, 2019

Association of State and Territorial Dental Directors
Topic Area: Oral Health

Labor, Health and Human Services, Education Appropriations Bill
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division of Oral Health

(dollars in thousands)

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
Division of Oral Health	$19,000	$17,000	$36,500

Funding recommendation: The CDC Division of Oral Health, which is located in the CDC National Center for Chronic Disease Prevention and Health Promotion, currently receives $19 million from Congress to distribute to states for oral heal prevention programs. The Association of State and Territorial Dental Directors strongly recommends an appropriation of $36.5 million for the Division of Oral Health, which is a $17.5 million increase from their current funding over FY19 levels. Of the additional $17.5M, $11.5M would go towards funding 30 more states, $3.5M would support the provision of program technical assistance and support for surveillance, evaluation, policy and communication activities, and $2.5M would go towards research, epidemiologic analysis, translation of science to action, infection prevention, etc.

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

Role of the state health agency: State health agencies are responsible for assessing and tracking oral disease in the state's population, developing and implementing policies and programs to prevent or minimize the disease, and 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 states that were previously funded, are no longer funded (Alaska, Hawaii, Illinois, Maine, Michigan, Mississippi, Nevada, New York, Oregon, Texas, Wisconsin).

Public health impacts:

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

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

For more information: http://astdd.org

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Date: April 4, 2019

Topic Area: Public Health Data/IT Systems Modernization

Departments of Labor, Health and Human Services, Education and Related Agencies
Centers for Disease Control and Prevention
Public Health Scientific Services

(dollars in millions)

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
NEW! Data/IT Systems Modernization	--	--	$100 million

Funding recommendation: Appropriate $1 billion over 10 years—$100 million in FY 2020—for a new comprehensive, transformative initiative that will modernize the public health surveillance enterprise by both upgrading IT systems and recruiting and retaining skilled data scientists at CDC and state, local, tribal, and territorial health departments.

Bill or report language: *Public Health Data/IT Systems Modernization* – The nation's public health data systems are antiquated, rely on obsolete surveillance methods, and are in dire need of security upgrades. Lack of interoperability, reporting consistency, and data standards leads to errors in quality, timeliness, and communication. In addition, public health professionals are faced with rapid advances in data science and evolving cybersecurity threats, and many do not yet have the necessary 21st century skills to understand and securely integrate health data. The Committee provides $100 million in FY 2020 to the Centers for Disease Control and Prevention (CDC) to modernize IT systems and recruit and retain skilled data scientists both at CDC, and state, local, and territorial health departments.

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

The development of 21st century data systems and the public health workforce needed to operate and maintain them have been woefully underfunded.

In the same way a $40 billion federal investment in the private sector 10 years ago transformed health care delivery, a $1 billion investment over the next decade at CDC and health departments would transform today's public health surveillance into a state of the art, secure, rapid response system.

In addition, public health professionals are faced with rapid advances in data science and evolving cybersecurity threats. Degree programs and early- and mid-career workforce development overhauls

are needed for epidemiologists, vital registrars, and laboratorians, and other public health professionals to perform 21st century skills.

This funding would represent the first-ever comprehensive, dedicated, and sustained investment in public health surveillance modernization.

Role of the state health agency: Critical public health data originate in the community. Public health departments are responsible for the collection, reporting, analysis, and security of these data provided by health care providers via health records, vital records, and laboratory samples. These data are shared by health departments with CDC to provide national data on health.

How funds are allocated or used: CDC would allocate funding to state, local, tribal, and territorial health departments to support improvements in the following:

- **National Notifiable Disease Surveillance System (NNDSS)**. NNDSS collects vital individual case investigation data at state, local, tribal, and territorial public health agencies from hospitals, physicians, and labs and sends case investigation data to the CDC to create a national snapshot of health.

  Funding for NNDSS would improve (1) data security across the infrastructure, (2) automated electronic receipt of data (existing and new data sources), (3) interoperability, integration, intelligent and real-time analysis of data from multiple sources (clinical, lab, epidemiologic), and (4) rapid, seamless, efficient communication of robust data to and from health care providers and CDC, which would result in accelerated disease prevention.

- **Electronic Case Reporting (eCR).** eCR is the automatic submission of disease reports directly from electronic health records at clinical care organizations (e.g., hospitals, health systems, community health centers) to state, local, tribal, and territorial public health departments.

  Funding for eCR would be transformational and (1) initiate broad-scale, secure reporting from electronic health records in clinical care organizations to public health agencies from a handful of sites to across all jurisdictions, (2) support interoperability, intelligent, seamless and real-time reporting from multiple sources and; (3) eliminate paper-based provider reporting.

- **Syndromic Surveillance.** Syndromic surveillance provides near real-time data on every hospital emergency department visit for near real-time detection and continuous monitoring of community health incidents, such as the impact of natural disasters including hurricanes, flu pandemics, and opioid overdoses.

  Funding for syndromic surveillance would (1) expand the number of hospitals participating, (2) expand reporting to other health system entry points such as urgent care centers (3) add predictive analytics and artificial intelligence detection algorithms to uncover changes in the occurrence of illnesses and injuries.

- **Electronic Vital Records System.** The electronic vital records system is a national, but federated system of 57 vital records jurisdictions that provide secure electronic collection of birth and death data from hospitals, funeral homes, physicians and medical examiners.

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

- **Laboratory Systems.** Laboratory systems—including Laboratory Information Management Systems (LIMS), the Laboratory Response Network (LRN), electronic lab reporting (ELR)—and are the backbone of how laboratory data is collected, managed, and shared to inform public health decision-making, including such aspects as sample submission, tracking, results, and communication of results to submitters and to disease detectives and investigators.

  Funding for laboratory information systems would (1) expand public health laboratories' data storage capacity, exchange, and analytics as they implement next generation bioinformatics tools, including advanced molecular detection (AMD), (2) enhance systems to interface LIMS with laboratory instruments to eliminate hand data entry of results leading to faster, more accurate reporting, (3) build robust electronic test order and result (ETOR) systems that rapidly share sample status and results across public health departments and with CDC, and (4) ensure secure, instantaneous communication of results from the public and private sector to disease detectives and investigators

- **Public Health Workforce.** The public health workforce of today and tomorrow must acquire new skills to understand and securely integrate health data to:

  - Provide more complete, accurate, and timely population-level monitoring;
  - Ensure optimal health security through robust public health surveillance to prevent death and disease;
  - Move data to action by driving policy and practice to accelerate health improvement;
  - Reduce provider reporting burden; and
  - Bolster and maintain cybersecurity.

  Developing this newly-skilled, public health data scientist will require direct hiring authority for federal agencies, an increase in salary caps to recruit and retain optimal staff, new curricula, professional development, post-graduate fellowships, and on-the-job training. New jobs are needed in the public and private sector across jurisdictions including assurance of adequate cross training and scalable surge capacity staffing to effectively meet public health response and data systems demands.

Public health impacts: The development of 21st century data systems and the public health workforce needed to operate and maintain them have been woefully underfunded. National public health surveillance saves lives, and has been built through a strong, long-standing partnership with the CDC and state, local, tribal, and territorial public health departments. But just as health threats continue to evolve, so too must public health's modes and methods. In the same way a $40 billion federal investment in the private sector 10 years ago transformed health care delivery, a $1 billion investment over the next decade ($100 million in FY 2020) at CDC—and through it, funding to directly support the state, local, tribal, and territorial health departments—would transform today's public health surveillance into a state of the art, secure, and fully interoperable system. Indeed, it's the connection of

the health care and public health systems—seamlessly sharing information—that will offer returns on these investments, and ultimately improve Americans' health.

Supporting organizations: The following organizations support this request: Association of Public Health Laboratories, Council of State and Territorial Epidemiologists, National Association for Public Health Statistics and Information Systems.

For more information: https://www.cdc.gov/surveillance/pdfs/Data-and-IT-Transformation-IB-508.pdf

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Date: April 4, 2019

Topic Area: Sexually Transmitted Disease

Labor, Health and Human Services Bill
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
Division of STD Prevention (DSTDP)

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
Division of STD Prevention	$157.3 million	$157.3 million	$227.31 million

Funding recommendation: Appropriate $207.31 million for base activities at the Division of STD Prevention (DSTDP), which is a $50 million increase over FY19 levels, as well as $20 million for a new initiative to eliminate congenital (mother-to-child) syphilis.

Bill or report language: CDC - HIV, Viral, Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention:
Sexually Transmitted Infections (STIs) – The Committee is concerned with the continued rise in STIs. According to the CDC it is estimated that nearly 20 million new cases of STIs occur each year and one in two persons will contract an STI by the age of 25. The Committee directs the CDC to increase direct funding to State and local health departments to provide resources for identifying, tracking, and treating those infected with an STI. The Committee further directs that within the additional funding provided, a portion of these funds may be used to increase funding to STD training centers.

For the fourth year in a row STDs are at a record high.

STD funding has remained flat for the last 20 years.

Congenital syphilis has increased 154% since 2013.

CDC:
Congenital Syphilis (CS) – The Committee is concerned regarding the recent data showing that CS cases are at the highest level since 1997. Untreated syphilis during pregnancy is associated with spontaneous abortion, stillbirth, infant mortality and can facilitate HIV transmission. To address the rise in CS cases, the Committee has included $20 million for congenital syphilis elimination initiative, with funds distributed to all STD funded health departments with a priority given to jurisdictions with the highest prevalence of CS cases. The Committee urges the CDC to design an initiative that will, among other approaches, strengthen prenatal outreach programs in high burden states, for patients, including those with a drug addiction, who are at a high risk for contracting syphilis. The Committee further urges the CDC to increase awareness of CS through community organizations and urges the CDC to inform STD and drug addiction clinics of the importance of multi-testing throughout pregnancy.

Justification: STDs are currently at their highest levels ever and have dire health consequences. The Division of STD Prevention at CDC funds all 50 state health departments and seven large local health

departments to engage in STD prevention and control. In most jurisdictions, this is the only funding stream for STD prevention. The current funding level is $157.3 million. We must increase funding for STD prevention to $227.3 million annually to avert the below consequences.

Increases in syphilis and congenital syphilis
Syphilis is at the highest levels ever and is associated with significant complications, including facilitating the transmission and acquisition of HIV. Congenital syphilis, mother-to-child transmission, is now at the highest rate since 2000. If left untreated passing on the infection during pregnancy can lead to infant death in up to 40 percent of cases.

Infertility
In 2016, almost 1.6 million new cases of chlamydia were reported, but this statistic is believed to be less than one-quarter of all new cases. Up to 40 percent of women with untreated chlamydia develop pelvic inflammatory disease (PID) that can require hospitalization and one in five women with untreated chlamydia will lose the ability to have children.

New cases of untreatable gonorrhea
Untreated gonorrhea can cause serious and permanent health problems including infertility in men and women. There is only one antibiotic option left to treat gonorrhea, and with drug resistant gonorrhea cases spreading in the world, it is only a matter of time before it arrives in the U.S. We must act now before it is too late.

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

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

Public health impacts: 2016 data released from the Centers for Disease Control and Prevention (CDC) show that STDs hit record highs in the U.S. for the fourth year in a row. Approximately 2.3 million cases of chlamydia, gonorrhea, and syphilis were diagnosed in 2017, an increase of more than 200,000 cases compared to 2016 and a more than 30 percent increase in the last five years. These entirely preventable, life-threatening infections cost the health care system more than $16 billion a year. Particularly alarming is that congenital syphilis has increased 154% since 2013. Congenital syphilis is totally preventable, each new case represents a major failure of the health care system and passing on the infection during pregnancy can lead to infant death in 40 percent of cases.

For more information: www.ncsddc.org

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Date: April 4, 2019

NAPHSIS
Protecting Personal Identity
Promoting Public Health

Topic Area: Vital Statistics

Labor, Health and Human Services, Education and Related Agencies
Centers for Disease Control and Prevention
National Center for Health Statistics

(dollars in millions)

Program	FY19 Enacted	FY20 President's Request	FY20 Recommendation
National Center for Health Statistics	$160.4 million	$155,000	$175 million

Funding recommendation: Appropriate $175 million, which is a $14.6 million or 9.2 percent increase over FY19 for the National Center for Health Statistics (NCHS).

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

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

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

The vital records jurisdictions—50 states, five territories, District of Columbia, and New York City—are legally responsible for the registrations of vital events including births, deaths, and fetal deaths.

In an example of effective federalism, the National Center for Health Statistics (NCHS) enters into contracts with the jurisdictions to obtain data on these events and compile national vital statistics through the Vital Statistics Cooperative Program.

Role of the state health agency: Vital records are permanent legal records of life events, including live births, deaths, fetal deaths, marriages, and divorces. Consistent with the constitutional framework set forth by our founding fathers in 1785, states were assigned certain powers. The 57 vital records jurisdictions, not the federal government, have legal authority for the registration of these records, which are thus governed under state laws. The laws governing what information may be shared, with whom, and under what circumstances varies by jurisdiction. In an example of effective federalism, the vital records jurisdictions provide the federal government with data collected through birth and death records to compile national health statistics, facilitate secure Social Security number (SSN) issuance to newborns through the Enumeration at Birth (EAB) Program, and report individual's deaths.

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

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

Supporting organizations: Friends of NCHS coalition (www.friendsofnchs.org)

For more information: www.naphsis.org

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