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FY24 Governmental

Public Health Appropriations Book

Dear Members of Congress:

The Association of State and Territorial Health Officials (ASTHO) is the national professional society representing state and territorial public health agencies. ASTHO's members—the chief public health officials of these jurisdictions—are dedicated to formulating, influencing, and implementing sound, evidence-based public health policy and assuring excellence in state-based public health practice. This work is supported by a network of 20 affiliate organizations with the mission to promote and protect the public's health and prevent illness and injury.

Public health depends on federal investment. As emergency supplemental funding expires, it is critical that Congress provide increased-long term, sustained, and flexible discretionary funding to support the public health workforce, modernize our data systems, and strengthen 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 state affiliate organizations strongly urge Congress to prioritize funding for all public health programs in FY24 so that this important work can continue.

This book compiles top federal funding priorities and recommendations for public health associations in FY24, aiming to ensure that Congress appropriates the necessary resources for federal health promotion and protection agencies. It includes appropriations recommendations from the following organizations:

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

We are 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 requests, please do not hesitate to contact a member of ASTHO's government affairs team: Jeffrey Ekoma (jekoma@astho.org) or Devon Page (dpage@astho.org).

Sincerely,

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

TABLE OF CONTENTS

ASPR APPROPRIATIONS

ASTHO - Hospital Preparedness Program..... 1

CDC APPROPRIATIONS

ASTHO - Preventive Health and Health Services Block Grant..... 3
ASTHO - Public Health Emergency Preparedness..... 5
ASTHO - Public Health Infrastructure and Capacity..... 7
ASTHO - Social Determinants of Health..... 9
Public Health Data Modernization Initiative..... 11
Center for Emerging and Zoonotic Infectious Diseases..... 13
Core State Injury Prevention Program..... 15
Firearm Injury & Mortality Prevention..... 17
HIV Prevention..... 19
National Center for Health Statistics..... 21
National Violent Death Reporting System..... 23
Nutrition, Physical Activity, and Obesity..... 25
Oral Health..... 27
STD Prevention..... 29
Section 317 Immunization Funding..... 31
Viral Hepatitis..... 33

HRSA APPROPRIATIONS

Bureau of Primary Health Care..... 35
Maternal and Child Health Bureau..... 37
Ryan White HIV/AIDS program..... 39

Topic area: Public Health Preparedness and Response
Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies
Agency: Administration for Strategic Preparedness and Response (ASPR)
Program, office, or center: Hospital Preparedness Program (HPP)

Program	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
Hospital Preparedness Program (HPP)	$295,555,000	$305,055,000	$312,055,000	$500,000,000

Funding recommendation: Appropriate $500 million, a $195 million—or 39%—increase over the FY23 enacted level for the Hospital Preparedness Program (HPP). At its height, funding for HPP was $515 million in FY03. After adjusting for inflation, program funds were halved over the past decade. The program authorization is in sections 319C-1 and 319C-2 of the PHS Act.

Fast Facts:

- HPP prepares the nation's healthcare system to save lives during emergencies and disasters.
- ASPR data show that approximately 96% of participating hospitals feel that HPP support has improved their ability to decrease morbidity and mortality during disasters.

Bill or report language: This funding is critical and provides grants to states to build healthcare coalitions that enhance regional and local hospital preparedness and improve overall surge capacity in public health emergencies. HPP must continue to fund existing awardees—all states, territories, freely associated states, and four directly funded large cities—as this program is critical to the foundational capabilities of healthcare preparedness.

Justification: As the only source of federal funding for health care system preparedness and response, HPP promotes a consistent national focus to improve patient outcomes during emergencies and disasters and enables rapid recovery. HPP supports health care coalitions (HCC). A HCC is a network of individual public and private organizations that are sometimes competitive entities that work together to respond to emergencies and disasters, ultimately increasing local and regional resilience. Despite modest annual appropriations increases and COVID-19 emergency funding, the HPP remains stretched due to prolonged emergency responses; increased preparedness and response requirements, and annual discretionary funding has not kept pace with inflation.

Role of the state health agency: State, territorial, and freely associated states' health agencies are critical to our nation's ability to prepare for, respond to, and recover from public health emergencies and threats. ASPR's HPP provides leadership and funding through cooperative agreements to states, territories, freely associated states, and localities to improve the healthcare system's capacity to plan for and respond to large-scale emergencies and disasters. Awardees (typically the state or territory) disburse funds to incentivize diverse and often competitive healthcare organizations to work together to prepare for and respond to medical surge events by forming healthcare coalitions. These coalitions organize at the local and regional levels to work together to prepare for, respond to, and recover from

all-hazards threats and emergencies. Foundational to this program is the expertise and training of grantees and responders with these resources.

How funds are allocated or used: The current project period is from 2019-2023. There was a one-year extension to the program period to 2023 due to the COVID-19 emergency. According to law, each awardee must make nonfederal contributions of 10% or $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, eight U.S. territories, and the freely associated states.

Public health impacts: HPP has contributed to healthcare system progress throughout the years, especially to the COVID-19 response, allowing hospitals to share PPE and other resources and coordinate among the coalitions to increase the efficiency of their services to the communities. HPP also supports responses and readiness exercises for various events, including the recent mpox and Ebola virus outbreaks, active shooters, chemical explosions, and hurricanes. HPP supports regional healthcare coalitions to incentivize healthcare readiness, assessing risks and needs, training the workforce, and maintaining preparedness among organizations that might otherwise see each other as competitors. According to an ASPR survey, 96% of awardees feel that HPP support has improved their ability to decrease morbidity and mortality during disasters.

For more information: See ASTHO's preparedness web page or the U.S. Department of Health and Human Services HPP web page.
Contact information: Jeffrey Ekoma, Senior Director of Government Affairs, ASTHO, jekoma@astho.org (443) 754-0393

See updates to this paper at: https://www.astho.org/globalassets/pdf/astho-appropriations-book.pdf
Last revised: April 11, 2023

Organization name: Association of State and Territorial Health Officials and 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	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
Preventive Health and Health Services Block Grant	$160,000,000	$160,000,000	$160,000,000	$175,000,000

Funding recommendation: Appropriation of $175 million, which is a $15 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. All these factors can be reduced or prevented through proven strategies involving state health agencies leading local communities to healthier more productive living. Increased funding is essential to maintain and expand current efforts in every state. Critical clinical community linkages and health promotion efforts are required to meet these goals.

Fast Facts:

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

Role of the state health agency: State health agencies have a unique role in efforts to coordinate activity and steer resources to communities most in need, creating linkages across systems with healthcare providers, insurers, educators, community organizations, and others. State participation is needed to maximize federal actions and 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 linkage with local governments and provider communities make states the logical and most efficient vehicle to manage these critical public health programs.

How funds are allocated or used: Funds are targeted to support state action to lead activities and

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

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

Background information: At the turn of the 20th century, the major causes of death and disease were markedly different from today. Modern challenges from infectious diseases have been far surpassed by chronic diseases such as diabetes, heart disease, stroke, and cancer. Significantly, seven out of 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 are, by definition, 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: ASTHO and NACDD work closely with many national partners to assure high-quality and consistent approaches to address these public health challenges. These include the American Diabetes Association, the American Heart Association, the 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
See updates to this paper at: https://chronicdisease.org/page/appropriations_fs/
Last revised: April 11, 2023

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: Office of Readiness and Response

Program	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
Public Health Emergency Preparedness	$715,000,000	$735,000,000	$735,000,000	$1,000,000,000

Funding recommendation: Appropriate $1 billion, a $265 million—or 36%—increase over FY23 enacted levels for the Public Health Emergency Preparedness Cooperative Agreement. At its height, funding for PHEP was $939 million in FY03. Therefore, a funding level of at least $1 billion will bring this program back to prior levels. Statutory authority for this program can be found in Section 319C-1 of the Public Health Service (PHS) Act (47 USC § 247d-3a), as amended.

Bill or report language: The committee provides increased investments to continue to enhance public health departments in developing and maintaining capable, flexible, and adaptable public health systems to respond to public health emergencies. America's public health preparedness systems need increased and stable base funding to rebuild, improve, and continue preparing for future public health emergencies.

Fast Facts:

- There are 62 PHEP cooperative agreement awardees: all 50 states, four metropolitan areas (Chicago, Los Angeles County, New York City, and Washington, D.C.), and eight U.S. territories and freely associated states that have developed strong public health emergency preparedness and response capabilities.
- Fully functional emergency operations centers, robust risk communication capabilities, and a nationwide laboratory and epidemiologic system are just a few readiness accomplishments achieved thanks to this federal investment.

Justification: ASTHO members are grateful for the increased funding provided for this program in the previous fiscal year. According to CDC data, as of Jan. 2023, PHEP funds supported more than 70% of state and local public health labs and more than 5,800 state, local, tribal, and territorial (SLTT) personnel, of which federal funds wholly support approximately 2,300 positions. Emergency supplemental funding for the COVID-19 response supported the immediate needs of the emergency. The pandemic response demonstrated the need to invest in these programs to rebuild and bolster the United States' preparedness response. CDC is currently refreshing its strategy based on lessons learned from COVID-19 to support and bolster SLTT public health with an updated response framework that prioritizes essential areas for the public to prepare for, respond to, and recover from health threats in the next five-year funding cycle beginning in FY24. America's public health preparedness systems will need increased and stable base funding for years to rebuild, improve and ensure our country is safe from 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 often legal authority 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 is stable and dependable. Increased base funding for this program should be commensurate with this need.

How funds are allocated or used: The PHEP program covers, in broad terms, the entire U.S. population and the public health systems within the United States and its territories and freely associated states. Specifically, Congress intends for the funds to support the needs of any community impacted by a public health emergency or disaster and to ensure that public health systems are ready and capable of keeping their communities safe and mitigating the impacts of any public health emergency. Additionally, there is a particular emphasis on ensuring the health needs of tribal populations, at-risk populations, and those with access and functional needs to ensure that plans and processes are in place pre-event and during an event to address the unique needs of this population. The 2019-2024 funding opportunity provides fiscal resources to 62 total SLTT public health agencies to advance their ability to demonstrate response readiness. It requires states to make available nonfederal 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. Subject to funding availability, CDC may introduce future projects through PHEP that support the development of critical public health preparedness capabilities in high-population cities during the 2019-2024 performance period.

Public health impacts: Since Sept. 11, 2001, PHEP has collaborated with SLTT health departments to prepare and plan for emergencies, resulting in measurable improvement. This program, over the years, 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 SLTT public health preparedness and response capability through a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action. An effective public health response prevents or reduces morbidity and mortality due to public health threats whose scale, rapid onset, or unpredictability stresses the public health system and ensures the earliest possible recovery and return of the system to pre-incident levels or improved functioning.

For more information: ASTHO's Preparedness web page and CDC's Emergency Preparedness Program and Guidance web page.

Contact information:
Jeffrey Ekoma, Senior Director of Government Affairs, ASTHO, jekoma@astho.org, (443) 754-0393

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

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Organization name: Association of State and Territorial Health Officials
Topic area: Core Public Health Capabilities
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	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
Public Health Infrastructure and Capacity	$200,000,000	$350,000,000	$600,000,000	$1,000,000,000

Funding recommendation: Appropriate $1 billion, a $650 million increase over FY23 enacted levels, for public health infrastructure and capacity.

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 emergency supplemental public health funding to mobilize a response. The ensuing "bust" is after the supplemental funding expires without increasing discretionary base funding of agencies when the acute public health threat subsides. This practice has a significant impact on the ability of jurisdictions to maintain workforce capacity and often results in shuttering programs.

Fast Facts:
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.

Increasing funding for public health infrastructure and capacity will disrupt this cycle by supporting 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. That this funding is disease-agnostic, flexible, and sustainable is imperative 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 identify community risks and strengthen partnerships.
- Create a comprehensive workforce development plan and develop a performance management system.
- Assessing the current capacity, gaps, and opportunities to modernize public health data collection and infrastructure.
- Enhancing workforce capacity 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.

Background information: In 2022, through the American Rescue Plan Act, CDC awarded $3.14 billion over five years to public health jurisdictions to support public health infrastructure, aiming to enhance the public health workforce and health departments' systems and processes. At the end of the five year period, recipients are expected to achieve specific outcomes. CDC hopes to award more than $4 billion over the grant period to ensure recipients' success. With the grant program expiring in November 2027, recipients face a funding cliff that will make increases in discretionary appropriation critical to support departments' infrastructure and innovation.

Supporting Organizations: Association of Public Health Nurses (APHN)
For more information: https://www.cdc.gov/infrastructure/index.html
Contact information: Devon Page, Government Affairs Analyst, ASTHO, dpage@astho.org
See updates to this paper at: https://www.astho.org/advocacy/federal-government-affairs/
Last revised: April 11, 2023

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	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
Social Determinants of Health	$8,000,000	$8,000,000	$100,000,000	$153,000,000

Funding recommendation: Appropriate $153 million, a $145 million increase over FY23 enacted levels, for social determinants of health (SDOHs) funding at the CDC.

Justification: SDOHs are critical drivers of health outcomes and rising health care costs. But through community-level assessments and long-term planning, changes in policies, programs, systems, and environments can improve SDOH in communities with the poorest health outcomes. An increase in funding will support the expansion of such activities, as well as ancillary activities including implementing stronger accelerator plans and building the evidence base to better understand factors that affect health.

Fast Facts:
Chronic diseases are leading causes of death and illness in the United States and leading drivers of the nation's annual $4.1trillion in health care costs (CDC, 2022).

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, 2022)

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. They are uniquely positioned to support community-driven SDOH work by providing actionable data, identifying and promoting evidence-based practices and policy interventions, as well as aligning community efforts across the state to ensure a shared mission and collective impact.

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 per grantee. Funds are used to develop action plans that assess community needs and identify ways to improve health outcomes related to chronic health conditions among population groups experiencing health disparities.

Background information: Conditions are less than optimal for many Americans, 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. Much of our health is influenced by non-medical, non-clinical factors, including our living environments, where we work, the quality of our housing, our access to meaningful employment, education, healthy foods, and recreational areas. These, among other factors, are social determinants of health (SDOHs); and by carefully and scientifically tailoring our resources to improve them, the health of Americans can profit tremendously.

For more information: https://www.cdc.gov/populationhealth/sdoh/index.htm
Contact information: Devon Page, Government Affairs Analyst, ASTHO, dpage@astho.org
See updates to this paper at: https://www.astho.org/advocacy/federal-government-affairs/
Last revised: April 11, 2023

Organization name: Association of Public Health Laboratories, Council of State and Territorial Epidemiologists, and 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: Centers for Disease Control and Prevention (CDC)
Program, office, or center: Public Health Data Modernization

Program	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
Data Modernization Initiative (DMI)	$100,000,000	$175,000,000	$340,000,000	$250,000,000

Funding recommendation: Appropriate $250 million, which is a $75 million increase, for the Data Modernization Initiative (DMI).

Bill or report language: "The committee is pleased to see progress towards the implementation of CDC's DMI and encourages the agency to continue to invest in the five key pillars of data modernization: electronic case reporting, laboratory information management systems, syndromic surveillance, electronic vital records systems, and the national notifiable disease surveillance system. The committee recommends CDC create an advisory council to formalize its engagement with representatives from state, territorial, local, and tribal (STLT) public health departments, health care providers, and the private sector towards the development and implementation of enterprise level public health data systems. The Committee recommends at least 50 percent of the funds be prioritized for STLT health departments."

Fast Facts:

More than 20,200 healthcare facilities adopted eCR between Jan. 2020 and Oct. 2022 for a total of more than 20,400 facilities.

All 50 states, DC, Puerto Rico, and 13 local jurisdictions have received initial electronic case reports for COVID-19.

Justification: The CDC's DMI is a commitment to build a world-class public health data infrastructure. Public health data are essential for an effective daily public health response and during public health emergencies. Despite this, many state, territorial, local, and tribal (STLT) health departments lack modern data systems and, while improvements have been made, still receive data from healthcare providers by fax or phone, inhibiting their ability to address public health threats in real time. STLT health departments rely on federal funding and do not have the resources to modernize their data systems without sustained annual resources.

Congress has provided more than $1 billion to date for DMI through annual and supplemental appropriations. These investments are already paying off. However, success cannot continue without

sustained annual funding for DMI. The Data: Elemental to Health campaign estimates the actual cost for DMI implementation at the state and local level is $1.57 billion per year for at least five years. Additional funds will be needed at the federal level. We are calling on Congress to invest at least $250 million in FY24 appropriations funding for DMI—an important annual commitment towards the total funding needed through additional federal sources.

Funding for DMI will also make possible the work of the Center for Forecasting and Outbreak Analytics (CFA). A $100 million appropriation for CFA in FY24 will fund the center to facilitate the use of data, modeling, and analytics to improve pandemic preparedness and response. CFA is already transforming our disease modeling capabilities.

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 to protect patient privacy. 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: STLT health departments and vital records offices apply for DMI funding through a competitive grant process. Awarded initiatives focus on the implementation of or upgrade to electronic, interoperable public health data and vital records systems, strengthening the underlying infrastructure and policy framework to facilitate the optimal use of these systems, and workforce development and training activities to build and retain a technically competent public health workforce. Improvements will be made across five key pillars of data modernization: the National Notifiable Disease Surveillance System, electronic case reporting (eCR), syndromic surveillance, electronic vital records systems, and laboratory systems, which encompasses Laboratory Information Management Systems (LIMS), Electronic Test Ordering and Reporting (ETOR), and Electronic Laboratory Reporting (ELR).

Public health impacts: Sustained investment in these critical activities is crucial for ensuring a strong and resilient nationwide public health network. Despite advancements in electronic lab reporting and eCR in many jurisdictions, much of public health data is still reliant on manual, disjointed processes, from paper and fax to antiquated web portals dependent on labor-intensive data entry. Recent public health events, including the COVID-19 pandemic and mpox, highlight the dangers of relying on outdated public health systems. Investing in the modernization of enterprise-wide public health laboratory and surveillance systems will support automated reporting between healthcare organizations and public health, improving the quality and timeliness of data for public health authorities and reducing the burden on medical providers and healthcare facilities.

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: For more information visit the CDC website and navigate to DMI and visit https://www.cste.org/page/DM-2021
Contact information: Meghan Riley, Vice President, CRD Associates, mriley@dc-crd.com
Last revised: April 11, 2023

Organization name: Association of Public Health Laboratories and Council of State and Territorial Epidemiologists
Topic area: Epidemiology and Laboratory Capacity Program
Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies
Agency: Centers for Disease Control and Prevention (CDC)
Program, office, or center: Emerging and Zoonotic Infectious Diseases and Epidemiology and Laboratory Capacity Program

Program	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
Center for Emerging and Zoonotic Infectious Diseases	$693,272,000	$750,773,000	$845,772,000	$1,300,467,000

Funding recommendation: Appropriate at least $1.3 billion for the Center for Emerging and Zoonotic Infectious Diseases. Funding from across this center is used to fund the Epidemiology and Laboratory Capacity (ELC) program. Additionally, Congress should appropriate at least $120 million for ELC's base funding, an $80 million increase, and make at least $500 million available through the ELC funding mechanism.

Fast Facts:

In FY20, public health departments requested $500 million through the ELC program, but CDC was only able to award $238 million. This gap must be addressed.

Bill or report language: "The Committee recognizes the need to increase resources that provide flexibility to state, territorial, and large local (STL) health departments to address gaps that are not funded by the disease-specific sections of the ELC cooperative agreement. The ELC program provides critical foundational support for STL health departments to fund epidemiology, surveillance, laboratory, and data science staff positions that provide the backbone for STL public health programs. This increase will allow STL health departments to build the public health workforce and infrastructure that will allow them to be better prepared to respond to emerging threats more quickly."

Justification: Funding across CDC's Emerging and Zoonotic Infectious Diseases (EZID) program is essential to combating new and emerging threats. Disease specific EZID funding bolsters the ELC program by directly supporting capacity within the specific program areas (e.g., vector-borne disease, foodborne disease, influenza, and healthcare-acquired infections); however, this funding is tied to a specific disease category and cannot easily be reassigned when a new threat emerges. Increased funding across EZID programs will allow for an increase in funding available to STL health departments through

the ELC mechanism, and it must be coupled with an increase in the foundational ELC program line, which has not been increased from $40 million since 2011.

The ELC program strengthens the epidemiologic and laboratory capacity in 50 states, six local health departments, and eight territories. As recent years have demonstrated via concurrent outbreaks of COVID-19, pediatric hepatitis associated with adenovirus, mpox, Ebola Sudan virus, and other threats, the United States is at high risk for new and emerging diseases. STL health departments require epidemiology, laboratory, and data science staff to address a wide range of disease threats. The ELC program is unique to CDC as it is the only source of support for core epidemiology and labs specifically intended to respond to outbreaks across the spectrum of infectious diseases. Increased funding is needed to enhance the core epidemiological response, which allows epidemiologists to respond to and support outbreaks for multiple disease threats.

With increased funds, CDC can provide additional support to reinforce everyday infectious disease programs and ensure they are able to adequately respond to future infectious disease outbreaks. Increased funding will also help to build the epidemiology workforce, allowing state and local health departments to begin to move towards establishing a minimum epidemiology workforce. Additional funds will also allow ELC to expand funding to large 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, and physical space and facilities.

Role of the state health agency: State and local health departments and laboratories are critical partners in these activities, serving on the front lines and conducting surveillance and epidemiologic investigations. 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, which represent our nation's leading causes of death.

How funds are allocated or used: The core ELC program is funded directly from the ELC program line and supports flexible positions to sustain broad infectious disease epidemiology and surveillance, laboratory, informatics, and data science staff. This section of the ELC program is intentionally broad and allows STL health departments to address their gaps in areas that are not funded by the disease-specific sections of the cooperative agreement grant (e.g., zoonotic diseases). In addition, ELC's leadership project is a relatively new part of the core ELC program that recognizes the need to fund dedicated leadership, management, and fiscal oversight positions at the STL level to make the best use of all funding awarded through ELC. Currently, only 25% of states get funding for staff to support leadership and fiscal oversight of these grant funds. An additional $23 million is needed within the core ELC line to bring this capacity to all jurisdictions. Last, Congress should give CDC authority for laboratory construction.

Public health impacts: Supported by funding from the ELC, 50 states, six local health departments, and eight territories monitor and respond to public health threats as they surge across the country and regularly respond to infectious disease outbreaks nationwide.

For more information: https://www.cdc.gov/ncezid/dpei/elc/history/core-funding-2021.html
Contact information: Meghan Riley, Vice President, CRD Associates, mriley@dc-crd.com
Last revised: April 11, 2023

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	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
Core SIPP	$6,700,000	$7,700,000	$7,700,000	$12,700,000

Funding recommendation: Appropriate $12.70 million, which is a $5 million increase for the Core SIPP program.

Bill or report language: "The agreement includes an increase of $5,000,000 to enhance efforts to identify and respond to injury threats with data-driven public health actions."

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 provides 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 is only able to fund 23 states. While these states have achieved important accomplishments, the program is not nearly large enough to meet its goal of impacting injury and violence at the population level. Congress approved an increase of $1 million in FY23, we would expect an additional 2-3 states to be funded with that increase.

Fast Facts:

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

- More than 240,000 die each year due to a sustained injury.
- 27 million people suffer nonfatal injuries requiring an ER visit.

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 that were prioritized by the NCIPC in 2021, which include traumatic brain injury, Adverse Childhood Experiences (ACEs), 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 limited availability of federal funds and support basic program funding for coordinated and comprehensive state injury and violence prevention programs.

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

- **North Carolina** is working to shift cultural standards related to youth sports concussion by identifying concussions and processes through the implementation of the CDC's HEADS UP initiative in middle and high schools throughout the state.

- **Kentucky** is implementing an evidence-based pediatric abusive head trauma (PAHT) education program for emergency medical services. This education program focuses on risk factors and prevention of PAHT.

- **Tennessee** is implementing *Coaching Boys into Men*. This is an evidence-based program that engages athletic coaches as positive role models to deliver violence-prevention messages to young male athletes. The Tennessee Core SVIPP is recruiting and training coaches to implement this program.

- **Louisiana** is supporting evidence-based projects, such as Graduated Driver Licensing and child passenger restraint, to reduce the rates of MVC injuries and fatalities. Louisiana focused on data and evaluation to inform statewide efforts, as well as linking MVC data to hospital discharge data.

For more information: https://www.cdc.gov/injury/stateprograms/index.html
Contact information: Chris D. Iacaruso, Manager of Government Relations, 678-608-1909, chris.iacaruso@safestates.org
Last revised: April 11, 2023

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 & Mortality Prevention Research

Program	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
Firearm Injury & Mortality Prevention Research	$12,500,000	$12,500,000	$35,000,000	$35,000,000

Funding recommendation: Appropriate $35 million in FY24 for the Firearm Injury & Mortality Prevention Research program at CDC.

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 a crucial step toward keeping individuals, families, schools, and communities safe from firearm violence and its consequences.

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

Fast Facts:

- In 2020, over 45,000 people died from gun-related injuries.
- More than 90,000 non-fatal injuries treated in ERs.
- $229 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 focused 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 greatest potential for public health impact.

Public health impacts: The National Center for Injury Prevention and Control funding opportunities are intended to support research that addresses:

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

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

Research Grants to Prevent Firearm-Related Violence and Injuries

The National Center for Injury Prevention and Control, Division for Violence Prevention is currently supporting 20 research awards to improve understanding of firearm injury, inform the development of innovative and promising prevention strategies, and rigorously evaluate the effectiveness of strategies to keep individuals, families, schools, and communities safe from firearm-related injuries, deaths, and crime.

Firearm Injury Surveillance Through Emergency Rooms (FASTER)

CDC's Division of Violence Prevention is funding 10 state health departments as part of a competitively funded initiative to provide surveillance data in near-real time on emergency visits for nonfatal firearm injuries.

For more information: https://www.cdc.gov/violenceprevention/firearms/index.html
Contact information: [Chris D. Iacaruso, Manager of Government Relations, 671-608-1909, chris.iacaruso@safestates.org
Last revised: April 11, 2023

Organization name: National Alliance of State & 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	FY22 Enacted	FY23 Enacted	FY24 President's Budget	FY24 Recommendation
Domestic HIV Prevention	$1,064,712,000	$1,013,000,000	$1,155,712,000	$1,222,700,000

Funding recommendation: Appropriate $1.22 billion, which is a $209.7 million increase, for the Division of HIV Prevention. Of the HIV prevention funding, $400 million is for the Ending the HIV Epidemic Initiative's implementation.

Justification: With the confluence of advances in science and policy, the United States has an unprecedented opportunity to achieve large-scale, measurable impact in a relatively short timeframe, drastically reduce health disparities, and end the HIV epidemic. To achieve this goal, the Domestic HIV Prevention and Research program must see increased funding. 60 health departments receive this funding (all 50 states, Washington, D.C., Puerto Rico, the 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 programs have challenges maintaining access to services, reporting significant decreases in testing and other prevention services. They 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 during this time, investments must be made in the public health system to ensure continuity of services during public health emergencies.

Fast Facts:

- PrEP (pre-exposure prophylaxis) can reduce your chance of getting HIV from sex or injection drug use. When taken as prescribed, PrEP is highly effective for preventing HIV.
- The number of PrEP users in the U.S. increased by 23% from 2020 to 2021.

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, D.C., 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 testing, linkage to care, and access to prevention modalities. Of the HIV prevention funding, $400 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. It is clear that early detection, linkage to and retention in care, and adherence to treatment will suppress

individual and community viral loads and reduce the incidence of HIV. Unfortunately, only 56% of people living with HIV have an undetectable viral load.

Role of the state health agency: Health departments are the cornerstone implementers of HIV prevention, coordinating federal, state, and local public health program and policy efforts. These efforts are essential in meeting high-impact prevention and the nation's established goals to combat the HIV epidemic: reducing the annual number of new HIV diagnoses and reducing HIV-related health disparities, particularly among communities of color and gay, bisexual, and other men who have sex with men of all races and ethnicities. Providing funding to health departments is CDC's single largest investment in HIV prevention, 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 Division of HIV Prevention is critical to continuing the progress we have made.

Pre-exposure prophylaxis (PrEP) is a course of medications used to prevent HIV transmission 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 states and eligible local health departments by formula, and states and eligible local health departments may apply for Category B funds for demonstration projects through competitive awards. Health departments can provide sub-grant awards to local health departments and/or community-based organizations. Health departments that are eligible for 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, but since 2013, new HIV diagnoses have plateaued at around 38,000 per year. From 2015 to 2019, new HIV diagnoses decreased by 9%. New diagnoses among women decreased 15%. 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 transmissions is imperative. An overwhelming percentage of new HIV diagnoses are among gay, bisexual, and other men who have sex with men.

Supporting organizations: The AIDS Budget and Appropriations Coalition supports this ask.
For more information: www.NASTAD.org
Contact information: Emily McCloskey, Senior Director, Policy & Legislative Affairs, NASTAD, (202) 897-0078, emccloskey@NASTAD.org
See updates to this paper: https://www.nastad.org/domestic/policy-legislative-affairs
Last revised: April 11, 2023

NAPHSIS
Protecting Personal Identity
Promoting Public Health

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	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
National Center for Health Statistics (NCHS)	$180,397,000	$187,397,000	$189,464,000	$215,000,000

Funding recommendation: Appropriate $215 million, which is a $27.6 million increase, for the National Center for Health Statistics (NCHS).

Bill or report language: "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 recommends CDC ensure that funding from the Data Modernization Initiative (DMI) is allocated to jurisdictions through NCHS to support necessary upgrades to their vital statistics systems to enable more, better, and faster vital records data."

Fast facts:
• Vital records systems capture data from about 6 million births and deaths annually and can signal trends and help monitor public health events.

• CDC's Data Modernization Initiative is working across CDC and states to improve electronic vital records systems.

Justification: NCHS data have long been the gold standard for measuring health status and changes in health outcomes for the most vulnerable populations and identifying emerging health issues for the nation. To remain so and to meet evolving data needs, NCHS' statistical systems need major upgrades. NCHS faces the challenge of continuing to provide essential data while also making these upgrades. Additional funds are required to support testing and innovation while NCHS continues to provide timely data.

Electronic Vital Records Systems, overseen by NCHS, are one of the five core pillars of the U.S. public health surveillance enterprise and requires urgent modernization to protect the health security of all Americans. The Electronic Vital Records System is a national network 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.

With additional annual investments, NCHS would continue to improve the vital records sharing process with states and jurisdictions. These investments will help advance public health to a fully modernized system capable of tracking critical mortality trends, such as opioid overdoses, suicides, and COVID-19 deaths.

NCHS plays a direct role in the DMI (see page on DMI) at CDC. For many years, states have been working to move from paper-based records to electronic vital records. Many "early-adopter" electronic states lack the resources to modernize their existing electronic systems to keep pace with new technology. Continued investment will help to maximize the potential of electronic systems and enhance data quality, specificity, accuracy, security, and timeliness. 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 legal authority for the registration of these records, which are thus governed under state laws. The laws governing what information may be shared, and with whom, and under what circumstances vary by jurisdiction. In an example of effective federalism, the vital records jurisdictions provide the federal government with data collected through birth and death records to compile national health statistics, facilitate secure social security number issuance to newborns through the Enumeration at Birth program, and report individual 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, for each of the 57 vital records jurisdictions. This is not nearly enough to run a state vital records program. Vital Records Offices are universally financially challenged and rely on data set and certificate sales to support their operations.

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% in 2010 to 65% in 2022.

Supporting organizations: Friends of NCHS (www.friendsofnchs.org)
For more information: https://www.cdc.gov/nchs/about/budget.htm
Contact information: Meghan Riley, Vice President, CRD Associates, mriley@dc-crd.com, (202) 484-1100
Last revised: April 11, 2023

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	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
National Violent Death Reporting System	$24,500,000	$24,500,000	$34,500,000	$34,500,000

Funding recommendation: Appropriate $34.5 million, which is a $10 million increase, for the National Violent Death Reporting System.

Fast Facts:
In the United States:

- Over seven people per hour die a violent death.
- Nearly 25,000 people were victims of homicide in 2020.
- 45,679 people died by suicide in 2022.

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

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

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

As NVDRS continues to expand, the program's infrastructure must be improved to allow states to analyze violent deaths across their entire population, capture complete data sets, and meet the needs of a true nationwide program. Moreover, for NVDRS to solidify its standing as the premier data repository

used to inform violent death research and practice, additional resources are needed to support greater data utilization, while testing innovative approaches that improve data collection, timeliness, and analysis.

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 provides states with valuable context about violent deaths, such as relationship problems; mental health conditions and treatment; toxicology results; and life stressors, including recent money- or work-related problems or physical health problems. With this more complete picture, public health officials are more effective at working together to identify those at risk and putting into place effective prevention policies and programs that may save lives.

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

Public health impacts: NVDRS data helps to build the evidence-based that informs the design and implementation of violent death prevention programs. Examples include:

- Kansas Attorney General used KS-VDRS to form a Youth Suicide Prevention Task Force. The task force used KS-VDRS data and CDC suicide prevention resources to develop eight recommendations for the state. Because of these recommendations, the attorney general's office appointed a legislatively mandated Youth Suicide Prevention Coordinator and is developing a suicide prevention mobile application to provide youth with mental health resources.
- The Wisconsin Department of Public Instruction used WI-VDRS data inform which school districts and communities would benefit most from the Wisconsin School Mental Health Project, which includes a focus on youth suicide prevention. The project aims to reduce perceived stigma associated with mental illness and accessing mental health services.
- Oklahoma used NVDRS data on intimate partner violence homicides to evaluate the effectiveness of a pilot lethality assessment program. Police responding to domestic violence incidents connected victims at high risk for homicide with a local domestic violence service provider.
- The Utah Department of Health's Violence and Injury Prevention Program used NVDRS data to develop a suicide awareness toolkit to equip local media to more adequately report on suicide trends in the state.

For more information: https://www.cdc.gov/violenceprevention/datasources/nvdrs/index.html
Contact information: Chris D. Iacaruso, Manager of Government Relations, 678-608-1909, chris.iacaruso@safestates.org
Last revised: April 11, 2023

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

Program	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
Nutrition, Physical Activity, and Obesity	$74,920,000	$74,920,000	$130,420,000	$125,000,000

Funding recommendation: The National Association of Chronic Disease Directors strongly recommends an appropriation of $125 million, which is a $53.08 million increase, for nutrition, physical activity, and obesity.

Fast Facts:

• Obesity costs the United States 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.

Justification: An increase in funding in FY24 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 and quality of life and help individuals maintain optimal health at every age. 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 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 non-profit partner organizations.

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. Nationally, 42% of adults and 19% of all children and adolescents (ages 2 to 19 years) have obesity. 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 1 in 4 young adults are too heavy to serve in our military.

Supporting organizations: NACDD works closely with many national partners to assure high quality and consistent approaches to address public health challenges. These include the American Diabetes Association, the American Heart Association, the 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
See update to this paper at: https://chronicdisease.org/page/appropriations_fs/
Last revised: April 11, 2023

Organization name: Association of State and Territorial Dental Directors
Topic area: Oral Health
Name of Appropriations bill: Labor, Health and Human Services, Education Appropriations Bill
Agency: Centers for Disease Control and Prevention
Program, office, or center: National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health

Program	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
Oral Health	$19,750,000	$20,250,000	$20,250,000	$44,250,000

Funding recommendation: The Association of State and Territorial Dental Directors strongly recommends an appropriation of $44.25 million for the Division of Oral Health, a $24 million increase over FY23 levels. With this increase, $4 million will go towards advancing medical-dental integration, including promoting recommendations from the National Action Framework to support whole-person integrated care and supporting partner engagement; $5 million will support updating infection prevention and control guidelines for dental settings; $5 million to initiate a mini-grant program for water systems to replace aging fluoridation equipment or initiate the use of new tablet technology that can bring fluoride to rural systems; and $10 million to overhaul the nation's surveillance systems to better identify oral health burden at national, state, and local levels and make data available more quickly. These activities are critical to ensuring that public health needs are addressed by investing in capacity at the national level.

Justification: The mouth and teeth are integral to human health and well-being. Oral diseases, including cavities, gum diseases, 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 chronic, just like diabetes and high blood pressure. They cause people to lose time from work, affect school performance, and impact some people's ability to get a job or enlist in the military. While CDC provides funding to every state health department for cancer, diabetes, cardiovascular diseases, and tobacco control programs, it funds less than half of states for oral disease prevention programs. These proposed efforts will allow CDC to identify areas with the greatest need, improve access to effective interventions, and improve care coordination for chronic diseases associated with poor oral health.

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

How funds are allocated or used: CDC grants are competitively awarded to 20 state health departments and one territory to implement core activities to improve oral health, and five states to integrate oral health with other chronic disease programs. State oral health programs assist in efforts to decrease cavities, oral health disparities, and other chronic diseases associated with poor oral health.

Public health impacts:

- Cavities are the most common chronic diseases in the United States.
- Over half (52%) of children aged 6 to 8 years have had a cavity in their primary (baby) teeth.
- 1 in 7 (13%) adolescents aged 12 to 19 years has at least one untreated cavity.
- 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 cavities in children could be prevented.
- More than 1 in 4 (27%) adults in the United States have untreated cavities.
- Nearly half (46%) of all adults aged 30 years or older show signs of gum disease; severe gum disease affects about 9% of adults.
- On average, over 34 million school hours are lost each year because of unplanned (emergency) dental care.
- Over $45 billion is lost in productivity in the United States each year because of untreated oral disease.
- The U.S. healthcare system could save up to $100 million a year if dental offices screened patients for diabetes, high blood pressure, and high cholesterol and referred them for treatment.
- Nearly 18% of working-age adults report that the appearance of their mouth and teeth affects their ability to interview for a job. For people with low incomes, the percentage increases to 29%.
- Oral health has been linked with other chronic diseases, like diabetes and heart disease. Risk behaviors such as tobacco use and consuming sugary foods and beverages have also been linked.

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, ASTDD, (775) 626-5008**,** cwood@astdd.org
Last revised: April 11, 2023

Organization name: National Coalition of STD Directors
Topic area: Sexually transmitted diseases
Name of appropriations bill: Labor, Health, and Human Services
Agency: Centers for Disease Control and Prevention (CDC)
Program, office, or center: National Center for HIV, Viral Hepatitis, STD and TB Prevention – Division of STD Prevention

Program	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
National Center for HIV, Viral Hepatitis, STD and TB Prevention – Division of STD Prevention	$164,300,000	$174,300,000	$174,300,000	$312,500,000

Funding recommendation: Appropriate $312.5 million, which is a $138.2 million increase, for the Division of STD Prevention at CDC.
Report language: "The Committee has included $312,500,000 to reduce and prevent the high incidence of sexually transmitted infections (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 outbreaks. Within the funds provided, the Committee has included $15,000,000 to move the grant year forward by one month to provide a more efficient expenditure of funds and improve grantee activities, with the intention that the grant year will be moved forward by one month each year for the next two years; and $3,000,000 to ensure that none of the grantees receives less than the amount received in FY 2023. The funds also include increased funding for training centers. The Committee also directs that the CDC lift the 10% cap on clinical services for STD health department grants, as well as caps on supplemental grants to give grantees the tools to effectively respond to STIs and the lingering effects of COVID-19 and mpox."

Fast Facts:

• STI rates have risen for the seventh year in a row.

• Chlamydia, gonorrhea, and syphilis cost the United States 1.1 billion in direct medical costs each year.

• After 20 years of funding declines, in 2023, federal funding finally returned to 2003 levels. Adjusted for inflation, departments have lost 40% of their purchasing power in that time.

Justification: STIs 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 STI prevention and control. In most jurisdictions, this is the only funding stream for STI 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 STI health infrastructure. In addition, the COVID-19 emergency response continues to have significant impacts on STI prevention efforts across the nation. During the pandemic response, 78% of the STD/HIV health department workforce was redeployed to the COVID-19 emergency response, including a large portion of the disease intervention specialists and contact tracers who were tracking STIs. These disruptions to STI prevention efforts have a direct correlation to the increase in STI rates, which were

further exacerbated by the 2022 mpox outbreak due to capacity and resources being diverted from core prevention work.

Building on the direction from Congress in FY 2023, which instructed the Division of STD Prevention to hold harmless state health departments' STI prevention and control funding levels and move the grant year forward one month to alleviate administrative burdens, the language request for FY 2024 includes a $3,000,000 set aside to hold harmless funding levels for awardees that may otherwise see a reduction in funding due to the nuances of the funding formula and includes another one-time investment of $15,000,000 to move the grant year forward another month in FY 2024 from February to March, with the ultimate goal of moving the grant year to July by 2028. This language is crucial to enable awardees to build on existing programs and not lose ground in the fight against STIs.

Role of the state health agency: CDC's Division of STD Prevention partners with all 50 state health departments and seven large urban areas to support STI prevention and surveillance through this funding.

How funds are allocated or used: Funds are awarded to state and city health agencies through an STI morbidity-based formula, and in FY 2023, no jurisdiction will receive less than it did in FY 2022. This funding is used by health agencies to support STI monitoring, outbreak response, assurance of appropriate screening and treatment by healthcare providers, contact tracing, linkage to care, and providing STI prevention information to the general public. In most jurisdictions, the state health agency is the sole entity doing this essential work.

Public health impacts: STIs are a growing threat to our nation's health. Chlamydia, gonorrhea, and syphilis infections breached 2.4 million reported cases in 2021. STIs 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 235% since 2016, and deaths associated with congenital syphilis have increased 210%.

For more information: www.ncsddc.org
Contact information: Stephanie Arnold Pang, Senior Director, Policy and Government Relations, NCSDDC, sarnold@ncsddc.org, (612) 220-2446
Last revised: April 11, 2023

Organization name: Association of Immunization Managers
Topic area: Immunization Funding
Name of appropriations bill: Labor-HHS-Education Appropriations Bill
Agency: Centers for Disease Control and Prevention (CDC)
Program: Section 317 Immunization Funding

Program	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
Section 317 Immunization Funding	$650,797,000	$681,933,000	$999,000,000	$1,130,000,000

Funding recommendation: Appropriate $1.13 billion, which is a $448 million increase, for the Section 317 Immunization Program. This increase is critical to avoid a funding cliff and sustain and build upon improvements made to conduct the COVID-19 vaccination campaign. It will support urgent routine vaccination catch-up efforts as well as 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.

Fast Facts:

- The COVID vaccination campaign illustrates the power of vaccines – saving 3.2 million lives, preventing over 18 million hospitalizations, and avoiding over $1 trillion in health care costs.
- Millions of children and adults are still behind on routine vaccinations due to the pandemic.
- Other infectious disease threats remain - 1,282 measles cases were confirmed in 2019, the greatest number of cases reported in U.S. since 1992, and the high number of flu, RSV, and COVID hospitalizations in winter 2022-23 stressed already stretched health care systems.
- 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.
- The U.S. spends nearly $27 billion annually to treat four vaccine-preventable illnesses (flu, pertussis, pneumococcal, and shingles).

Committee report language: "The Committee recognizes that the COVID-19 pandemic exposed critical gaps in our nation's immunization infrastructure resulting from years of stagnant funding. The agreement includes an increase to sustain improvements made with one-time emergency funding. It will enhance immunization efforts by increasing annual funding to jurisdictions to promote routine vaccines, improving data collection and public data presentation, and expanding and sustaining a network of public and private providers to ensure access to vaccines in all communities. CDC is expected to use this funding to promote enhanced and equitable access to protection from vaccine preventable diseases, as well as address vaccine hesitancy."

Justification: The need to establish and maintain a robust public health immunization infrastructure has never been greater. Jurisdictions need significant new resources to sustain improvements made with one-time emergency funding and avoid a funding cliff when emergency funds expire. Additional

resources are also needed to implement recent recommendations from the CDC Advisory Committee on Immunization Practices for expanded adult vaccination against hepatitis B, pneumococcal, and shingles, as well as potential breakthroughs addressing RSV.
Additional new program requirements from CDC to have all jurisdictions report all vaccine doses in real time to CDC cannot happen without new investments. 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 community-based organizations to build vaccine confidence and reduce disparities.

In 2019, the World Health Organization declared vaccine hesitancy as one of the top ten global threats. This threat is not going away and must be aggressively addressed by every state and local community. Congress can assert leadership now to assure that our nation's public health system does not repeat past cycles of panic and neglect. Now is the time to sustain the improvements being made through emergency supplemental funding. This will ensure that both routine immunization is 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 vaccine for uninsured adults; conduct outbreak response; enroll, educate, and provide vaccine to over 40,000 private physicians in the Vaccines for Children Program (vaccinating millions of children annually); track vaccination rates and vaccine inventory; and identify disease incidence and stop transmission of deadly, preventable disease.

How funds are allocated or used: Funds are awarded to 64 state, local, and territorial health agencies by a formula based largely on population.

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, CDC estimates that vaccination of children born between 1994 and 2021 will prevent 472 million illnesses, 29.8 million hospitalizations, and help avoid 1,052,000 deaths, saving nearly $2.2 trillion in total societal costs.

Inadequate vaccination will 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, Association of Immunization Managers, channan@immunizationmanagers.org, (301) 424-6080
Last revised: April 11, 2023. Data citations available upon request.

Organization name: NASTAD (National Alliance of State & Territorial AIDS Directors)
Topic area: HIV and Hepatitis Programs
Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies
Agency: Centers for Disease Control and Prevention
Program, office, or center: Viral Hepatitis Programs

Program	FY22 Enacted	FY23 Enacted	FY24 President's Budget	FY24 Recommendation
Viral Hepatitis Prevention	$39,379,000	$43,000,000	$54,500,000	$150,000,000

Funding recommendation: Appropriate $150 million, an increase of $107 million, for the Viral Hepatitis Prevention program at the Centers for Disease Control and Prevention (CDC) Division of Viral Hepatitis.

Justification: Currently, 59 jurisdictions receive funding for hepatitis prevention and surveillance. The nation is committed to eliminating the public health threat of 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, and recent increases in the number of new hepatitis B (HBV) and hepatitis C (HCV) cases driven by injection drug use, as well as the strains on the workforce caused by the COVID-19 pandemic, place a new urgency on increasing funding to viral hepatitis prevention programs. According to the CDC's 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 the use of shared injection equipment. Additionally, despite the availability of preventive HBV vaccines, declining rates of HBV prevention have stagnated and are beginning to reverse.

Fast Facts:

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

• Health departments need more resources to ensure that the nation is on track to eliminate viral hepatitis by 2030.

Increasing funding would allow CDC's hepatitis program to: enhance existing and create new program and clinical capacity in 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 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 programs are increasingly strained by the pandemic and have seen a significant decrease in their ability to do outreach, education, testing, and linkage services. Hepatitis programs are similarly seeking innovative ways to continue hepatitis testing, including integrating hepatitis testing with COVID-19 testing. To scale up innovative programs that 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 the COVID-19 response, and they also play an important role in addressing racial disparities and stigma through a focus on community-based networks and services.

Role of the state health agency: The state health department is the only government-funded entity in most states that is focused on hepatitis prevention and 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 HBV or HCV.

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 are tested for these infections, made aware of their infection, and linked to recommended care and treatment services.

Public health impacts: CDC estimates that up to 5.3 million people live with HBV and/or HCV in the United States. As many as 75% of those people 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 for most other cancers. Hepatitis disproportionately impacts several communities, particularly people who inject drugs, African Americans, Asian Americans, Latinos, Native Americans, men who have sex with men, residents of rural and remote areas, and people living with HIV. While people born between 1945 and 1965 represent the group with the highest HCV-related morbidity and mortality, there has been a rise in HCV infection among young people throughout the country. Some jurisdictions have noted that the number of people ages 15 to 29 being diagnosed with HCV infection now exceeds the number of people diagnosed in all other age groups combined, which is typically attributed to injection drug use.

Supporting organizations: The Hepatitis Appropriations Partnership supports this ask.
For more information: www.NASTAD.org
Contact information: Emily McCloskey, Senior Director, Policy & Legislative Affairs, NASTAD, (202) 897-0078, emccloskey@NASTAD.org
See updates to this paper at: https://www.nastad.org/domestic/policy-legislative-affairs
Last revised: April 11, 2023

Organization name: National Coalition of STD Directors
Topic area: Clinical services for sexually transmitted infections
Name of appropriations bill: Labor, Health, and Human Services
Agency: Health Resources and Services Administration
Program, office, or center: Bureau of Primary Health Care

Program	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
Bureau of Primary Health Care	N/A	N/A	N/A	$200,000,000

Funding recommendation: Appropriate $200 million for a new program at the Health Resources and Services Administration (HRSA) to provide the first direct federal support for sexually transmitted infections (STI) clinics.

Bill report language: "The Committee has included, within the Bureau of Primary Health Care, $200,000,000 for demonstration projects to support grants and contracts to public and private nonprofit STI clinics. Funds are to be used to address staffing, training, clinical services and expand capacity to address shortages in STI clinical services."

Bill Language: "Provided, that $200,000,000 to remain available until expended, shall be to carry out a program to award grants 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))."

Fast Facts:

• STIs are currently at the highest levels ever.

• There is no dedicated federal funding stream for STI clinical services.

• Our current approach to STIs is failing to keep up, and the COVID-19 pandemic and mpox outbreak have exacerbated existing issues.

Justification: As STI rates continue to rise, neither private nor public health care systems have effectively addressed these epidemics. STIs represent a growing public health concern, especially as the mpox outbreak stretched thin existing infectious disease resources and revealed the syndemic risk of STIs alongside HIV and mpox. In 2022, America's STI clinics were simultaneously our first and last line of defense for community responses to mpox; STI clinics diverted resources to ensure people could be tested, treated, and vaccinated for mpox and saw their capacity decimated by the pressure of the outbreak. However, in the midst of a public health emergency, these clinics received no federal funding support due to the lack of an existing funding infrastructure. America needs a dedicated funding stream for public and nonprofit STI clinics so that we can take a consistent and national public health approach to the treatment of STIs and other emerging infectious diseases.

Role of the state health agency: By applying HRSA's safety-net clinical service expertise to the out-of-control STI epidemics, this program will directly complement the surveillance and prevention work being done by CDC-funded state STD programs by injecting much-needed investments into their jurisdictions

via a currently under-resourced vehicle: STI clinics. Additionally, state health agencies with public clinics will be eligible to apply for funding under this new project.

How funds are allocated or used: The HRSA demonstration project will provide a dedicated federal funding stream ($600 million over three years) for STI clinical services to ensure providers are fully equipped to provide comprehensive STI testing and treatment in their communities. The project will also include a rigorous evaluation to determine outcomes.

The project would be administered by HRSA's Bureau of Primary Health Care. Funds would be distributed in accordance with a funding formula devised to advance the STI National Strategic Plan, with allocations to clinical providers based on morbidity and services, and awarded by a competitive application process. Public health clinics or private non-profit clinics who have demonstrated the ability to provide sexual health services to target populations would be eligible to apply for funding. Clinics must demonstrate the ability to provide key STI clinical services or develop the capacity to do so within six months of receipt of funds. In order 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 six months of receiving funds.

Public health impacts: It is time for a new investment that treats STIs within a public health framework. STIs are a growing threat to our nation's health. Chlamydia, gonorrhea, and syphilis infections breached 2.4 million reported cases in 2021. STIs can have life-changing and life-threatening consequences, including infertility, cancer, ectopic pregnancy, and pelvic inflammatory disease. Increasing cases of congenital syphilis in newborns are particularly worrisome; cases of congenital syphilis have increased 235% since 2016, and deaths associated with congenital syphilis have increased 210%. Treatment is prevention for these bacterial infections and creating a federal funding stream to support STI clinical services across the country is a crucial component of reversing these epidemics.

Background information: Our nation's safety net clinical services are funded through HRSA, the clinical service expert in HHS. This makes HRSA the obvious choice to run this first-ever dedicated federal STI clinical funding stream and provide an opportunity to further integrate STI clinical services into the activities of HRSA.

For more information: www.ncsddc.org
Contact information: Stephanie Arnold Pang, Senior Director, Policy and Government Relations, National Coalition of STD Directors, sarnold@ncsddc.org, (612) 220-2446
Last revised: April 11, 2023

Organization name: Association of Maternal & Child Health Programs (AMCHP)
Topic area: Maternal and Child Health
Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies
Agency: Department of Health and Human Services
Program, office, or center: HRSA's Maternal and Child Health Bureau

Program	FY22 Enacted	FY23 Enacted	FY24 President's Request	FY24 Recommendation
Maternal and Child Health Block Grant	$747,700,000	$822,700,000	$937,300,000	$1,000,000,000

Funding recommendation: Appropriate $1 billion, which is a $177.3 million increase, for the Maternal and Child Health (MCH) Block Grant.

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

Role of the state health agency: State MCH 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 MCH population in their state, including for children and youth with special healthcare needs.

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

Public health impacts: In FY 2021, approximately 92% of pregnant women, 98% of infants, and 58% 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.

The MCH Block Grant Highlights:

- Builds local and community-based workforce capacity to address cultural awareness, racism, and implicit bias.
- Promotes access to high-quality, family-centered healthcare for all children, including those with special healthcare needs.
- Broadens the inclusivity of state and local maternal and child health data collection
- Addresses social determinants of health to improve pregnancy, birth, and infant health outcomes.
- Reduces racial and ethnic disparities in maternal, child, and infant mortality rates.

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

Supporting organizations: A total of 108 organizations signed onto this letter in support of Title V funding, including the Association of State and Territorial Health Officials, the Association of Public Health Laboratories, the Association of State Public Health Nutritionists, NASTAD, and the Safe States Alliance.

For more information: www.amchp.org
Contact information: Sherie Lou Santos, Director of Policy and Government Affairs, AMCHP, ssantos@amchp.org, (202) 964-2411
Last revised: April 11, 2023

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

Program	FY22 Enacted	FY23 Enacted	FY24 President's Budget	FY24 Recommendation
Ryan White Part B	$1,344,240,000	$1,364,900,000	$1,364,878,000	$1,488,300,000

Funding recommendation: Appropriate $1.49 billion which is a $123.4 million increase, for the Ryan White HIV/AIDS program Part B, inclusive of the AIDS Drug Assistance Program (ADAP).

Justification: The Ryan White Program Part B funds all 50 states, 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 people living with HIV who have limited or no coverage from private insurance, Medicare, and/or Medicaid.

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

Fast Facts:
77% of RWHAP ADAP/Part B programs reported that more funding was needed for either ADAP or Part B to accommodate strains from the COVID-19 pandemic.

Over 70% of Ryan White ADAP/Part B programs anticipate an increase in the uninsured rate in their jurisdiction, bringing new clients into the program.

Launched in 2019, Ending the HIV Epidemic: A Plan for America intends to reduce new transmissions by 75% in the next five years, and by 90% in the next 10 years by focusing on increasing diagnosis, access to care, access to biomedical prevention modalities, and rapid response to clusters and outbreaks. To achieve this goal, state health agencies will need additional funding.
State health agencies provide both core medical and supportive services to people living with HIV. By

HRSA's definition "Core medical services include outpatient and ambulatory health services, AIDS Drug Assistance Program, AIDS pharmaceutical assistance, oral health care, early intervention services, health insurance premium and cost-sharing assistance, home health care, medical nutrition therapy, hospice services, home and community-based health services, mental health services, outpatient substance abuse care, and medical case management, including treatment-adherence services. Support services must be linked to medical outcomes and may include outreach, medical transportation, linguistic services, respite care for caregivers of people with HIV/AIDS, referrals for health care and other support services, non-medical case management, and residential substance abuse treatment services. Grant recipients are required to spend at least 75% of their Part B grant funds on core medical services and no more than 25% on support services."

How funds are allocated or used: All 50 states, Washington, D.C., Puerto Rico, Guam, the U.S. Virgin Islands, and the five U.S. Pacific Territories/Associated Jurisdictions are eligible for Part B funding. Within the Part B award, there is a base grant for core medical and support services, the 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 in the United States who have been diagnosed. The RWHAP is crucial to meeting the healthcare needs of people living with HIV and improving health outcomes. Part B of the Ryan White Program funds state health departments to provide care, treatment, and support services and 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 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 2020, 89.4% of Ryan White Program clients had reached viral suppression. This figure exceeds the national viral suppression rate for people living with HIV. 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 transmissions. Underfunding the Ryan White Program system of care will only serve to exacerbate existing structural challenges such as the disproportionate impact of HIV on communities of color, greater poverty, lack of employment and educational opportunities, and lack of access to vital prevention, care, and treatment services.

Supporting organizations: The AIDS Budget and Appropriations Coalition supports this ask.
For more information: www.NASTAD.org
Contact information: Emily McCloskey, Senior Director, Policy & Legislative Affairs, NASTAD, (202) 897-0078, emccloskey@NASTAD.org
See updates to this paper at: https://www.nastad.org/domestic/policy-legislative-affairs
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National Headquarters: 2231 Crystal Dr #450, Arlington, VA 22202
Regional Office: 600 Peachtree Street NE, Suite 1000, Atlanta, GA 30308

www.astho.org

202–371–9090